Adults, Mental Health

Access to Prevention, Care, Treatment and Services Saves Lives and Treasury

For individuals with Mental and Substance Use conditions, access to community Education, Prevention, Care, Treatment and Services improves client outcomes, contributes to safe and healthy communities, and produces savings.

Provider Results from across the state demonstrate the value of access to community mental health and substance use prevention, care, treatment and services in children, adolescents and adult lives.

Investments in community care, treatment and services for mental and substance use disorders and conditions pay dividends. Illinois’ health care reform for complex and "high-need populations" must address health care disparities, provide culturally and linguistically appropriate care, and contain costs or generate net savings - saving both lives and treasury.

The Provider Results’ summaries from providers across Illinois provide the backdrop for the real stories on how:

- Prevention Works!
- Treatment is Effective!
- People Recover!

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Community Counseling Centers of Chicago

Eileen Durkin
President & Chief Executive Officer

Program Results:

- **Over 130** individuals successfully transitioned from institutional care to independent, community life.

- On average, those assisted through the Williams Decree have been living independently for 8 months; the first moved into the community in June of 2012.

- At an annual cost of approximately $27,500 to stay in an IMD, **C4’s work with Williams clients saves the state of Illinois approximately $1,969,000 per year**, based on the current number of consumers. The amount saved will increase as more consumers are successfully moved to community-based care and remain in the community.

- C4’s Drop-in Center, funded through the Williams Consent Decree, now serves **over 1000** individuals per month.

- Due to demand, the Drop-in Center has increased its hours to include weekends and holidays.

Community Counseling Centers of Chicago, C4, as one of the initial group of agencies serving individuals moving out of Institutes for Mental Disease (IMD) as part of the Williams Consent decree, has assisted over 130 individuals in meeting their goals of independent living by offering community based services which help individuals develop plans and successfully transition to the community, maintain their stability after transition and continue to increase their independence and community connections. As part of developing community plans, individuals are helped with all of the many steps from locating housing, to purchasing furniture, stocking their kitchens, finding a primary care physician, learning a new neighborhood and practicing and strengthening the skills to shop, cook, clean and enjoy themselves in the community.

While statistics and cost savings are impressive, the most meaningful successes are the individuals who have successfully moved to the community, are living in their own apartments and leading more independent lives.

**Success Story**
Sarah is a 55 year old woman who estimates she had had over ten hospitalizations and had been living in IMD’s for seven years before engaging with C4 and moving into her own apartment in the fall of 2012. She now has a place to enjoy visits from her children, her grandchildren, her cousins and friends. She gets her primary medical care through Heartland Health Care on-site at C4. She sees a psychiatrist at C4 every two months to continue her medications. She receives service from one of C4’s community support teams and only needs their services two or three times a week for a total of about three hours. What a change from living 24 hours a day in an institution.
Psychosocial Rehabilitation (PSR) Program

Saving and Improving Lives

The PSR program is designed to help clients with severe or persistent mental illness live an independent, quality life in their community, free of stigma. Groups cover a range of topics, including coping with illness, life management skills, prevocational skills, health and wellness, problem solving, political action, and other individual and group activities that foster growth in recovery, empowerment and competency. Groups within the PSR program are held primarily on-site at Turning Point, though some groups do travel within the local area to promote community integration. Groups are offered every day, between the hours of 9am and 3pm; during the busiest hours of the program, 2-3 groups are offered each hour, providing members with flexibility and choice in identifying groups, with the help of their individual providers, that best match their individual treatment goals.

Program Outcomes

Internal reviews of outcomes of clients who participate in the PSR program has demonstrated goal attainment at Expected or Better than Expected levels in 100% of reviewed members. Members who have transitioned or “graduated” from the program have self-reported improvements in symptom management, increase in comfort in social interactions, attainment of skills of independent living, with many obtaining employment, subsidized housing, or volunteer opportunities through support received from PSR program and their individual program providers.

Population Served

Turning Point Behavioral Health Care Center’s Psychosocial Rehabilitation program (PSR) is for adults (18 years old and older) with severe and/or persistent mental illness. The PSR program currently has approximately 80 individuals.

Goals of Program

The PSR Program is built around supporting each client's Individual Treatment Plan as developed with his/her individual therapist or case manager. The focus is on respecting individual differences in abilities and competencies while advocating for client's rights and promoting a sense of self worth.

Turning Point’s PSR Program is designed to provide a wide range of groups to serve the varying needs of adults with chronic mental illness. There are groups to help clients who have the capacity and desire to achieve the level of independence needed to return to employment or community roles. There are also groups that aim to achieve the following: 1) to help clients live with their illness and maintain their highest level of functioning, 2) to assist clients as they work to improve their levels of community integration, 3) to provide opportunities for self expression, 4) to help clients in developing social, coping and independent living skills through safe, social-recreational events. Groups are interpersonal, supportive, skills-building, process, and educational in nature.

Solid support. When you need it most.

Accredited by the Commission on Accreditation of Rehabilitation Facilities
The Living Room at Turning Point

Saving and Improving Lives
Community-Based Alternative. Reduces Costly Emergency Room Visits and Promotes Recovery

“I thought I might need to use the ER, but then I saw this brochure and thought, ‘Maybe I don’t.’,” a recent “guest” to The Living Room at Turning Point describes the decision to try something different.

Some of the important outcomes achieved by The Living Room include:

1. $348,036 average savings in Emergency Room Visits in FY2013, and $276,644 as of December 2013 in FY2014
2. Over 93% of guests to The Living Room at Turning Point were deflected from EDs over the course of FY2013 and up to December in FY2014
3. Eighty-four percent of guests as of December in FY2014 who arrive in crisis at The Living Room at Turning Point leave feeling the crisis has been resolved at time of departure.
4. Waiting Time and overall time spent on psychiatric crises is greatly reduced compared to EDs and often determined by the pace of the person in crisis. Guests of The Living Room at Turning Point on average spent under 2 hours managing crisis per visit.

The Living Room at Turning Point, was developed to provide an alternative option for addressing people experiencing mental health crisis. It is focused on providing a warm, inviting, non-sterile environment in which “guests”, people traditionally called patients, can resolve their crises without requiring an Emergency Department (ED). The goal of the program is to provide a calm, safe environment without more intrusive intervention. In addition, when people can resolve their crises without the use of Emergency Departments, they experience less disruption in their lives and they are empowered in their recoveries. Therefore, The Living Room at Turning Point is a win for both mental health consumers and the State of Illinois by offering consumers an alternative to EDs while simultaneously decreasing demand on the EDs at nearby hospitals.

Research on psychosocial rehabilitation (PSR) interventions generally indicates that these approaches are effective in facilitating improved functioning for persons with serious mental illness. For example, from 2002 to 2008, a Midwestern VA Medical Center implemented a number of PSR interventions. Analyses revealed that the provision of PSR services to veterans with serious mental illness who had been hospitalized was associated with decreased duration of hospitalizations and costs savings of $17,739 per veteran per year in total mental health care. (VanMeerten NJ, Harris JI, Nienow TM, Hegeman BM, Sherburne A, Winskowski AM, Schumacher M, Sponheim SR, 2013. Inpatient utilization before and after implementation of psychosocial rehabilitation programs: analysis of cost reductions. Psychol Serv. Nov;10(4):420-7. doi: 10.1037/a0031159. Epub 2013 Feb 11).

Solid support. When you need it most.

Accredited by the Commission on Accreditation of Rehabilitation Facilities
Trinity Services Inc. is a nonprofit, non-sectarian organization that serves persons with mental illness and intellectual disabilities. In addition to being the largest Community Integrated Living Arrangements (CILA) provider for persons with Intellectual Disabilities in Illinois, Trinity Services also operates a behavioral health department that offers a number of mental health services within a variety of settings. Trinity has three psychosocial rehabilitation programs (PSR) in the southwest suburbs that specialize in serving persons with mild intellectual disabilities and/or serious mental illness. The goals of these PSR programs include promoting increased independence, improved physical and mental health, and maximizing potential. The programs are founded on evidenced-based psychotherapeutic models, and they provide individual and group psychotherapy, as well as community integration. Persons with mild intellectual disabilities and/or serious mental illness often present with significant clinical challenges, and most of the program participants were previously discharged from other providers. It is common for these individuals to have numerous and prolonged hospital stays and periods of incarceration prior to receiving services at Trinity. For instance, one individual had more than 12 psychiatric hospitalizations in the year prior to her admission to Trinity’s PSR program and residential program. Since beginning services at Trinity, she has had no psychiatric hospitalizations. Comparing the year before she was served by Trinity and the year after, the reduction in hospital admissions resulted in a costs saving of approximately $40,000. Additionally, another individual was incarcerated for 2 months prior to beginning services with Trinity. Since her admission to Trinity this past July she has not been incarcerated, resulting in an estimated cost savings of $20,000.

The Trinity Services Family Counseling Center (FCC) is a community mental health center that has 4 locations throughout the southwest suburbs of Illinois. In FY13, there were 7,374 clinical contact hours. In addition to individual and group psychotherapy, the Family Counseling Center also offers the Individual Placement and Support (IPS) program. The Department of Human Services played an integral role in this program’s development. The IPS is a joint effort between FCC and Supported Employment staff to ensure rapid job development. This program utilizes evidenced-based supported employment procedures and operates on the theory that employment is a part of the healing process, and continues even when the individual is displaying symptoms or is not medication compliant. This program has allowed persons with a serious mental illness who would have not traditionally been able to access supported employment services to obtain and maintain employment.

Additionally, Trinity operates the Illinois Centers for Fetal Alcohol Spectrum Disorders (ICFASD), located in Naperville and Des Plaines. The ICFASD is the only facility in the state of Illinois that supports persons with Fetal Alcohol Spectrum Disorders (FASD). Its primary goals include education, advocacy, and supporting persons with FASD and their family members. Fetal Alcohol Spectrum Disorders affect approximately 40,000 babies each year. It has also been estimated that approximately 75% of children in the foster care system have been exposed to alcohol prenatally, and between 25 – 40% of inmates in
corrections facilities were exposed prenatally to alcohol. The average lifetime cost for persons born with Fetal Alcohol Syndrome has been estimated at $2 million dollars, which includes medical treatment, special education, residential care and productivity losses. Since 2011, the ICFASD has served more than 40 persons with FASD. Outcomes have included transitioning an individual from a homeless shelter to supportive housing and helping consumers graduate from high school. In addition, every month a Pediatrician visits the ICFASD, which has reduced the frequency of emergency room visits and hospitalizations.
Robert Young Center
Summary of the Donated Funds Initiative Grant Results
Vicki Zude BSN, RN

CBHA excerpts

Received URAC Award in October of 2013

Goals
To develop a system of care that collaborates and coordinates care between behavioral and primary care providers.

- Physical examinations of all recipients
- Protocol for referral of high-risks individuals.
- Procedure for co-management and stabilization of patients.
- Referral process for follow-up care.
- Established integrated treatment planning.
- Increased the capacity of the FQHC to provide proactive follow-up and management of patients with behavioral health conditions in the primary care setting.

Outcome One
80% Compliance Rate for Medical/Behavioral Health Appointments

Outcome Two
100% of RYC Patients Identified to have a Chronic Health Condition Will Have an Annual Physical Completed

Outcome Three
95% of Those Identified as “at risk” for Co-Morbidity or who Have a Co-Morbidity will Receive Medical Case Management

Outcome Four
80% of Patients Receiving Medical Case Management Services will Rate an Improvement in their Quality of Life (SF 12v2)

Impact of DFI Care Coordination Bidirectional Integration and Care Coordination Project

Over Ten Quarters 3rd Q 2010 – 4th Q 2012
Average Number of Patients per Quarter 366

- 137% increase in Quality indicators

Payment data demonstrates
1. 49% decrease in Emergency room visits.
2. 54% decrease in Psychiatric admissions
3. 73 % in Psychiatric Admissions
4. Shorter length stay per admission
5. 32% decrease in Medical admissions
6. 88% decrease in Payments for Medical Admissions
Key Success Factors

- Assisting patients to navigate multiple health systems, and coordinating the care between providers.
- Providing Annual Health Risk Assessments to identify those at risk for or who have co-morbidities that may be poorly managed.
- Providing healthy living and disease management to promote self care, education; diabetes program, cardiovascular program, smoking cessation and 1:1 disease prevention and management with nursing staff.
- Implementing crisis plans and Wellness Self- Management Plans to help patients understand their path to recovery while recognizing signs of relapse and how to treat their early warning signs to prevent relapse.
- Utilizing evidence based practices such as the SF12, quality of life self- assessment that tells us if what we are doing is working so that we can modify the treatment plan if it isn't.
WellSpring Resources (WR) is changing the way our health care system works, especially for people with multiple, chronic health conditions. Through a HRSA-SAMHSA four year, $1.6 million grant, WR is integrating primary and behavioral health care for adults with serious mental illness (SMI).

Adults with serious mental illness die on average 25 years earlier than the mainstream population. They also experience higher rates of cardiovascular disease, hypertension, obesity, substance abuse, emergency room use, and hospitalization than those without SMI. The result is a group of frequent users of the health care system, with little coordination of care and poor outcomes.

It’s a challenging goal because many of the adults with SMI have problems with literacy due to poor cognitive functioning. More than 95% of participants live below the federal poverty limit. Another factor is the lack of system coordination for this group’s physical and mental health care, with the two systems treating related issues with little or no communication. As a result, follow up care and adherence to a medical regimen is poor.

Around 60% (n = 250) of all consumers recruited into Wellspring’s program smoked cigarettes at intake (of these, nearly 60% reported ‘daily’ smoking); 36% admitted to drinking alcohol, 20% smoked marijuana, 3% used crack/cocaine, and 4% used non-prescription opioids such as Oxycontin. Around 79% (n=317) of participants had experienced trauma or violence at some point in their lives.

In the first two years of the project, success has been steady - the program is at the top of all national cohorts in terms of enrolling consumers and integrating care. To date, 406 adults have enrolled in the program. Data on physical and behavioral health outcomes were collected initially and measured again at the six month point.

The results to date are significant:
- 7% of participants reduced or quit smoking
- After engagement in the program, the number of individuals who reported being homeless in the past year dropped from 43 to 2
- Emergency room visits decreased by 75% after participation in services
- Mental health hospitalizations were reduced by 82%
- Criminal justice system involvement decreased from 11 consumers to 0
- Consumers self-reported improved well-being and social connectedness
- Literally dozens of consumers are now addressing complex health issues that were previously untreated.
Glenda came to WellSpring Resources (WR) seeking help from a psychiatrist. She was the person who took care of everyone else. After several deaths in the family occurred, though, she found it hard to manage her grief and stress. She was also diagnosed with diabetes, which added to her stress. The combination made her feel depressed and lethargic.

"The doctor told me I had diabetes, but he didn’t explain what it meant. I didn’t really understand how to manage it. I was lost and really scared," says Glenda.

After enrolling in counseling, Glenda was referred to the Health Integration Project (HIP). The HIP nurses immediately began working with Glenda to get her diabetes under control. The nurses taught her how to tell if her sugar levels were too high and how to use insulin. Glenda says that the HIP nurses treated her with both respect and compassion.

"It happens a lot, that a person with mental illness is diagnosed with an additional condition — like diabetes — and the doctor doesn’t take the time to explain the condition," says Angela Manns, a nurse care specialist at WR. "They tell the patient to fix it, but don’t tell them how. People with mental illness often already feel like they are being judged, so sometimes it is hard for them to ask questions."

Glenda says that she is thankful for the HIP program and WR. "I think it is awesome that they have HIP—it makes me feel more in control of my health and it has made me feel better about myself," says Glenda.

Now Glenda is making healthier choices—she has a better understanding of how her food choices affect her diabetes and she is feeling much better, mentally and physically.

Since she feels better her relationships have improved, and she is able to spend time with friends again and is able to do more things with her kids. Glenda says she feels happier than she has in a long time.

Contact: Anne Tyree, Chief Development Officer (618) 462-2331
Homeless Young Mothers and Their Children

A collaboration between Beacon Therapeutic Diagnostic and Treatment Center and Heartland Alliance

Saving and Improving Lives!
- 80% increase in Stable Housing, Improved Educational and Income Status
- Improved Children and Mothers' Mental Health

**Family Assertive Community Treatment (FACT)** program in Chicago, Illinois on young, at-risk mothers between the ages of 18 and 25. FACT is one of four programs that participated in the **Strengthening At Risk Homeless Young Mothers and Children Initiative**. The Initiative aimed to stabilize young families in permanent housing, improve the well-being of mothers and children, and encourage collaboration across homelessness/housing and child welfare/development service systems.

The FACT program was an innovative project providing integrated, family-focused treatment and support services for young, homeless, at-risk mothers who had at least one child five years of age or younger and a co-occurring mental health and/or substance abuse disorder.

The women and children involved in FACT faced severe challenges. Upon entering the program, all were homeless, living in shelters or doubled-up with family or friends in overcrowded apartments. Many of the mothers and children had experienced high rates of traumatic life events including family separation, domestic violence and sexual assault. FACT provided services that met the needs of the families enrolled and ensured long-term stability.

The most important outcomes include the following:
- Participant’s housing stability greatly improved. At baseline, all the women were homeless or precariously housed. One year later 93 percent reported living in their own apartment in the past six months and 80 percent were currently in stable housing.
- Participant’s satisfaction with their housing improved from 28 percent to 71 percent over the one-year period.
- Participant’s ratings of improved housing increased from 23 percent to 63 percent over the one-year period.
- Participant’s level of education increased over the one-year period.
- Participant’s level of parental stress decreased over the one-year period.
- Average monthly income increased substantially from $622.08 to $881.33 over the one-year study period.
- Seventy-nine percent of the children that displayed concerns at their first or second screen improved their developmental scores.
Saving and Improving Lives

Association House serves a multi-cultural community by providing comprehensive, collaborative and effective programs in English and Spanish. We promote health and wellness and create opportunities for educational and economic advancement. Please review our most notable outcomes below:

Program Results:

- **86%** of Case Management program participants maintained housing in independent, semi-independent or family living arrangements.
- **95%** of Case Management program participants engaged regularly with a primary care doctor, specialized medical provider, and/or psychiatrist; as well as achieved or improved follow-through on treatment recommendations in order to improve health status, longevity, and quality of life.
- **78%** of Case Management program participants avoided psychiatric hospitalizations and **96%** of Counseling program participant’s avoided psychiatric hospitalizations.
- **90%** of Case Management program participants actively participated in mental health treatment and support services after being transitioned into the community in order to increase their independence and community functioning, and thus decreased the need for higher level of care services.
- **128 (92%)** Integrated Health program participants received primary health care services and were provided with education regarding hypertension, anxiety, diabetes, and importance of medication, lifestyle changes, and an opportunity for follow up with a physician, nurse and psychiatrist.
- **139 (100%)** Integrated Health program participants who received service were referred to a Primary Care Physician (PCP) and were screened for co-occurring disorders.
- Our Respite Program provided respite care/home care support to more than 60 families with persons with developmental disabilities such as low functioning autism, mental retardation, and the medically & developmentally fragile. *We are the only program in the area with capacity to serve Spanish speaking parents.*

Association House proven success and outcomes: *(Source: IL DASA Provider Performance and Outcome Report)*

- **95%** of our clients in Level I addiction treatment have no arrests 30 days prior to discharge from treatment.
- **95%** of our clients in Level II addiction treatment have no arrests 30 days prior to discharge from treatment.
- Our addiction Level I treatment completion rate is significantly higher (83.3%) than the State average (72.2%).
- **37.7%** of unemployed clients in Level II addiction treatment at Association House were gainfully employed by the end of treatment. State average is 32.8%.
We urge you to support sustainable funding in mental health and substance abuse prevention and treatment for a population that is already underserved and under resourced.

**The need for services in our community:**

- We serve a predominantly Latino population. We have one of highest rates of drug use, crime, and unemployment. The incidence of drug and alcohol related hospitalizations in the Humboldt Park area are higher than the city average. *Funding cuts will exacerbate the need for acute care and will increase State cost.*

- Substance abuse populations have about 15-30% employment rate (71-76% for non-abusers). Our community will lose comprehensive substance abuse and job training and placement services at Association House.

- We have one of the highest concentrations of released inmates. A disproportionate number of Latinos are involved in the criminal justice system due to drug use [SAMHSA, NCLR, 2009]. More than 50% of persons with substance abuse problems have a co-occurring mental health disorder however most service systems are not integrated, a problem that according to the US Department of Justice results in inappropriate services and recidivism. *Funding cuts will decimate by more than 80% our integrated substance abuse and mental health treatment even though our services have proven success.*
Community Care, Treatment and Services
Assisting Successful Recovery Across Illinois

Maine Center's Outpatient Mental Health Clinic

Our community mental health services are provided in Park Ridge and serve residents of Des Plaines, Park Ridge, Morton Grove, Niles, Glenview, the very northwest corner of Chicago, and the suburban area of Cook County north and east of O'Hare. Our primary commission is to serve adults with mental health needs with psychiatric services and an array of therapeutic outpatient treatment services to support and facilitate their recovery and integrated residence in their home communities. In addition, we provide outpatient therapy to children, their parents, and families, in support of their remaining in their schools and homes in the community.

In FY 2013, we served more than 2,000 adults and youth. Of those we served nearly 80% had individual or family incomes at or below 200% of the 2013 National Poverty Level. Our clinical staff, of fully licensed counselors and social workers, provide an array of evidence-based services which are individually planned and delivered to facilitate and support each client's needs to remain and thrive in their communities in the least restrictive environment appropriate for their needs.

- 89% of those active in their treatment were functioning at improved levels than in the previous year at the close of the fiscal year;
- 91% of those served and active in their treatment were able to remain in their communities and did not require inpatient care for the management of their mental health issues;
- 93% of those who were discharged from services report that they had made the progress in treatment that they had hoped for and were still maintaining that level of functioning three or more months after leaving services;
- 93% of those who were discharged reported that they were able to maintain themselves without need of ER or inpatient care since they left treatment at Maine Center.
- For over 35 years, Maine Center has prepared and supported dozens of folks who have moved from State supported housing into their own permanent and independent housing in the community, some with HUD supports and some completely self supported.

Maine Center services have positively served the needs of individuals as well as the taxpayers of Illinois by supporting people in their recovery and supporting them in their communities without their reliance on more costly services such as Emergency Room utilization and inpatient hospitalization.

Maine Center brings the pieces together to change lives.
Ecker’s Center’s 24/7 - 365 Crisis Teams

Outcomes:
During the period July 1, 2012 to June 30, 2013 recipients of Crisis services reported these immediate changes in their lives as a result of the service:

- 96% reported that they had a plan to take care of the crisis,
- For those in potentially life threatening emergencies their plan included an in-patient hospitalization.
- 92% reported they had referrals to the community resources they needed to carry out the plan and they understood more clearly the reason for their crisis and
- 65% said that their emotional distress was reduced as a result of the service.

As state and community in-patient psychiatric resources continue to shrink, individuals sometimes wait days in the emergency room adjacent to our Psychiatric Emergency Program office for an inpatient psychiatric bed.

Ecker Center’s Psychiatric Emergency Program provides quick psychiatric crisis intervention in person and by phone 24 hours a day 365 days a year. No appointment is needed to receive an assessment, counseling and plan development to address the presenting problem. From the hours of 5 pm to 8 am it is the only psychiatric emergency resource available for children, adolescents and their parents in the Elgin area. During these hours Ecker Center’s emergency therapists make home visits to youth in psychiatric crisis to help them and their families deal with the crisis. The program is staffed by Master’s degreed therapists.

Problems addressed:
Psychiatric emergencies involve psychotic, panicked, suicidal and/or homicidal individuals as well as those who have overdosed to the point of being suicidal. Those in crisis are often experiencing other problems such as poor health, family conflicts, job loss, homelessness and financial emergencies that contribute to their crisis and must also be addressed. For some, our services can mean the difference between life and death.

Population being served:
Psychiatric emergencies happen to people of all ages and genders. Last year (FY 13) our Psychiatric Emergency program served 318 children and teens and 1,365 adults.

Location:
The Psychiatric Emergency Program is located next to the emergency department at Advocate Sherman Hospital in Elgin. Due to its location, the staff can use the resources of the hospital’s emergency department and physicians as needed. The Ecker Psychiatric Emergency Program staff also provides on-call emergency assessments and short term crisis counseling at Presence St. Joseph and Delnor Hospitals.

Goals:
Our goal is to attend to the needs of community members of any age who are in crises. The Psychiatric Emergency Program provides a resource in the community for immediate crisis assessment and intervention for mental health problems with the goal of linkage to care in the least restricted environment but certifying admission to a community or state psychiatric hospital, when needed. Our staff evaluate, counsel, support and refer to the psychiatric hospital or agency best able to meet the client’s longer term needs with the goal of preventing more serious mental illness.
Title of Program
Bridge Program

Brief Description
This is an evidence-based transitional care model that identifies older adults in the hospital who are at risk of potential readmission post discharge.
Our community-based program assesses them in the hospital and connects them to home and community-based resources to reduce the readmission rate.
There is a strong emphasis on the psychosocial needs of older adults. The case coordinator helps the transition from hospital to home and follows up after two days. They also follow up on all referrals made in the 30-day post hospital discharge.

Goal
The goal of the program is to reduce 30-day readmission to hospital.

Population
This program focuses on people 60 years old and older.

Results
Readmission in the pilot program improved from the baseline of 21% readmissions to an average of 11.4% over the course of a year. The program funding was not renewed.
CBHA Provider Results

Title of Program:
Rural Behavioral Health Service Access via Telehealth

Brief Program Description:
- Phase I of the program was designed to provide Child/Adolescent Telepsychiatry to two of seven service counties designated as specialty shortage areas.
- Phase II of the program was an expansion of telepsychiatry services to these counties for Adult Psychiatry.
- Phase III of the program was further expanding the use of telehealth services to all NCBHS office locations within the 7 county area. Including 1 CILA Residential Facility.
- Phase IV of the program was imbedding the use of telehealth crisis services into all 8 hospital emergency departments within the 7 county area. This phase was initiated as a result of the Singer Mental Health Center Hospital closure in 2012 and known as the Northwest Crisis Care System (NCCS) project.
- Phase V of the program was imbedding the use of telehealth services within the LaSalle County Jail.

Goals of the Program:
- Creating access to specialty care in a cost effective manner by maximizing fixed human resources.
- Improving response time to crisis calls.
- Improving Emergency Department patient flow.
- Increase hospitalization deflection rates from emergency departments.

Population Served:
- The Rural Health Service Access via Technology program serves the entire age spectrum of clients who receive services with the agency 5 and up.
- Additionally, we are serving hospital emergency departments who have psychiatric crisis assessment needs.

Results/Positive Outcomes:
Goals of the telehealth program in enabling access to services; improving crisis response time, improving ER Department patient flow; and deflecting patients away from expensive inpatient hospitalizations were achieved. The settings for the telehealth services included hospitals, residential sites, NCBHS outpatient offices and jails. In Calendar Year 2014 almost 200 patients received telehealth services in hospitals and 4,670 hours of other behavioral health services were provided utilizing telehealth. It’s anticipated that future growth of the program will include expansion of telehealth to primary care settings, schools and other social service agencies. In addition, NCBHS currently has the capability to provide telehealth services in the home and work environments.
Title of Program:
LaSalle County Jail Behavioral Health Project

Brief Program Description:
Provide onsite access to specialty healthcare services for inmates residing in the county jail.

Goals of the Program:
- Provide availability of onsite psychiatry, medication management and psychiatric nursing services.
- Provide onsite therapy/counseling services
- Provide onsite and offsite case management services for inmates suffering from mental health and co-occurring substance issues.
- Mental Health Sick Call triage and management.
- Mental Health Crisis Service response as warranted.
- Availability of Mental Health First Aid training for all jail personnel.

Population Served:
- LaSalle County Jail inmates.

Results/Positive Outcomes:
Goals of the program in providing desperately needed mental health services and in reducing the costs of unmet mental health needs at the jail were achieved.

December 2012 – October 2014
LaSalle County Jail Service Summary

<table>
<thead>
<tr>
<th>Service</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unduplicated Clients Served</td>
<td>350</td>
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<tr>
<td>Therapy/Counseling Client Hours</td>
<td>1566</td>
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<tr>
<td>Community Support Client Hours</td>
<td>33</td>
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<tr>
<td>Psychiatric Services Client Hours (MD)</td>
<td>169</td>
</tr>
<tr>
<td>Medication Services Client Hours (RN)</td>
<td>216</td>
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<tr>
<td>Average # of Mental Health Sick Call Requests per week</td>
<td>11</td>
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<tr>
<td>Trustee Status Evaluations</td>
<td>1</td>
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<tr>
<td>Average cost per inmate for mental health services</td>
<td>$444.00</td>
</tr>
<tr>
<td>Percent of inmates linked for outpatient services upon release</td>
<td>70%</td>
</tr>
</tbody>
</table>

*Average based on 23 months of service delivery.
CBHA Provider Results

**Title of Program:**
Permanent Supported Housing

**Brief Program Description:**
North Central Behavioral Health System offers the opportunity for individuals to live in integrated permanent housing (typically rental apartments) linked with flexible community-based mental health services for individuals who have moderate to severe impairments or problems in functioning. These individuals are in need of moderate levels of continuous paid supports. The combination of housing and supportive services is designed to help individuals obtain or maintain stable housing and experience a more productive life.

**Goals of the Program:**
- To support individuals within their community to maintain their own residence and independence.
- To reduce the number of individuals who are living in 24-hour supervised residential homes.
- To reduce the length of stay for individuals residing in nursing homes.
- To reduce occurrences of psychiatric hospitalizations.
- To reduce occurrences of physical health hospitalizations.
- Increase individuals functioning, build skills, educate individuals about managing behavioral health symptoms.
- Meeting the basic needs of housing, employment, education, and natural supports.

**Population Served:**
- SPMI (seriously – persistently – mentally – ill)
- Diagnosis Categories of; Schizophrenia, Substance Use Disorder, Obsessive Compulsive Disorder, Major Depression, Bipolar, Trauma and Stress Disorders.

**Results/Positive Outcomes:**
- Overall 147 unduplicated clients were served during the four year period.
- From the start to end of year one there was a 50% increase in clients served
- From year one to year two there was 49% increase in clients served
- From year two to year three the number of new clients served doubled.
- The number of clients served in year four dropped slightly, but remained above the target of 90.
- Overall for the four year period 132 people remained housed and engaged in treatment out of 147 for 90% success rate.
- Goals of the program in reducing costs through deflections from much higher cost services were achieved.
Adult Mental Health at Metropolitan Family Services

Metropolitan Family Services is committed to support those who are most vulnerable by offering recovery-based services to avoid psychiatric hospitalization and to maintain clients in the communities. This cost-savings to the state of Illinois also supports reintegration into community-based living and reduces reliance on institutions to care indefinitely for clients at risk due to mental health conditions.

The adult mental health programs at Metropolitan Family Services provide an array of psychiatric and rehabilitative services aimed at supporting clients’ recovery and ability to manage the symptoms of their illness. We work with clients to live independently at highest level of functioning and social integration in the least restrictive environment possible.

Year to date the adult mental health programs at Metropolitan Family Services have serviced 1570 clients (18 years old and older) with severe and/or persistent mental illness predominately from the South Side of Chicago and Southwest suburbs.

**Adult Outpatient Mental Health (AMH):** Offers counseling, group services, case management and psychiatric services to individuals with severe and persistent mental illness to help them live productively and independently in their communities. The program also provides crisis intervention and special services for veterans. Hospitalization rates for these clients are consistently half the state’s average and through the second quarter the hospital recidivism rate is 2.3%.

**Community Integrated Living Arrangement (CILA):** Metropolitan Family Services has two CILAs which offers a supported, shared-apartment living environment for adults with mental illness, with staff on-site 24 hours a day. Staff provides counseling, case management, medication monitoring, transportation to medical appointments and training to learn daily living skills. 15 program graduates were able to move to community living thus reducing costs of residential or nursing home placements. Average time in CILA is 2 years before transitioning into the community, where the annual saving per client is estimate over $11,000.

**Acute Community Services (ACS):** DMH grant funded program that is part of the Region I South Crisis Care System. Intensive outpatient mental health and psychiatric services are available to adults being discharged from a hospital emergency room, psychiatric hospital or DASA crisis residential facility. The program provides crisis intervention and recovery oriented services with special programming for clients with psychotic disorders. Year to date the rate for hospital re-admissions within 30 days is 7%. The national rate is 22% (Center for Mental Health Services Administration Report, 2010).
Human Support Services  
Waterloo, Illinois  
www.hss1.org  

Provider Results that Improve Lives and Save Funds

Title of Program: Bradford Apartments Supervised Housing

Program Description: Bradford Apartments is a 22-unit housing program for adults with significant mental health concerns that require 24-hour on-site supportive services. This type of housing is for people who have difficulty living successfully in the community and who may become homeless or institutionalized without assistance.

Program Goals: For newer residents the primary goal is to help the residents learn to stabilize their symptoms and to improve their functioning in order to avoid hospitalizations and community problems. As improvements occur program staff then help residents to work on their illness self-management and to learn skills necessary for independent living. When these skills are acquired, a plan to transition the resident to a more independent setting is developed.

Program Functioning: The programming provided in the Bradford Apartments Supervised Housing program is designed to promote independence in daily living, economic self-sufficiency and integration into the community. Supports provided include financial case management, medical supervision and transportation. As residents achieve success and demonstrate the ability to live more independently the staff and residents then work together to move the residents to housing with more independence, most typically into supportive housing. Supportive housing units are special rental apartments that have trained staff available on an intermittent, not continuous, basis to assist residents. Residents in supportive housing continue to be linked to services offered in the HSS main building in Waterloo, including counseling, medications and vocational services as well as to other needed services in the community. Movement between these two levels of care is dictated by each resident’s need for services. The agency goal is to serve the client in the least restrictive environment.

Positive Outcomes: To be eligible to be a resident, individuals must have a history of either being hospitalized for mental health concerns or be eminently at risk of hospitalization or homelessness. Many of the residents have had multiple and at times lengthy hospitalizations. Our experience with these residents shows that over the last three years only 5% of residents required a hospitalization for mental health concerns. Also, all of these residents avoided emergency room visits due to their mental health concerns in this period (excluding ER visits occurring during an inpatient admission). On the other end of the spectrum, about 10% of program residents each year move successfully to a less restrictive setting. Another benefit to the individuals in the program and to the community is that while in the program no residents abuse alcohol or illegal drugs; staff are able to prevent this from occurring. Comparatively, national surveys suggest that 23.2% of individuals with serious mental illness, such as the residents at the Bradford Apartments, abuse or are dependent on drugs or alcohol. Often it is abuse of drugs and alcohol that lead to incarceration of persons with serious mental illness. Not surprisingly, none of the Bradford residents were jailed during their time in the program.
Title of the Program

Intensive Outpatient Crisis Program (IOCP)

Brief Program Description

The Intensive Outpatient Crisis Program (IOCP) is an interactive program that operates within our Crisis Residential Program. The IOCP focuses on problem solving and coping skills such as setting goals, recovery strategies, stress management, relapse prevention, and mindfulness.

Goals of the Program

The overall goal of Intensive Outpatient Crisis Program is for participants to learn, practice, and use skills that will improve their ability to function independently, manage their illness with as little outside intervention as possible, and achieve personal wellness goals. We encourage participants to learn about their illness, to identify areas in their lives that aren’t working out as well as they would like, and develop strategies to overcome these challenges.

Population Served

The Intensive Outpatient Crisis Program serves adults with serious mental illness who are in need of intensive therapeutic services.

Results/Positive Outcomes

Participating in IOCP groups has helped people to:
- avoid a hospitalization
- maintain their housing in the community
- return to their jobs
- improve relationships with their family/support system
- connect to needed services
- navigate multiple health systems
- coordinate their care modes to get their psychiatric, medical, and recreational needs met

Participants who completed at least 70% of the groups:
- improved their functioning (4.6 increase in GAF scores),
- engaged very well and exceeded their objective in the groups (86% engagement score), and
- completed most expectations within the groups (2.25 progress score out of a possible 3.00)
Title of the Program
Psychiatric Assessment Services

Brief Program Description
Human Resources Development Institute (HRDI) provides mobile assessment services for adults who are experiencing a psychiatric crisis and seek treatment at a local emergency department. During the assessment, adults in crisis (who are admitted to the emergency department at a hospital on the Southside of Chicago) are provided with supportive assistance and if necessary, linkages to resources within the community.

HRDI maintains professional clinical staff on duty 24-hours-a-day to provide mental health emergency services. Hospital staff at participating facilities are provided with an emergency crisis line where HRDI crisis clinicians receive calls 24 hours a day, 7 days a week. Once called, HRDI clinicians are required to be on site for the assessment within 60 minutes.

Goals of the Program
Psychiatric Assessment Services (PAS): PAS staff provides Eligibility, Disposition and Assessment (EDA) services to patients at Jackson Park Hospital, St. Bernard Hospital and Roseland Hospital who are experiencing a psychiatric crisis.

- Research supports the idea that individuals who require services should receive them in the moment of crisis. To that end, the Crisis program is required to ensure that an HRDI clinician will arrive on site within 60 minutes of an EDA referral.
- Additionally, in order to prevent recidivism and to prevent clients being lost to follow up after discharge from a psychiatric hospital, the crisis program is required to ensure that follow-up is completed within 24 hours for clients receiving an EDA assessment as well as linkage to services.

Population Served
Adults in psychiatric crisis.

Results/Positive Outcomes
- HRDI provided 218 EDA’s in the 4th QTR of 2014 for a total of 954 EDA’s to 834 unduplicated clients in FY’14. One-hundred percent (100%) received a follow-up and linkage within 24 hours.
- HRDI provided 310 EDA’s in the 2nd QTR of 2015, for a total of 693 FY-to-date. One-hundred percent (100%) received a follow-up and linkage within 24 hours.
- HRDI provided 218 EDA’s in the 4th QTR of 2014 for a total of 954 EDA’s FY’14. The clinician arrived on-site within 60 minutes of referral 100% of the time.
- HRDI provided 310 EDA’s in the 2nd QTR of 2015, for a total of 693 FY-to-date. The clinician arrived on-site within 60 minutes of referral 100% of the time.
Net Saving and Improving Lives

Title of the Program
Heartland Health Outreach’s Pathways Home

Pathways Home Program Description
Pathways Home is a continuum of residential and outpatient services designed to address the needs of homeless adults with serious mental illness and co-occurring substance use disorders, who are typically high utilizers of Medicaid services.

Goals of Pathways Home
The goals of Pathways Home program are:
- To engage individuals and build a trusting, therapeutic alliance.
- To encourage participation in mental health and substance abuse services as the participant is ready.
- To provide motivation to explore change.
- To improve the success and stability of linkage to necessary services.
- To address barriers and fill gaps in the service delivery system so that it may better serve individuals with dual disorders.
- To assist participants who wish to move in locating, securing and maintaining housing in the community.

Population Served by Pathways Home
Pathways Home serves individuals eighteen or older, who meet the HUD definition of homelessness, and who are diagnosed with a serious mental illness, and have a co-occurring substance use disorder. Many have been chronically homeless (seven years or more) and in addition to a mental illness and substance use disorder have more than one chronic physical health conditions.

Pathways Home’s Positive Outcomes
FY2014 Pathways Home positive outcomes include:
- Provided housing for 65 individuals who had been homeless and who have a serious mental illness and co-occurring substance use disorder.
- Provided 17,338 nights of service indicating maximum utilization of the program.
- 96 percent of participants routinely avoid psychiatric hospitalization, indicating that they have been able to achieve psychiatric stability.
- 95 percent of participants adhere to psychotropic medication treatment as evidence
by medication compliance.
• 70 percent of participants report stable or improved physical and emotional symptoms as measured by the SF-8 Health Survey.
• 96 percent of individuals are still housed 60 days post-discharge.
• 92 percent of individuals are linked to services 60 days post-discharge.
• Pathways Home program averages a score of 4 out of 5 on participant satisfaction surveys.

Cost Savings
The cost savings of these programs extends further into the Medicaid system. Medicaid costs between 2011, when all 31 were homeless, and 2013, when all had been stably housed and provided intensive case management for a full year indicate the following cost savings:
• A 50% decrease in inpatient hospitalizations at a cost savings of $265,000;
• A 27% decrease in outpatient hospitalizations at a cost savings of $17,000;
• A 100% decrease of the use of nursing homes at a cost savings of $112,000;
• Decreases were also seen in the costs of physician visits, pharmacy expenses, and other ancillary expenses for a total decrease of 34% in Medicaid expenditures for this population.
• The total cost savings for 31 participants was $417,000. That averages to $13,452 savings per individual. (Data from Centers for Housing and Health)
• In 2014 Pathways Home housed 65 individual and saved the Medicaid service system $874,380 dollars. As important, Pathways Home improved the lives of some of Illinois’ most vulnerable individuals, helping them recover housing, health, and hope.

Participant Story
In June HHO housed “Kyle”, within two weeks of its first engagement with him. “Kyle” is a 55 year old man who reported having been chronically homeless since he was 20, with his most recent episode having lasted two and one-half years. He has been diagnosed with Schizoaffective disorder and a substance use dependence. He has multiple medical conditions and a history of head trauma. By his own report, “Kyle” has used the emergency room over 100 times in the past two years, citing the need for medications, shelter, and food. The average cost of emergency room visit is $2,168. Based on Kyle’s self-report and the average cost of an emergency room visit, we project that, at minimum, Kyle has used $216,800 of emergency health care services over the last 2 ½ years. Furthermore, Kyle reports having “hundreds” of arrests for minor infractions, such as intoxications or fighting. The average cost of a day at Cook County jail is estimated to be $190. Based on Kyle’s self-report, if he were arrested and incarcerated 100 times that would be a cost of $19,000. However, he reports, having been arrested “hundreds” of times. “Kyle’s” use of emergency health care and his involvement with
the criminal justice system are typical of individuals who have a serious mental illness and substance use disorder and who are homeless. In fact, these systems are the defacto systems of care that Illinois provides for this population, when it fails to adequately support permanent supportive housing programs, such as Pathways Home.

Since having moved into HHO’s Pathways Home, Kyle has been hospitalized only once. He has not been arrested at all. He has agreed to allow staff to support him through medication monitoring, and he is now connected to a variety of medical and support services. He is also stably housed. In short, since he has been housed at Pathways Home, the healthcare and the justice system have been saved more than $100,000 dollars.
Tazwood Center for Wellness
Improving Lives and Saving Money for the State of Illinois

HOW LIVES ARE IMPROVED AND IMPACTED:  Tazwood Center for Wellness is the only community-based, outpatient, non-profit behavioral health agency serving Tazewell, Woodford, and Logan Counties. In FY 2014, we served more than 3,900 adults and youth residing in those and surrounding counties. Of those we served, nearly 3,760 were at or below the national poverty level. Also, of those we served, over 91.06% maintained or showed improvement.

If mental health and substance abuse capacity grant funding from the State is reduced, the lives and health of those we serve will be significantly impacted. Access to services would be severely affected because there are no other agencies which provide the full complement of mental health, substance abuse, case management, peer support, psychiatric, crisis/emergency, and residential services within the counties we serve.

HOW TAZWOOD SAVES THE STATE MONEY:  As an accredited outpatient provider of direct and supportive mental health and substance abuse counseling services, Tazwood Center for Wellness saves the State of Illinois money as follows:

- **Average Emergency Room Visit - $2,027 per visit***
  Tazwood provided initial services to 1,625 people; most were in crisis. Almost all visits were resolved without an Emergency Room visit. Average cost of initial visit was $140.

- **Average Hospital Inpatient Stay - $4,301 for a 6 to 10 day stay***
  Tazwood provided emergency room intervention services to 1,097 people. 90% were deflected from costly inpatient hospitalizations.

- **Average Annual Nursing Home Costs - $31,400 per year***
  Tazwood provided residential services to over 29 individuals last year. Average annual cost of stay was $10,800 per year.

- **Average Incarceration Costs - $430 per day per inmate* ($12,900 for 30 days)**
  Tazwood screened 962 people for substance abuse. 97% were not arrested in the last 30 days of treatment. Average cost of treatment was $2,500.

- In the last year, we have provided Psychiatric services to 865 unique individuals. These services are essential to reducing relapse from all forms of mental illness thus reducing hospital stays, emergency visits and referrals to nursing homes.

HOW YOU CAN HELP:

Support **no reduction** in mental health and substance abuse funding. Please consider the effect budget cuts to behavioral health funding will have on the population we serve, both the financial and human costs. Additionally, please consider that according to data provided by the Illinois Hospital Association, when the state reduced its behavioral health funding between 2009 and 2012, “…the state actually increased its costs by an estimated $18.4 million when it cut community treatment services.”*

*2013 Thresholds Policy Brief, Chicago Tribune editorial (Nov. 2014)
TAZWOOD CENTER FOR WELLNESS SERVICES

Outpatient Mental Health Services
Tazwood provides comprehensive outpatient mental health services that include assessment, individualized treatment planning, individual and group counseling, case management, skill building, peer support, support groups, and psychiatric services. Tazwood’s collaborative approach and quality services assist individuals in improving behavioral health, independent living skills, physical health, self-care, relationships, employment, education, and self advocacy. This combination of services provides the supportive environment that is essential in aiding individuals in maintaining wellness and in their recovery from emotional concerns, mental illness, and addiction and inturn living an independent, productive, and satisfying life.

Key Success Factors:
Outpatient counseling, community support, supportive housing, case management, and psychiatric services:
- Decrease emergency department visits, psychiatric hospitalizations, and risk to the individual and community through crisis and recovery planning.
- Decrease the need for residential and nursing home placement by assisting individuals in accessing necessary resources such as psychiatric appointments, pharmacies, physical healthcare providers, grocery stores, and food banks. Access to these resources improves ability to continue living in the community.
- Reduce the need for clinical services by supporting independent living, teaching daily living skills, improving coping skills, and linking to vocational supports.
- In FY14, Tazwood’s Counseling Program served over 1700 adults and youth struggling with significant mental health concerns such as depression, anxiety, abuse, and trauma. These counseling services improved individual’s ability to successfully function in the community.
- In FY14, Tazwood’s Community Support Program helped over 330 individuals live independently in the community. Without community support services, many of these individuals would decompensate and possibly need hospitalization or residential care.
- In FY14, Tazwood’s Supportive Housing Program assisted over 130 individuals in obtaining community based housing, accessing resources, obtaining healthcare benefits, and improving their ability to live independently. These services have increased engagement in community activities, led to individuals served forming non clinical support groups, and decreased the need for more intense clinical interventions.

Crisis Intervention/Emergency Services:
Tazwood offers 24/7 Emergency Response Services which provide crisis intervention with the goal of de-escalation and reduction of emergency department visits and psychiatric hospitalizations. Without having a 24/7 crisis service, many people seeking help for their crisis would be contacting the police or going to the Emergency Departments.

Key Success Factors:
- Tazwood has provided about 1200 hours of crisis services so far this fiscal year, averaging 170 hours per month.
- Approximately 90% of our crisis contacts are able to remain in the community and do not require emergency department visits or psychiatric hospitalization. Our crisis intervention services help keep individuals safe during transition and help them avoid becoming a serious threat to themselves or others.
- Funding our services helps improve the quality of life for the people we serve and helps prevent overburdening of other resources in the community.

Outpatient Substance Abuse Services
The mission of the Substance Abuse Department is to help people get achieve and maintain sobriety. Clients learn how they have been impacted by the disease of addiction and begin taking personal responsibility for their recovery. As a result, clients are enabled to make healthy decisions in all areas of life. These decisions have a dynamic and profound impact on their personal health, families, employers and communities.

Key Success Factors:
- 69% of our clients completed treatment, versus the state average of 51.2%
- 54.9% of our clients were connected with 12-Step support, versus the state average of 37.3%
- 97.7% of our clients developed supportive interactions with family and friends, versus the state average of 76.2%
- 52.3% of our clients are employed (part or full) at discharge, versus the state average of 42.6%

Tazwood relies heavily on Medicaid and DASA funding through the state to provide services to clients. A reduction in this funding would limit most clients’ access to services due to financial or mobility constraints.

Residential Programs
The mission of our residential programs is to help people recover. We do this best by providing a safe place to develop needed personal recovery goals, by fostering an environment conducive to both relationship-building and skill-building, and by giving individuals the opportunity to move past prior bad outcomes in their lives and create new ones. We have assisted these individuals in learning the skills necessary to live successfully in the community, to develop a confidence in themselves and their abilities. We strive to instill in our residents every day that recovery is real, and the continued success of our programs is testament to that belief.

Key Success Factors:
- Current residents collectively accounted for at least 90 psychiatric hospitalizations, with nearly 20% of those occurring in state-operated facilities.
- Almost half of all current residents have spent time living in nursing homes, resulting in 22 years of collective nursing home placement.
- In the last year, over 75% of new intakes into our residential programs came from more cost-prohibitive forms of care; almost half came from nursing homes.
- In the last two years, we have moved eleven individuals into independent apartments in the community.
Saving and Improving Lives

**Title of the Program**
Psychosocial Rehabilitation (PSR), Mount Sinai Hospital, Department of Psychiatry and Behavioral Health, Sinai Psychiatry and Behavioral Health

**Brief Program Description**
Psychosocial Rehabilitation Program is an intensive, five day per week, four hour per day, adult outpatient program that offers a scheduled series of structured, face to face therapeutic groups. Services include crisis intervention, treatment planning, assessment, individual and group therapy/counseling, recovery services and case management. Program serves up to 40 individuals.

**Goals of Program**
The goals of the Psychosocial Rehabilitation Program are to stabilize acute psychiatric symptoms, prevent hospitalizations and to promote recovery and community integration. The program is designed to help persons to optimize their personal and social competency in order to live successfully in the community.

**Population Served**
Adults, with Serious and Persistent Mental illness, who are at high risk of psychiatric hospitalization.

**Results /Positive Outcomes**
- Decreased psychiatric admissions
- Reduced symptoms of mental illness
- Improved recovery and community integration

February 24, 2015
Saving and Improving Lives

**Title of the Program**
Trauma Recovery and Empowerment (TREM), Mount Sinai Hospital, Department of Psychiatry and Behavioral Health, Sinai Psychiatry and Behavioral Health

**Brief Program Description**
TREM model guides leaders through the entire trauma recovery process. Therapist and physicians discovered that trauma (past or present) may cause the following problems: depression, anxiety, physical symptoms such as headaches, muscle aches, stomach cramps, addictions to drugs, alcohol or food and problems with relationships. This model was developed and refined to include interventions that include social skills, psycho educational and psychodynamic techniques, and peer support.

**Goals of Program**
- Basic Education about abuse and how current behaviors are linked to past abuse.
- Reframing of current symptoms as attempts to cope with unbearable trauma
- Problem solving attempts locked and hidden in repetitive behaviors
- Education on basic skills in self regulation, boundary maintenance, and communication
- Basic education about female sexuality, misperceptions and misconceptions
- Creation of healing community by providing recovery services
- Rediscovery and reconnection to lost memories, feelings and perceptions
- Opportunity to experience a sense of competence and resolution with demons from past
- Opportunity to trust their own experience and receive validation

**Population Served**
Women with Serious Mental Illness that are over 18 and have a history of trauma or are currently in abusive relationship

**Results /Positive Outcomes**
The TREM model is facilitated in a group model therefore two therapist spend two hours with 10-15 women in group. This maximizes staff utilization and enables our therapist to provide services to women with similar traumas, issues and build a support network for the clients to rely on when program is completed.

In review of last group, 15 clients began the TREM group over a period of five months. 8 clients reported feeling better and learning from the group. 7 dropped out of group and were unable to measure effectiveness.

February 23, 2015
“Net Savings and Improving Lives”
Region I Crisis Services Overview

The Eligibility and Disposition Assessment (EDA) service is an element of the Region 1 South Crisis Care System (R1S/CCS), and is intended to determine appropriate placement for unfunded clients with a psychiatric diagnosis who present at Emergency Departments.

The Emergency Behavioral Healthcare Center (EBHC) provides EDAs on a 24-hour, 7-day-per-week basis. The primary activities of the EDA Team are as follows:

- Conducting hospital-based screenings of adults who would have been served at the former state-operated Tinley Park Mental Health Center;
- Providing EDAs at Emergency Departments in the defined geographic area of Region 1 South;
- After assessment, linking eligible individuals to appropriate state-operated or Community Hospital Inpatient Psychiatric Services (CHIPS) hospital, substance abuse services (i.e., Department of Alcohol and Substance Abuse), crisis or outpatient services.

Program Goals:

To provide appropriate placement and clinical care for unfunded clients with a psychiatric diagnosis.

Population Served:

The population served includes those who:

- Are ages 18 and above who are unfunded with a psychiatric diagnosis.
- Present at South Suburban Hospital, St James Hospital (Chicago Heights and Olympia Fields), Palos Community Hospital, Little Company of Mary Hospital or Metro South Hospital in psychiatric crisis.
- Are without insurance, including Medicaid or veterans benefits.
- Have a preliminary diagnosis of mental illness, or dually diagnosed with mental illness and substance use disorder.

Results/Positive Outcomes:

GPS completed a crisis assessment for 762 unduplicated individuals who otherwise would have utilized more expensive hospital services or been hospitalized. In addition, provided follow-up, linkage, case management and psychiatric services to ensure successful recovery and decreased recidivism. In addition, GPS assisted individuals in applying for public entitlements to ensure continued medical and psychiatric care.
Psychiatric Services Overview

Psychiatric staff are available onsite at scheduled hours each week and available on-call to assist with clinical emergencies. Psychiatric staff also provides supervision to prescribing staff. The service provides clinical direction, medication education, administration, monitoring and management and performs care coordination activities with other healthcare providers on behalf of the patient.

Primary Services Provided:
- Medication management, monitoring and administration
- Individual and group therapy and counseling
- Crisis intervention
- Community-based services
- Case Management/Linkage and coordination of services
- Psychiatric consultation

Services are available at several locations and include day and evening hours. 24-hour services are available through the Emergency Mental Healthcare Center, a 10-bed inpatient stabilization unit aimed at preventing hospitalization thus, reducing recidivism.

Population Served:

This program assures access to psychiatric services for persons with serious mental illness (SMI) or serious emotional disturbance (SED) including children and adolescents.

Program Goals:

Psychiatric services provide behavioral healthcare services to individuals and families necessary to remain in the community and prevent psychiatric hospitalization. The primary objectives of the service are:

- To provide effective short-term, solution-focused treatment, and to maintain managed options for longer-term care;
- To provide clinical evaluation, including psychological and psychiatric assessment;
- To provide community education and family life education services to meet specific needs; and
- To develop and maintain specialized services to meet the needs of unique populations and circumstances.

Results/Positive Outcomes:

GPS provided aftercare psychiatric services for 2,339 unduplicated adults and children for whom without services may have resulted in psychiatric hospitalization, homelessness or possible involvement with the criminal justice system due to lack of care. GPS provided prevocational, volunteer and employment opportunities for individuals. Furthermore, through the Consumer Advisory Committee, the opportunity to engage in important decision making on a state and legislative level.
“Net Savings and Improving Lives”

Residential Services Overview
Continuum of Services

Grand Prairie Services (GPS) Residential Services is a resource for individuals who have a serious psychiatric condition which may place them at risk of homelessness. Residential Services’ overall mission is to provide a continuum of services that are clinically appropriate and medically necessary. Such services are provided to ensure recovery as individual transitions to increased independence in the community. Moreover, GPS partners with consumers in their quest toward their ultimate goal of independence.

Program Goals:

The aim of Residential Services is to provide the level of living support that will allow an individual to make continued progress toward his or her recovery goals. Support services are provided which rests on the foundational principles of recovery: preference, community integration, skill development, spirituality, economic self-sufficiency, health and wellness. GPS believes that the best course toward recovery and overall independence must include the following:

- Consumer Preference
- Community Integration & Support
- Skill Development
- Spiritual Development
- Economic Self-Sufficiency
- Health & Wellness

GPS Mental Illness Residential is comprised of eleven houses and/or apartment dwellings and 68 scattered site apartments scattered throughout the south suburban area. Residential Services has the capacity to provide care for over two-hundred individuals and families. All consumers residing in GPS residential facilities receive clinical services that are medically necessary and clinically appropriate.

Residential Services offers 4 levels of staff monitoring and supervision as follows:

Level One: Supervised - Residents reside in a shared bedroom. Staff is available twenty-four (24) hours a day to provide the necessary support for residents.

Level Two: Supported - Participants reside in an apartment or group home setting. Staff is available 36 hours per week. Consumers must show psychiatric stability, demonstrate medical necessity for supportive services and show a readiness to participate in vocational, educational and supportive services.

Level Three: Transitional Residential Services - Programs are transitional in nature, with a focus on assisting the individual in developing the skills necessary to transition to permanent supportive housing.
- **Supervised** - Residents reside in a group home setting. Individuals must demonstrate the need for 24 hour services and supports in a supervised living arrangement.

- **Transitional Living Center** - Participants reside in a home setting. Transitional living centers are designed for individuals who lack a safe living environment and meet clinical criteria for need of high intensity community based services.

**Level Four:**  
**Permanent Supported Housing** - Shelter plus Care Services/SHPA. Grand Prairie Services partners with other housing providers to provide scattered-site housing for families and individuals in the Southland area. Individuals and families live independently in the community and hold individual lease agreements. This is a voucher program.

**Population Served:**

Participants are adults eighteen years of age and older, who have a diagnosis of mental illness. Referrals may come from state operated facilities (SOF), GPS service providers, care facilities and service providers.

**Results/Positive Outcomes:**

GPS provided housing and/or outpatient services for 263 unduplicated individuals who, without care and homeless, could have become involved with the criminal justice system due to their psychiatric symptoms.

Community Residential Services is an excellent alternative to institutional care. Not only do such services allow consumer choice, the cost of Supportive Housing compares very positively with Institutional Care as follows:

- **$127,810**: Average cost per person/per year in a state mental hospital. *(FY 2015 budget; input from Illinois Department of Human Services, Division of Mental Health)*.
- **$38,268**: Average cost per person/per year in state prison. *(VERA Institute for Justice, 2012)*.
- **$4,000**: Average cost per person/per year for supportive housing services *(Illinois Department of Human Services, 2014)*. Support service plus rent ranges from $9,592 - $15,868, depending on location. *(HUD Fair Market Rent data)*. Fair market rent ranges from $5,592 to $9,592/year, depending on location *(HUD, 2015)*. The cost of supportive housing in this model includes coupling of the average cost of supportive services with the fair market rent for a one bedroom unit. Supportive services, on average, are $4,000/year. According to the HUD Fair Market Rent data, affordable housing’s fair market value rent, depending on location, ranges from $466 to $989/mo. ($5,592 – $11,868/yr.) for a one-bedroom unit. The cost of supportive housing (rent and service in a one bedroom unit) ranges from $9,592 ($5,592+$4,000) to $15,868 ($9,868 + $4,000), depending on location. *(Supportive Housing Providers Association)*
COMMUNITY RESOURCE CENTER
Centralia, IL
Carlyle, IL
Vandalia, IL
Salem, IL

Established in 1969 as a 501 c (3) nonprofit corporation, the Community Resource Center, Inc., (CRC) exists to develop, promote, and support programs for the prevention, intervention and treatment of mental health and substance abuse problems. CRC serves Marion, Clinton and Fayette counties in south central Illinois.

“Net Savings and Improved Outcomes”
(The following are samples of successful programs offered by CRC, but is not all inclusive)

Individual Placement and Support (IPS)
Adult and Adolescent IPS is an evidenced based program developed to support people with mental illness and substance abuse disorders in their efforts to achieve competitive employment. Research shows that when individuals are employed they have a greater chance of recovery.

The goals of IPS are:
1. to place prospective employees in a competitive employment environment that they choose.
2. to provide employee support to maintain competitive employment through regular contact and securing ancillary services that will enhance the employment experience.
3. to work closely with the employees treatment team, family, and significant others in fostering a winning job experience.
4. to develop close ties with willing employers who will hire those in the IPS program and make diligent efforts work around their disability.

The outcomes of securing employment:
1. to provide the employee with additional income to supplement disability payments.
2. to help the employee build a self esteem that rises the label of disabled.
3. to enhance the local workforce with employees who will work to dispel the myths of hiring disabled persons.
4. to be an example to others with psychosocial and/or substance abuse histories.

Outcomes:
- 68 individuals who are receiving services at CRC have completed a full referral to the IPS program.
- 34 of those individuals have secured competitive employment.
- 50% of the individuals referred have successfully been placed in competitive employment. For some individuals in the IPS program, this is their first employment experience.

Salem: 315 Westgate, Salem, IL 62881, 618-548-2181
Carlyle: 580 Eighth Street, Carlyle, IL 62231, 618-594-4581
Vandalia: 421 West Main, Vandalia, IL 62471, 618-283-4229
Adult Mental Health Program-

Participant's Story

We currently have the privilege of serving a 68 year old female that has Schizoaffective Disorder, Post Traumatic Stress Disorder and Borderline Personality Disorder. Her mental health symptoms began to develop as a young adult in which she began to have psychotic symptoms and severe depression that interfered with her ability to function independently in the community. She has her first psychiatric hospitalization as the age of 19. It is estimated she has been psychiatrically hospitalized 100 times and has attempted suicide multiple times in the past.

We began providing services to this individual 10 years ago. She entered our residential program to work on skills to increase her independence and improve the deficits as a result of her mental illness. She eventually was able to move out on her own and has received multiple services for symptom improvement including Psychosocial Rehabilitation, Community Support, Dialectical Behavior Therapy, Coping Skills group, Individual Therapy, and Psychiatric Services including medication evaluation and management. As a result of this client’s commitment to her recovery and services received, she has not had a hospitalization in over two years, is receiving only medication services and has been referred to the IPS program because of her desire to be employed.
Provider Results

Leyden Family Service & Mental Health Center
Psycho Social Rehabilitation Services

Brief Program Description

Provides psycho social rehabilitation skills training to people with severe and persistent mental illness.

Goals of Program

Reduce symptoms and hospitalizations, improve quality of life and work toward and achieve recovery goals.

Population Served

Adults with serious and persistent mental illnesses. 30% with concurrent serious medical conditions and 21% with substance abuse. There are 112 people involved in PSR services.

Results/Positive Outcomes

- increase in desirable results – back to work, school attendance; 41% or 46 individuals;
- decrease in Emergency Room visits; Emergency Room visits 4% or 4 individuals of 112 had emergency room visits in 2014;
- decrease in Psychiatric admissions; 87% or 98 individuals had multiple hospitalizations prior to beginning PSR services; 10% or 11 individuals had psychiatric admissions in 2014;
- assisting patients to navigate multiple health systems, and coordinating care; 30% or 34 people with complex medical conditions.
- reduction or quitting smoking; 3% or 3 of 112 individuals quit or reduced smoking;
- involvement in the criminal justice system decreased. Only 2% or 2 of 112 individuals were involved in criminal justice in 2014.
Program Description
Crisis/Case Management Program
Case Management
Provide a continuum of services that fluctuates in frequency and intensity as client’s needs dictate.

Crisis
Provides 24-hour emergency coverage seven days a week for individuals and families in emotional distress. Responses include onsite evaluation and coordination of psychiatric hospital discharges to provide aftercare to maintain psychiatric stability.

Program Goals
< Provide ongoing linkage and support to a wide range of clients.
< Reduce re-hospitalizations and emergency room visits.

Population Served
< Clients in crisis.
< Clients with serious and persistent mental illness.
< Hospital discharges from state operated facilities and private hospitals.

Key Findings
< We provided over 2,300 services to 321 clients.
< Providing follow-up services after hospital discharge has decreased recidivism by 80%.

< Behavioral Health Emergency Room visit $ 2,027
The average cost of an emergency room visit was estimated using average hospital charges provided by the IHA multiplied by an average state-wide cost-to-charge ratio of .318, calculated from the hospital cost-to-charge ratios reported in the 2012 hospital Medicare Cost Reports.

< Behavioral Health Admission $4,301
This cost estimate is based on the average charges for a mental or behavioral health inpatient stay provided by the IHA multiplied by the estimated average state wide hospital cost-to-charge ratio of .318.
Residential Services

Program Description
The Transitional Living Program provides housing and supportive services to foster independence and community integration. We also offer Community Support Team, Community Health Worker, and IWork services.

Program Goals
< Empower consumers to manage symptoms effectively to improve quality of life and avoid psychiatric hospitalizations.
< Find each consumer permanent supportive housing.
< Coordinate medical and mental health care.
< Assist consumers to find work, go to school, or find volunteer jobs.

Population Served
Adults with severe and persistent mental illness are served. These consumers come to us from a variety of settings, including psychiatric hospitals, institutes for mental disease, and homeless shelters.

Key Findings
< 70+ consumers have received assistance in obtaining permanent supportive housing.
< 36+ consumers are volunteering, working, or going to school
< Greater coordination of care has resulted in cost savings regarding hospitalizations and ER visits
< 3 consumers have interacted with law enforcement over the last year, but none have been arrested.
< Savings for consumers formerly in IMDs equals $239,140.
< Savings for consumers formerly in jail equals $249,535.
< Savings for consumers who were formerly homeless equals $43,935
< Savings for consumers released from prison equals $56,475
Substance Abuse and Mental Health Treatment Services are Critical to Our Community and Cost-Effective for Illinois

MARCH 2015

Rosecrance serves tens of thousands of your constituents.

When the state closed Singer Mental Health Center, Rosecrance worked with the state to create and enhance community-based services to meet your constituents’ needs.

When Singer closed, area emergency rooms were boarding people with mental illness for three to four days due to a shortage of beds. The jail census was at its highest, and people with mental illness were 14% of the jail population. To respond to these needs, Rosecrance created a new Rosecrance Ware Center—including a Recovery Resource Center—which provides services to people with chronic mental illness. We also created the new Mulberry Triage Center, (the “Triage Center”), which provides services to people in psychiatric crisis. It houses 12 crisis residential beds and four detox beds.

Rosecrance’s FY14 services and impact on our community

By providing community-based behavioral health services, Rosecrance helps keep people out of higher-cost ERs, hospitals and the criminal justice system.

Mental Health

- The new Rosecrance Ware Center served 10,000 people.
  - Most frequent diagnoses: depression, bipolar disorder, schizophrenia, anxiety disorders, and post-traumatic stress disorder.
  - The new Recovery Resource Center within the Ware Center served nearly 5,000 people. It provides a highly-effective recovery model that allows people with serious mental illness to be a part of a community rather than isolated, and links them to education, outlets, exercise and resources.
- The new Rosecrance Mulberry Triage Center served nearly 1,070 people. It is essentially a mental health emergency room—at a much lower cost than a hospital.
  - 61% were stabilized and returned home
  - 22% were referred to Crisis Residential Beds within the Triage Center
  - 9% were sent to emergency room for medical stabilization
  - 8% were sent to emergency room for psychiatric stabilization
- The Crisis Residential beds at the Triage Center served 181 people, with an average length of stay of nine days.
  - 80% were stabilized and returned home
  - 10% were sent to emergency room for medical stabilization
  - 10% were sent to emergency room for psychiatric stabilization

(See reverse side for more information.)
Substance Abuse
- Rosecrance served nearly 6,500 people in FY14
  - 5,048 adults primarily at our Harrison Campus
  - 1,408 adolescents primarily at our Griffin-Williamson Campus

Community-based behavioral health services are a great investment of state funding. They reduce costs to the state and society.

- The national annual cost to society of substance abuse is $510.8 B – including nearly $340 B in lost productivity costs.
  Source: U.S. Dept. of Health and Human Services' 2008 Cost-Benefit Analysis of Substance Abuse Prevention Dollars
- Untreated behavioral health problems cost Illinois money in many budget areas: criminal justice, education, health, child/family assistance and mental health/developmentally disabled.
  Source: The National Center on Addiction and Substance Abuse (NCASA, 2001)
- Community-based care costs less than hospital care.
  - One ER visit/hospitalization for someone in behavioral health crisis costs $6,328. Multiple hospitalizations are the norm when treatment is not available. If five visits are assumed, the annual cost is $31,640.
  - A full year of community-based treatment for a serious mental illness costs significantly less: $10,243.
- Investing in community-based treatment enables recovery and prevents costly, unnecessary care.

Cuts to mental health/addiction treatment services don’t make fiscal sense.

- Between FY09-FY11, Illinois cut mental health and addiction treatment services by $113M. As a result: Illinois paid $131.4M in increased hospitalizations and institutionalizations, and emergency room visits for people in behavioral health crises spiked by nearly 20%—costing far more than the cuts.
  Source: Illinois Hospital Association
- More cuts would mean thousands of people with serious mental illnesses and substance use disorders will go without treatment, and begin to churn through multiple hospitalizations, ER visits, and other state systems, including the criminal justice system.

Please preserve mental health and substance abuse funding and prevent cuts from critical behavioral health services.

- We are most concerned about these budget lines:
  - Psychiatric Leadership Capacity grants ($27.0M)
  - Eligibility & Disposition & Assessment Services ($3.6M)
  - 10% reduction in Heroin Addiction Treatment Services ($1.9M)
  - 20% reduction in DASA Global Treatment Service ($23.4M)

For further information, please contact:
Mary Ann Abate, VP of Public Policy, Rosecrance, at 815.387.5644 or mabate@rosecrance.org
or Kate O’Malley, 312-307-4206, kate@kostrategies.com

www.rosecrance.org
Family Counseling Center, Inc.

Community Investments in Southern Illinois

Family Counseling Center, Inc. (FCC, Inc.) has served Southern Illinois for nearly 41 years. FCC, Inc. serves the southern 7 counties with 12 programs for youth and adults within the Behavioral Health Division. Several of these programs include services such as counseling/therapy, substance abuse outpatient treatment, child welfare, case management, community support, psychiatric services, screening for psychiatric hospitalization, psychosocial rehabilitation, residential, and crisis intervention.

FCC, Inc.’s overall goal is to reduce barriers to effective behavioral and mental health services in counties with limited resources who have an average poverty rate of 20.1% compared to the state average of 14.1%. In addition, FCC, Inc. collaborates closely with local organizations and entities such as the school systems and the local judicial system to deliver competent services to decrease individuals’ mental health symptoms that can negatively affect their level of functioning in the community.

In 2013, within the Behavioral Health Division, 930 clients were served with a total of 29,950 service hours delivered. In 2014, 970 clients were serviced with a total of 32,185 service hours delivered. Out of the 970 clients served, 185 clients had a previous psychiatric hospitalization admission that was able to be stabilized in the community.

To identify one significant program in further detail, Screening Assessment Support Services Program (SASS) provides crisis intervention for youth that are considered harm to themselves or others. Screening and crisis services are initiated to divert possible psychiatric hospitalization and assimilate the youth into community-based services. After the initial assessment, the youth enrolls in the program for 90 days and are provided with intensive-based community services to reduce the rate of crises and recidivism. In 2013, 136 youth were screened for hospitalization through the SASS program with crisis intervention achieving 64% in community stabilization. This resulted in savings of at least $427,500 given that an average psychiatric hospital stay can cost around $5,700, according to the Healthcare Cost and Utilization Project. In fact, from 2009—2013, Family Counseling Center, Inc. has consistently achieved an average of 65% community stabilization. The overall savings to the State of Illinois for the past 5 years is $1,362,300 for those youth who were deflected from psychiatric hospitalization.

Additional positive outcomes from the various programs in the Behavioral Health Division consist of diverting youth from the various systems. In the Comprehensive Community Based Youth Services (CCBYS), 5 out of 32 youth were successfully diverted from juvenile justice system. The Illinois Auditor General estimates that incarceration in a DJJ “Youth Center” cost $86,861 per year, per youth in FY10. FCC, Inc. was able to save $434,305 by diverting these youth in 2014. FCC, Inc. is an expert in achieving success in the reunification of families as it has provided CCBYS services since 1985.

Furthermore, Family Counseling Center, Inc. has developed interagency initiatives to deliver quality support services that are not funded by the state. Over the past 5 years, FCC, Inc. has raised $31,000 in funds to aid families and youth in the southern region of Illinois. These funds have been used to assist in the costs of housing, utilities, clothing, extracurricular activities, and food. Family Counseling Center, Inc. realizes the importance of engagement and reducing barriers in order to provide the most effective and cost-saving services.

All of these examples of quality driven and outcome based services have positioned Family Counseling Center, Inc. to be a leader of services to Illinois citizens with behavioral health needs in the southern region. It is our hope that the Governor and legislature realize how important behavioral health services are and continue to invest in the community as FCC, Inc. has done since 1974.
The Wabash County Health Department Behavior Health Division, most recently named The Depot Counseling Center, has been providing services for 25 years.

Our Mission is “to provide effective, efficient, and quality services to promote better health for a brighter tomorrow.”

We provide Outpatient Counseling, Psychiatric Evaluations, Medication Monitoring Services, Crisis Services, DUI Evaluations, Driver’s Risk Education, Substance Abuse Treatment, Anger Management, and more.

Services are provided to children, adolescents and adults ages 3 - 99+ years of age.

In FY 2014, we provided over:

- 3000 hours of Mental Health Services
- 314 hours of Crisis Intervention Services
- 295 hours of Substance Abuse Services
- 859 Psychiatric encounters via face-to-face and Telepsychiatry

Services are delivered in a rural community in Wabash County which has a population of approximately 12,000 with 13% living below the poverty level. The median income for Wabash County is $47,365, well below the state medium income of $56,797.

- 72% of individuals served had Medicaid
- 11% of individuals served had Insurance or were self-pay
- 15% of individuals served were funded through non-medicaid contract with the Illinois department of human services, department of Mental Health

Services are delivered within the least restrictive environment within the agency as well as the hospital, jail, schools, homes and community settings.

- 85.25% of the individuals we served measured improvement in quality of life/functioning.
- 98% of the individuals we serve report being very satisfied with the services provided.
- 50% of the individuals we screened were deflected from inpatient hospitalizations and were maintained in the community.

The Wabash County Health Department, Depot Counseling Center is licensed by the Illinois Department of Human Services, Division of Mental Health, as well as the Division of Alcohol and Substance Abuse. We also successfully maintain CARF accreditation.
STEPPING STONES OF ROCKFORD – CRIMINAL JUSTICE INITIATIVE

The transition team for Governor Rauner has stated that the Illinois prison system has 49,000 prisoners and estimates about 6,000 of this number represents people with mental illnesses. The Governor has called for ‘investment’ to ‘improve evidence based reentry programs’ to reduce the prison population and costs. This initiative, undertaken in partnership with the Winnebago County criminal justice system takes a modest but important step in that direction.

POPULATION SERVED

Stepping Stones is already engaged in a 24 hour supervised Conditional Release program for people who have been judged to be NGRI (not guilty by reason of insanity) for which a capacity of 8 has been established with clients coming from the Elgin forensic facility. The agency will also seek additional grant funds for a similar facility for 6 women from Elgin. Likewise, Stepping Stones has a long and positive relationship treating people from the Winnebago County Mental Health Court with a current agency census of 10. This initiative will build on those successes by providing treatment for an additional 20 referrals from the Winnebago County criminal justice system. The people served in all areas will be adults 18 years of age or older, have a primary diagnosis of mental illness (and secondary substance abuse problems), be Medicaid eligible, assessed appropriate for community placement and safety, motivated for treatment or restoration and reentry into local community life. The sources of referral would be:

- State’s Attorneys’ Office for the Deferred Prosecution Program.
- Winnebago County Probation Department Community Supervision for Pre-trail/release, probation, and parole.
- Community restoration for people in the County jail declared to be UST (unfit to stand trial) by the County courts and DMH Region 2 forensic evaluation but not in need of institutional restoration.

SERVICES

Stepping Stones will provide all eligible services under Rule 132 Medicaid with non-eligible services covered by the agency’s current grant. Stepping Stones is accredited by CARF to provide these services to criminal justice clients. The current program has full staffing trained in all agency required and criminal justice current evidenced based practices as well as psychiatry, psychiatric nursing, 24/7 crisis intervention, which maintains a strong link to the County criminal justice system, integrated health care case management, medication management, housing at several different levels of supervision, transportation and community life skills development. The agency offers MISA treatment (or community 12 step if desired) and on site drug and alcohol testing, an employment specialist (IPS) and recovery/WRAP training through a Consumer Recovery Specialist (CRSS). This partnership would also depend importantly on the County’s Adult Probation efforts in the proper structuring of probation requirements which is in positive study in NC and reduces return to incarceration.
OUTCOMES
Outcomes for this particular initiative are not readily available but similar data does strongly suggest program effectiveness and savings as apparent in the data outlined here. Research data was reviewed from both the Virginia and Kentucky ‘pre-trial release’ programs, Governor Rauner’s transition team prison recommendations and some start up data from an integrated (medical/psychiatric) community program directed toward people with chronic mental illness by Heritage Behavioral Healthcare in Decatur, IL. The combined data, further study of the markers in this research and general research in other states, along with the inclusion of a strong community mental health component indicates the following:

- Offenders with serious mental illness given release until their court date are less likely to ‘fail to appear’ or be rearrested at a rate of about 6% compared to the study figure of about 15%. This results in a safer community and efficient courts.
- The same population in community supervision (probation/parole) are about 33% likely to return to prison and 50% to jail. Stepping Stones 10 years’ experience and current work with the local mental health court indicates a return rate of closer to 5%.
- Offenders with chronic mental illness that are in a structured community program like Stepping Stones have medical/psychiatric costs including hospitalizations that show a cost savings of just over $9,000 a year compared to those who are not in treatment.
- Data demonstrates that Adult Redeploy, which is provided by Winnebago County and a likely component of this proposal saves about $2,233 a year per enrolled participant.

The data above is gleaned from several different sources in two different fields, and, though similar, not exactly like what is proposed. The top figure suggested by the data’s financial figures including medical, psychiatric and criminal justice could be as high as about $245,000 annually. Assuming 90% capacity, or 18/20 beds, the savings to both DHS, DOC and Winnebago combined would be about $12,000 per bed (person) annually, or about $220,000. This should not ignore the improved safety factor for the community as a whole.

One word of caution; a significant part of the funding to make this project viable is Rule 132 Medicaid and the use of State grant funds which Stepping Stones already receives. Loss of those funds, or a significant reduction could easily jeopardize this project, the lives of the people involved and significant savings.
March 9, 2015

The **Medically Integrated Crisis Community Support (MICCS) Team**, was created in the Spring of 2014, in part, with funding from DHS-DMH. With the goal of decreasing unnecessary visits to the ED, the **MICCS Team** combines the typical range of interventions used to stabilize a psychiatric crises with new interventions and methods. The Team follows patients when they are at other hospitals, psychiatric units, in jail, at home or in a shelter. The Team also uses electronic methods of staying in contact with high-risk patients in order to “intercept” them before they return to a hospital emergency room, use 911 services, or run come into contact with the police. If they do come to the Emergency Department, a new feature of the EMR system “flags” the patient and the **MICCS Team** is contacted so that they can assist with the treatment and discharge planning for the patient. The service delivers a high intensity of care but in the community settings frequented by the patient. This initiative is a strategic extension of the long-standing ED-Crisis Service at Advocate Illinois Masonic Medical Center, a Level 1 Trauma Center and Chicago Police Department (CPD) drop-off site for 3 police districts. The Crisis Service provides care to more than 4,000 people presenting with psychiatric issues each year.

The **MICCS Team** is composed of an LCSW, MSW/Peer Specialist, MSW (former CPD Sergeant & Crisis Intervention Team Leader), psychiatric RN, bilingual Case Manager, Psychiatrist, Chaplain, and two MSW trainees. The team operates Monday-Saturday from 9 AM to 8 PM. This team has been in operation for ten months and has moved patients out of the hospital into community based care. The following are samples of the work being done and associated outcomes.

I. John is in his mid-50s with a history of schizoaffective disorder, alcohol abuse, and long-term homeless. He had no stable social supports, a history of verbal aggression when symptomatic, and spent most nights in one of several Chicago EDs because he is often denied access to shelters. From January 1, 2013 through mid-June 2014, he had **81 ER visits** at Advocate Illinois Masonic, 2 of which required a medical admission. **The cost for the Advocate care alone at that time, was $155,794.**

**RESULTS:** As a result of MICCS team interventions, this patient
- has had only 3 ER visits in the past nine months
- has agreed to have a representative payee; he is able to fund his basic needs
- applied for training at a local Animal Shelter where he is now a regular volunteer. He has a CTA pass, stable housing, and is compliant with medication for psychiatric and physical needs.

II. Joe is 81 years old, with a long history of depression, anxiety, alcohol abuse, and multiple medical problems, including diabetes. Joe lived alone in an apartment; had minimal family support. In the past he had had home health nursing care, but was non-compliant and services ceased. Joe called 911 almost daily reporting abdominal pain, which resulted in many Chicago Fire Department ambulance trips to the Illinois Masonic ED and **81 visits to the Illinois Masonic ED in the previous 18 months**, 14 of the ED visits resulted in inpatient admissions. **The cost of his medical care at Advocate was $303,087.**

**RESULTS:** As a result of MICCS team interventions, this patient
• Moved to a medical nursing home and has had one hospitalization in the past 8 months - for hyperglycemia. The Nursing Home reports he has stopped drinking alcohol; his blood sugars are controlled.

III. Jane is 55 years old and has a history of bipolar disorder and alcohol abuse. She used to come to the Illinois Masonic ED 1-3 times per day. Jane was often “kicked out” of other hospitals, she did not engage in outpatient care. She has a record of at least seven head injuries in a 2 year period from falls and seizures, and therefore, has had 62 CT scans. On occasion she has agreed to nursing home placement, but typically leaves AMA after one or two weeks. Jane is well known to many Chicago ERs, firemen and police officers. At Illinois Masonic alone she has had a total of 741 visits to the ED since 2006. The cost of her care at Illinois Masonic was $2,613,230. (NOTE: This does not reflect costs incurred at other hospitals, or the costs to the Chicago Fire Department, the Chicago Police Department, and other support services.)

RESULTS: As a result of MICCS team interventions, this patient
• has had only 6 ER visits in the past 8 months
• has been placed in supportive permanent housing.
• Has an AA sponsor and is now a moderate drinker

The MICCS Team has a current caseload of 40-50 complex patients similar to those mentioned above.
Massac County Mental Health
And Family Counseling Center, Inc.
206 W. Fifth St. – Metropolis, IL 62960

Massac County Mental Health and Family Counseling Center, Inc. is a community outpatient mental health and substance abuse treatment facility serving the citizens of Massac and surrounding communities. Our services are integrated into the community. We work closely with local schools to streamline access to care for students and their families, providing services in the schools on an on-going basis. We are well connected with the local health, legal and social service system in order to enhance coordination of care. We formed a community drug awareness coalition that is now an independent and sustainable non-profit organization working to address and eliminate substance abuse in the community. We utilize evidence-based services endorsed by the Substance Abuse and Mental Health Services Administration (SAMHSA), including medication management, problem-focused psychotherapies (cognitive-behavioral, interpersonal therapy), client advocacy, and family education. Our outcome indicators clearly reinforce the effectiveness of mental health treatment.

Brief agency highlights include the following:

1. MCMH provided over 6,415 hours of counseling services to over 500 adults and children in FY14.

2. 92% of clients report or demonstrate an improvement in their functioning after treatment.

3. 98% of clients report they are satisfied or very satisfied with the progress they are making toward recovery and would recommend our services to a friend.

4. All clients who contact us in a mental health crisis receive prompt and effective intervention in the least restrictive environment. In many instances, we are able to resolve the crisis and connect the person/family to services and supports without the need for hospitalization.

5. 251 of 270 [93%] of individuals seeking crisis services have maintained community tenure and been deflected from a more restrictive level of care/hospitalization.

6. The agency provides 24 hour crisis intervention services and the average response time in FY14 was 15 minutes. Massac County Mental Health Center is highly respected and an integral part of the small rural community. Our services are designed to eliminate financial, geographic, language, cultural and other barriers to care. Over eighty percent (80%) of our clients are covered under Medicaid; <5% are covered under insurance and 15% had no insurance in FY14. Most persons served are below the federal poverty guidelines. MCMH services are readily accessible and we have an outstanding working relationship with community partners including law enforcement, hospital, emergency room and education. This collaboration allows us to provide interventions before problems escalate and become more costly to the community and society.