Mental Health Action Plan

McLean County Board

2015

Background ……. **Page 1**

Executive Summary…….. **Page 4**

Chapter 1 Collaboration…….. **Page 11**

Chapter 2 Medication and Medical Management……. **Page 26**

Chapter 3 Juvenile Services……. **Page 31**

Chapter 4 Housing…… **Page 44**

Chapter 5 Crisis Services …….. **Page 49**

Appendix …… **Page 56**

BACKGROUND

McLean County Government's most recent formal battle with mental health & substance abuse within the community began in 2007. Even with a County Health Department's mental health program providing "capacity" grants to community mental health programs for access to treatment/care of those underinsured/insured, a systemic trend of increasing number of repeat co-occurring mental health patients/drug offenders within the community were identified. A team of Court Officers, led by Chief Judge Elizabeth Robb identified the opportunity to develop what was then an emerging philosophy of providing a specialized judicial proceeding to address the increasing challenges these co-occurring mental health patients create. The Court worked in concert with the McLean County Board and community leaders to obtain congressional support for a Department of Justice (DOJ) Drug Court Grant. This Grant was authorized in September of 2008 and McLean County became of Illinois' first Drug Court.

McLean County government is mandated by state statute to provide for court functions and correctional facilities operation. Therefore, it is not surprising that County Government was one of the first community members to raise concerns about the increasing numbers of individuals being treated for mental illnesses in jails. Jails across the nation serve an estimated 2 million people with serious mental illnesses each year, almost three-quarters of which also have substance use disorders. This prevalence of people with serious mental illnesses in jails is three to six times higher than for the general population. Once incarcerated, they tend to stay longer in jail and upon release, are at a higher risk of returning than individuals without these disorders. The cost to taxpayers is only marginalized by the dramatic distress to individuals and families who find themselves or family members jailed because it is the best opportunity to obtain treatment. Correctional Facilities spend many times more on detainees with mental illnesses than those without those requirements. Unfortunately, individuals who could be better and more appropriately treated in a community environment are sometimes deposited into the criminal justice system due to lack of community alternatives for mental health treatment.

In 2008, McLean County also requested that the National Institute of Corrections (NIC) complete a report on the Adult Jail System within McLean County. This report was completed in January 2009. The major outcome of this assessment was a recommendation to form a Criminal Justice Coordinating Council.

With the expiration of the DOJ Drug Court grant in 2009, the McLean County Board, through its Board of Health, appropriated local funding to continue the McLean County Drug Court. Subsequently, Illinois State law has mandated the provision of a drug court in all jurisdictions.

On July 1, 2009 the Circuit Court of McLean County established the Criminal Justice Coordinating Council (CJCC). The primary mission of the Council is to examine the policies and procedures of the McLean County Criminal Justice System, identify model practices, identify deficiencies, and formulate policies, plans, and programs based on well-established research and statistical methodologies designed to promote change when opportunity presents itself. As a part of this Action Plan, the McLean County Board committed to an Agreement with Illinois State University's Stevenson Center to do statistical analysis on the criminal justice system with emphasis on the Adult Correctional facility population.

The Council makes recommendations of policy and procedural changes that will affect the entire criminal justice system and it is the role of all Council members to become agents of change, to provide leadership in communicating the need for self-examination, participation in data gathering efforts, to be open to monitoring program implementation, and evaluating policy decisions. Largely as a result of the work of the CJCC, from 2009 – 2013, McLean made application for and received a second DOJ Drug Court Grant, a Bureau of Justice Assistance (BJA) Mental Health Court Grant and Grants from the Substance Abuse and Mental Health Services Administration (SAMHSA) for both Drug and Mental Health Court.

In late 2012, McLean County requested that the National Institute of Corrections (NIC) review mental health provisions within the McLean County Jail. This report was completed in January of 2013. Two primary focuses of improvement resulted from this report, 1) improving environments for detainees with a range of mental health challenges; and 2) resolving a gap in services for those released from detainment or incarceration back into the community. Following this report, McLean County requested the NIC return and completed a report on Jail Mental Health Design and Programming options at the McLean County Jail. This report was completed in July 2013. The primary recommendations were to expand and improve County jail facilities for mental health services and strengthen transition processes and community services.

In January 2014, the McLean County Board issued a Request for Proposals for Jail Needs Assessment & Pre-Architectural design, including options to provide for mental health units for both corrections facility and community stabilization. The Board sought qualified criminal justice consulting firms who possess knowledge, skills, and experience in pre-architectural jail planning to conduct a comprehensive jail needs assessment study and provide pre-architectural consulting services. The purpose of the study was to develop a plan that will establish current and future capacity requirements and operational costs associated with the renovation/expansion of the current facilities and provide an initial estimate of the cost of construction and operational requirements for facilities, specifically with respect to provision of mental health stabilization service options for both detention facilities & community services. The contract for these services was awarded in April 2014 and the report was delivered to the County Board in March of 2015.

In February of 2014, the McLean County Board Executive Committee convened two interagency, public-private workgroups, one to identify community mental health needs and one to identify best practices. These workgroups were challenged to plan, create, and begin coordinating and evaluating mental health services within the Community. The goals of these work groups included, 1) Improve the general understanding of mental illnesses and emotional disturbances; 2) assess the state of the mental health care system in McLean County, focusing on identifying the gaps between services provided and community needs in both urban and rural areas; 3) Identify and review best practices and determine the feasibility of implementation in McLean County; and 4) develop strategies to maintain dialogue among community leaders regarding mental health.

In March of 2014, the Bloomington-Normal/McLean County Economic Development Council brought Community leaders together, traveling to Washington, DC to meet with legislators and staff members from the Department of Health and Rehabilitative Services and the Department of Justice to discuss the community's challenges with mental health both inside and outside the criminal justice system.

In June 2014, the two community mental health advisory groups provided their reports to the County Board. These reports identified both mental health needs within the community, as well as best practices. Based upon the reports of the initial two(2) advisory groups on Community Mental Health, Chairman Matt Sorensen subsequently appointed an Advisory Group to review the reports received by the first two advisory groups and report back to the Executive Committee and County Board recommended action items which would be consistent within the framework of the initial reports. This Action Plan would include immediate and long term steps for the community and the County Board to consider and act upon.

EXECUTIVE SUMMARY

This report represents the second phase of work for the County Board Executive Committee's workgroups on Community Mental Health. The five distinct chapters represent the five greatest areas of need identified by the first two workgroups. Individual chapters of this report stand alone and have been developed independent of one another. The individual writing groups identified many common needs and solutions.

The general findings of the report indicate that, notwithstanding the County's capacity grants to community mental health providers, significant gaps exist, including delays in service delivery. There is an urgent need to enhance the transitions of individuals between institutions and community providers. Lack of interagency communication, absence of data rich reporting, failure to insure that other payers for mental health services are leveraged first (payer of last resort), and inadequate supply of mental health practitioners were all identified as primary weaknesses of the community delivery system. Priority service gaps were identified in the area of crisis stabilization, appropriate housing options, and inpatient psychiatric services for juveniles (under 21 years of age).

Strengthening community based services will require that improved systems be developed and implemented, facilitating interagency communication. Steps must be taken to insure a continuing community dialogue on the topic of community mental health, expanding input by the community and its providers into the behavioral health needs and solutions and ensuring that services cost–benefit analysis is taking place with an integrated program evaluation/prioritization process. The County criminal justice system will also need to improve and expand its capacity and capability to appropriately provide for a continuing number of detainees with behavioral health needs.

Moreover, due to lack of support outside the justice system, treatment within the justice system goes for naught, as detainees return to unstructured and untreated environments that relegate improvements and stabilization within the criminal justice system and recidivism continues. While the County has made efforts to address the mental health problem through specialty courts and better identification/treatment of mental illness within the justice system, these initiatives are reactive in nature and do not address the systemic community gap which exists for mental health services. Nor do the actions resolve significant obstacles; including the need to better coordinate services between multiple entities/organizations. Notwithstanding future improvements in community capabilities to link individuals to treatment, the County's current correctional facilities are not designed to appropriately deal with the large numbers of people with mental illnesses who will continue to cycle through the criminal justice system.

Recognizing the important role local officials play in supporting change, the County Board will continue to lead a community dialogue, including a diverse team of leaders and decision makers to help advance the community's efforts. This Mental Health Action Plan will build on the many innovative and evidence-based practices being implemented across the country to improve the delivery of mental health services within and outside the justice system, with the goal to reduce the number of adults with mental and co-occurring substance use disorders within the community. The Action Plan engages a varied group of organizations with expertise on these issues, including state and federal agencies, those representing

mental health and substance use treatment providers, law enforcement, judicial and court officers, people with mental illnesses and their families, and other stakeholders.

The Community has demonstrated a shared commitment to a multi-step planning process that can achieve concrete results, focusing on developing an Action Plan that can be used to achieve changes. The Action Plan should maintain awareness of the mental illness challenges the community faces and create both short term and long-term improvements that utilize practices and strategies to have a positive impact upon the community.

Many of the short and long term objectives will require community partners and groups from both the public and private sector to work together. Ultimately, opportunities exist to improve service delivery, expand revenue recovery, and reduce redundancy. It is the community's responsibility to address this significant issue. Today, local mental health funding comes almost exclusively from property taxes. Significant efforts should be made to diversify the revenue funding streams for mental health service to more equitably distribute this community obligation.

Some short-term goals have been realized. During the summer of 2014, 1) the Bloomington Federally Qualified Health Center (FQHC) provider Chestnut Health Systems was awarded $500,000 to provide expanded mental health services to the Community; 2) McLean County Government and Chestnut also agreed to a Memorandum of Understanding to construct an expanded the FQHC at the County's Fairview Campus; and 3) at the urging of local officials and providers, the State of Illinois Department of Human Services committed a $700,000 investment to allow Chestnut to establish an adult mental health crisis and substance abuse detox program for McLean County which provides a needed alternative for families, medical staff and law enforcement in dealing with adults with mental illness.

There are several objectives which fall within the independent authority of the McLean County Board. The following objectives are recommended for consideration by the McLean County Board and its respective oversight Committees.

COUNTY BOARD ACTION OBJECTIVES

- Create a McLean County Behavioral Health Coordinating Council to assist the County Board with Policy Decisions
- Appoint a County Board Oversight Committee for Health/Human Services to maintain focus on this and similar issues
- Approve resolutions of participation in state, regional, and national mental health initiatives
- Establish better visibility and public communication processes for Behavioral Health programs within County Government
- Expand the community dialogue on behavioral health solutions to include all Departments within County Government, including the Regional Office of Education for purposes of a School Task Force on Mental Health
- County Government should open a dialogue with other local government entities to explore the diversification of mental health funding streams

Several of the objectives that were identified commonly throughout the process are cited below:

OTHER SHORT TERM OBJECTIVES*

- Embrace a Community of Practice Coordinating Philosophy for Adults/Children
- Embrace No Wrong Door approach within the community
- Use a System of Care model which delivers dependent upon need
- Expand follow-up services being coordinated by PATH
- Improve and better Define the Mental Health Delivery system structure
- Appoint a Mental Health Advisory Committee to Assist the Board of Health with Implementation decisions
- Initiate and expand community mental health training
- Develop standardized data collection guidelines
- Seek additional Federal housing vouchers for behavioral Health Clients
- Hold Chairman's Roundtable discussions with Providers/Partners
- Facilitate an annual Community Mental Health Forum

***implementation strategies for several of the short-term objectives have begun**

OTHER LONG TERM OBJECTIVES

- Create a Community-wide commitment to diversified funding for Mental Health
- McLean County must become the payer of last resort for Mental Health Services
- Expand the role of a Behavioral Health / Development Disabilities Coordinator
- Continue to engage federal and state legislators regarding Community needs
- Utilize technology to develop integrated systems to track progress to enhance data collection and reporting processes regarding services research-based approaches that advance the plan
- Develop strategies to better merge the infrastructure, oversight and funding for behavioral health (mental health and substance use) and intellectual disabilities/developmental disabilities to facilitate integrated cross-systems planning, service delivery, and accountability
- Develop a WRAP team approach of multiple providers to fully cover a variety of services
- Determine community support to transition to 708 Board

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Mental Health Action Plan

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Mental Health Action Plan

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Acronyms and Abbreviations

ACA	Affordable Care Act
ACMHAI	Association of Community Mental Health Authorities of Illinois
ACT	Assertive Community Treatment
Advocate	Advocate Bromenn Hospital
AOK	All Our Kids
APN	Advance Practice Nurse
BOH	Board of Health
CEU	Continuing Education Unit
Chestnut	Chestnut Health Systems
CHS	Center for Human Services
CIT	Crisis Intervention Teams
CJCC	Criminal Justice Coordinating Council
CSU	Crisis Stabilization Unit
CYFS	Center for Youth and Family Solutions
DD	Developmental Disabilities
DHS	Illinois Department of Human Services
DOJ	Department of Justice
EAV	Equalized Assessed Valuation
ED	Emergency Department
EDC	Economic Development Council
EMR	Electronic Medical Records
EMS	Emergency Medical Service
FQHC	Federally Qualified Health Center
HHS	US Department of Health and Human Services
HUD	Housing and Urban Development
ILCS	Illinois Compiled Statutes
LWV	League of Women Voters
MCBHCC	McLean County Behavioral Health Coordinating Council
MCDF	McLean County Detention Facility
MCHD	McLean County Health Department
MHAB	Mental Health Advisory Board
MI	Mental Illness
NAMI	National Alliance on Mental Illness
NIC	National Institute of Corrections
OMA	Open Meetings Act
OSF	St. Joseph Hospital
PATH	Providing Access To Help
PBIS	Positive Behavioral Intervention and Supports
SA	Substance Abuse
SAMHSA	Substance Abuse and Mental Health Services Administration
SASS	Screening Assessment and Support Services
SOC	System of Care
WRAP	Wellness Recovery Action Plan
WRAP	Wraparound

McLean County

COLLABORATION

AND

COORDINATION

COLLABORATION

Communities of practice are groups of people who share a concern or a passion for something they do and who interacts regularly to learn how to do it better.

1. **The domain:** It has an identity defined by a shared domain of interest. Membership therefore implies a commitment to the domain and therefore a shared competence that distinguishes members from other people.
2. **The community:** In pursuing their interest in their domain, members engage in joint activities and discussions, help each other, and share information. They build relationships that enable them to learn from each other.
3. **The practice:** Members of a community of practice are practitioners. They develop a shared repertoire of resources: experiences, stories, tools, ways of addressing recurring problems—in short, a shared practice. This takes time and sustained interaction.

What do communities of practice look like?

Communities develop their practice through a variety of activities. The following table provides a few typical examples:

Problem solving	"Can we work on this design and brainstorm some ideas; I'm stuck."
Requests for information	"Where can I find the code to connect to the server?"
Seeking experience	"Has anyone dealt with a customer in this situation?"
Reusing assets	"I have a proposal for a local area network I wrote for a client last year. I can send it to you and you can easily tweak it for this new client."
Coordination and synergy	"Can we combine our purchases of solvent to achieve bulk discounts?"
Discussing developments	"What do you think of the new CAD system? Does it really help?"
Documentation projects	"We have faced this problem five times now. Let us write it down once and for all."
Visits	"Can we come and see your after-school program? We need to establish one in our city."
Mapping knowledge and identifying gaps	"Who knows what, and what are we missing? What other groups should we connect with?"

However, the very characteristics that make communities of practice a good fit for stewarding knowledge—autonomy, practitioner-orientation, informality, crossing boundaries—are also characteristics that make them a challenge for traditional hierarchical organizations. How this challenge is going to affect these organizations remains to be seen. [1]

[1] Communities of Practice: Learning, Meaning, and Identity. By Etienne Wenger, Cambridge University Press, 1998

Lack of collaboration and integration of services by agencies has resulted in a silo approach to provide to for behavioral health in McLean County. Studies from Mental Health America of McLean County, OSF St. Joseph, Advocate Bromenn, United Way, the National Institute of Corrections (NIC), and others, have been critical of community engagement with the behaviorally ill population. Although there are numerous service providers in the community, there is often disconnect and providers may not be aware an appropriate service exists to refer their clients.

Stakeholders and community leaders including government, hospitals, service providers, and others gathered to determine needs and gaps to improve the behavioral health services for McLean County residents.

Current Accomplishments

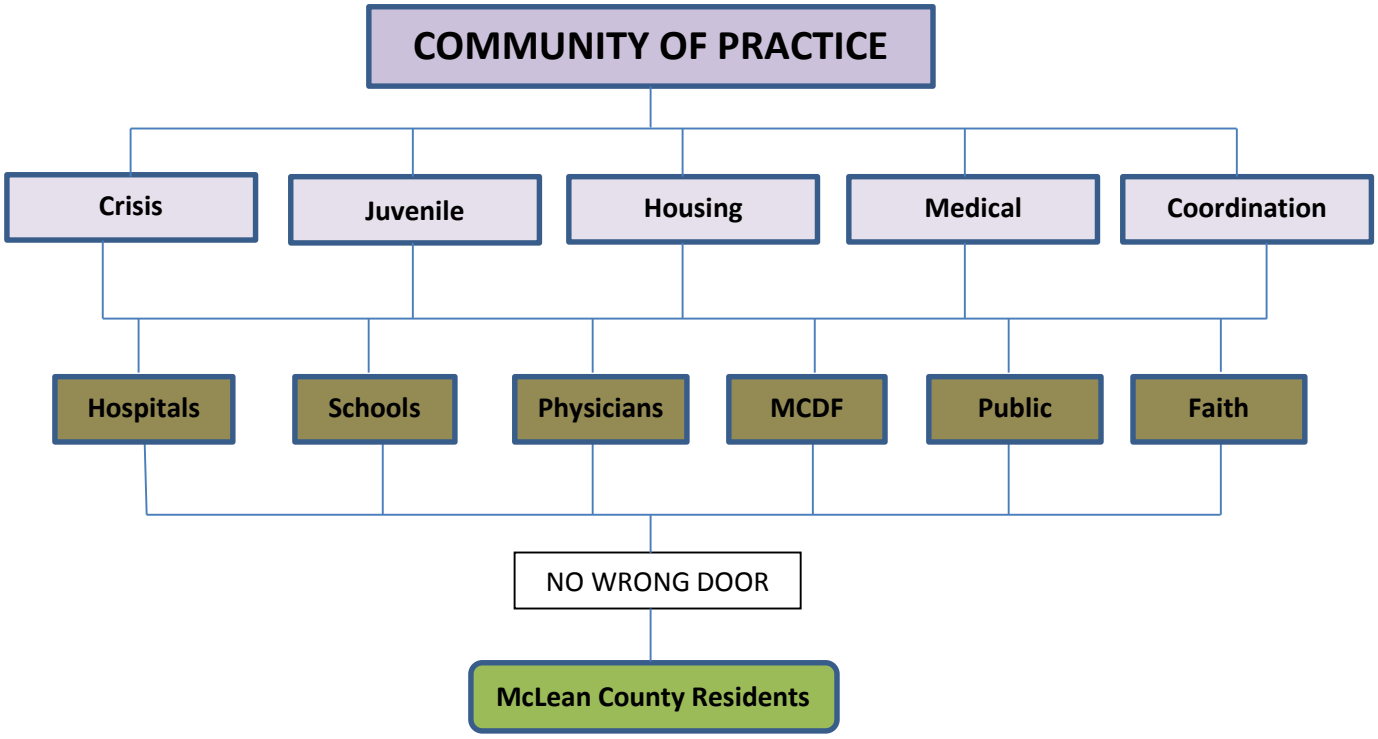
Since the July 2013 NIC report, numerous changes have occurred in the collaboration arena.

- In January 2014, facilitated by the McLean County Health Department, the jail staff has been meeting with the Center for Human Services (CHS) to track released incarcerated individuals who need follow up psychiatric services.
- A crisis planning group, also facilitated by MCHD, has been meeting since July 2014 to improve mobile crisis response. Stakeholders include Center for Human Services, Advocate, OSF, Chestnut, first responders, and government officials.
- The State of Illinois Department of Human Services has provided an annual $700,000 grant to Chestnut Health Systems to create and operate a Crisis Stabilization Unit in McLean County planned to open early 2015.
- Chestnut received a Federal $500,000 grant towards expansion of behavioral health services at the Federally Qualified Heath Center (FQHC). Plans for construction of a new facility have begun with an anticipated opening in 2016. FQHC's have behavioral health providers to serve Medicaid and uninsured residents.
- Advocate has collaborated with CHS and MCHD to host Mental Health First Aid, a best practice, for community members.
- First responders have increased the number of members who have completed CIT training.
- Better reporting, coordinated by PATH, from CHS, OSF, and Advocate, is improving accountability.
- The One Voice trip to Washington, DC in March 2014 and 2015 advocated for increased funding in a variety of areas for behavioral health. Advocacy at both the state and federal level is continuing.
- Business partnerships have been created in order to share some records to improve communication between acute crisis and follow-up services. Partnerships are being expanded to other providers and are viewed very positively by the clients.

SHORT TERM OBJECTIVES

In addition to the positive changes that have occurred in the past year, providers must be challenged to collaborate. Opportunities exist for organizations to go outside of their boundaries to develop new collaborations to improve the service delivery system. Such Collaborations would result in a stronger and more robust system, benefiting the community as a whole.

1. Embrace the Community of Practice philosophy for McLean County



Based on the need "McLean County needs to establish a single advisory group consisting of decision makers from behavioral health providers and funding agencies across the community committed to working in a coordinated and intentional manner to evaluate the state of mental health services, to formulate an overarching statement of purpose, and to develop an action plan addressing community mental health needs. These actions should be agreed upon and adopted across all behavior health agencies and providers."

2. Institute Chairman's Roundtable

To provide an opportunity for specialized candid discussion on specific topics relating to mental health, an informal process of periodic provider/partner meetings should be utilized, allowing participants to exchange ideas and explore solutions in an atmosphere which promotes open and honest dialogue.

3. Create a McLean County Behavioral Health Coordinating Council

Modeled closely after the Criminal Justice Coordinating Council, the BHCC would serve as an umbrella for organizations in the behavioral health system, including publicly and privately funded, and non- and for- profit groups. It will be the "glue" for the organizations. The BHCC would serve as a forum to discuss differences, facilitate communication, align strategic plans, and assist with the pursuit of external funding and technical assistance. The BHCC will be a conduit for information sharing between the Council, other Counties, and regional mental health organizations. The BHCC will also be consulted regarding new programs the BHCC partners develop.

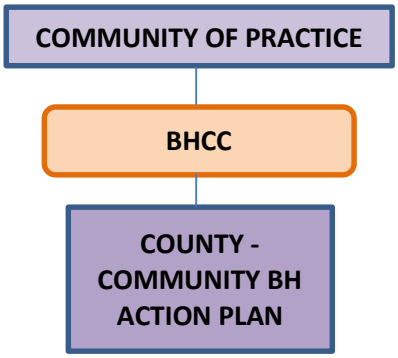
The Chairman of the McLean County Board would appoint the members, with advice of the County Board. Care must be taken when evaluating and inviting appropriate members to sit on the BHCC and its Committees.

- The key partners to the BHCC must committed to furthering the mission and have assigned the appropriate staff resources to do the work
- There can be no "turf" issues, the silo approach is ineffective with the changing healthcare landscape
- Members must be able to speak freely, openly, and honestly
- Members must be the decision makers for the organization they represent
- Prevent duplication of other advisory groups
- Formally adopt resolutions of participation in state, regional, and national mental health initiatives
- The BHCC should strive to engage funding entities in discussions about community priorities

These are very lean times in Illinois and there is a need to share resources and funding opportunities to adequately serve the public.

The BHCC should use the Committee structure for reporting on action steps and sharing information, meeting as a whole group on a quarterly basis.

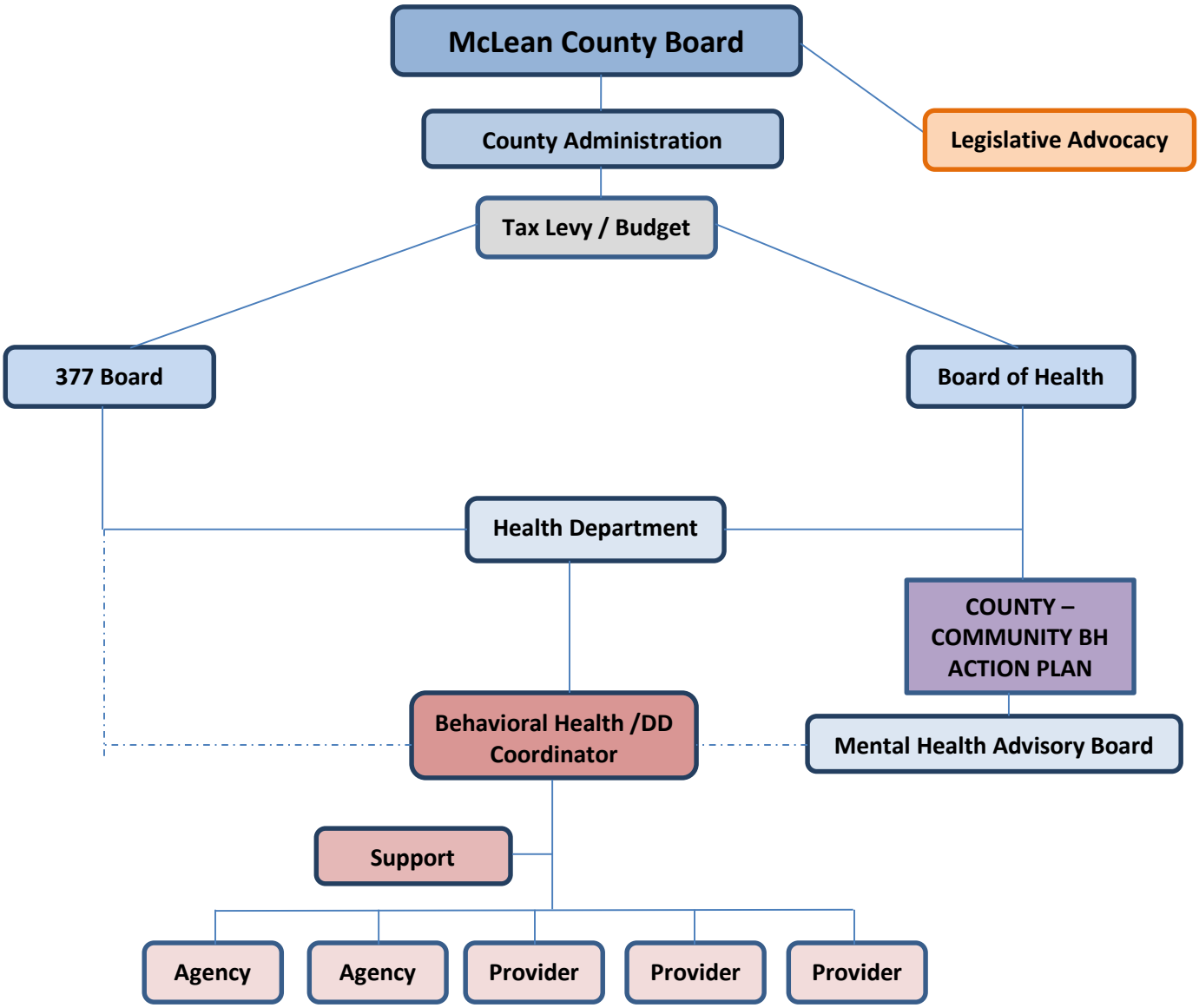
The BHCC should serve as a conduit of information regarding the behavioral health system in McLean County to the federal and state officials that represent us. Several needs have been identified where the BHCC would be the voice for legislative advocacy.



In order to address the need "McLean County needs an integrated, coordinated, and data-informed behavioral health system which realigns resources as priorities and needs change", along with objective 2, the tax supported behavioral health system structure should be formalized.

4. Define the system structure for Community Mental Health

SYSTEM STRUCTURE FOR BEHAVORAL HEALTH



5. Appoint a Mental Health Advisory Board

(55 ILCS 5/5-25025)(b) states, "The president or chairman of the county board of health shall appoint a mental health advisory board composed of not less than 9 nor more than 15 members who have special knowledge and interest in the field of mental health. Initially, 1/3 of the board members shall be appointed for terms of one year, 1/3 for 2 years, and 1/3 for 3 years. Thereafter, all terms shall be for 3 years. This advisory board shall meet at least twice each year and provide counsel, direction, and advice to the county board of health in the field of mental health." (Appendix A)

The MHAB would act as a trusted advisor to the BOH. The BOH will retain and exercise final responsibility for priorities, budgeting, and appropriations. The Board of Health may create initial by-laws for the MHAB to provide structure such as purpose, duties, membership, officers, meetings, etc. The MHAB would actively participate via recommendations and reporting to the BOH the goals and objectives as determined by the BOH. More specifically, responsibilities would include:

- Working closely with the BHDD Coordinator (described below)
- Assisting the BOH in its development of the strategic funding objectives utilizing the county-community action plan to assist them in determining tax supported funding priorities
- Assist the BOH in interpreting the community mental health plan as it applies to BOH priorities
- Analyzing data collected
- Reviewing and evaluating tax supported funding requests
- Monthly reporting to the BOH

As an advisory body of a subsidiary of McLean County, it would be subject to the Open Meetings Act.

A "377 Board" or Board for the Care and Treatment of Persons with Developmental Disabilities provides services to the developmentally disabled and their families. This board is separate from the BOH; however, there are often dual diagnoses of DD and MH/SA. Statue does not preclude the MHAB from offering advice to the 377 board on issues that impact both boards.

6. Expand the role of Behavioral Health / Development Disabilities Coordinator

Several needs would be addressed by a dedicated behavioral health/(MI, DD, SA) coordinator position. These include: "McLean County needs a designated individual or individuals to administer, monitor, report, and coordinate publicly funded mental health services ", "McLean County needs to develop or access effective assessment tools which include measurable outcomes for all publicly funded mental health programs", and "McLean County needs behavioral health service providers and agencies to have greater accountability for and transparency in the expenditure of funds along with the need for long term, stable funding." Providers will need to engage in system-wide expansion to meet the community needs. This entry-level management position, along with a clerical support position, is currently funded, beginning with the county FY 2015 budget.

System wide outcome measures supporting interagency partnerships are critical in evaluating objectives and strategic plans. These measures would aid in managing tax supported funding decisions, provide a set of strategic objectives by which progress can be measured while providing transparency for McLean County taxpayers.

The 377 board should continue utilizing the services of the coordinator to assist them in making informed decisions on allocating taxpayer dollars effectively.

The coordinator falls under supervision of the Health Department. The position will have routinely interact with the MHAB, the BOH, and the 377 Board. This position would evolve into a Health Department division head as responsibilities and staff increase.

7. Develop standardized data collection guidelines

The Crisis Note (Appendix C) is an example providing information between agencies and providers with several applications.

First, the first two pages of the report are passed to PATH for crisis follow-up purposes. The entire report is passed to both hospitals and is scanned into the patient's medical record. Agencies should utilize the entire report and apply relevant information into their screening process. This will reduce the redundancy of screening questions, can improve productivity for agencies, thereby reducing costs regardless of who is funding.

Second, the data collected would be the basis for standardized reporting from all agencies and providers to measure outcomes, reveal possible gaps in the system, and move to a purchase of services system for funding. HIPAA and other privacy issues must be kept in mind when determining data to collect.

8. McLean County must become the payer of last resort

Current behavioral health system providers in McLean County should be reminded of the limited availability of local levy resources. Funding should supplement, not supplant, other funding sources. County mental health contracts must include definitive language requiring providers to seek grants and other funding first. All other funding sources such as federal, state, and non-taxpayer grants, and billing options, such as becoming insurance credentialed and Medicaid billing certified should be fully utilized by the service providers before billing for local taxpayer funding. This may result in service providers examining their policies and procedures to capitalize on other funding opportunities.

9. No Wrong Door approach to Delivery

"McLean County needs a service delivery system that permits ease of access and coordination among points of entry for citizens seeking services from the behavioral health delivery system, supported by an increased amount of public education regarding access points" and "McLean County needs to establish easily accessible sources of information regarding available behavioral health services and enhance public education to permit consumers to more efficiently navigate the behavioral health service delivery system." are the associated with the no wrong door best practice.

Strategies of implementation include, 1) utilize a variety of media sources to educate the public as an access point for no wrong door. Newspapers, websites, both private and public, social media, etc. are a few of the many ways to reach the public; 2) developing key personnel involved in direct services, training them to train other community groups in behavioral health care. (Train the trainers); and 3) identify every single group that could benefit from presentations in behavioral health. These groups would include: public and private employers, schools, faith communities, social groups, professional groups, etc.

"McLean County needs the local medical community to increase efforts to develop a multi-disciplinary approach to behavioral health care."

10. Engage the medical community
Find a key entity to lead and have key medical community members create a plan and provide training to medical staff in every medical setting.

11. Explore a grant writer / grant coordinator
Addressing "McLean County needs to provide positive incentives to encourage collaboration among service providers to integrate behavioral health services", a grant writer/coordinator should be utilized. The position should be contractual in nature, possibly utilizing the local universities, and would be under the guidance whereas to benefit multiple departments of the county. This would not supplant individual agencies or county departments from writing applicable grants but be responsible for grant funding opportunities affecting the larger vision of McLean County. Other departments such as the MCDF, the justice system, along with county-wide initiatives such as MHAB and CJCC would benefit from this position.

There are 3 options to fund the grant writer:

- An annual or monthly fee paid by providers to utilize the services of the grant writer
- Contractually via an administrative fee for grant applications
- If available, from an unencumbered fund(s) of the benefiting department(s). While this method is not sustainable, it would be an investment in future revenue opportunities.

By providers consenting to remunerate for services of the grant writer, it allows smaller providers the ability to secure additional funding where they do not have the resources. The benefit is both to the provider and to the taxpayer, by reducing demands for taxpayer funding.

By utilizing a grant writer, it creates the opportunity to collaborate and pool resources to pull agencies/providers together to secure grants where collaboration, integration, and possibly in-kind requirements are required but no one agency would qualify on their own.

LONG TERM OBJECTIVES

1. Determine community support to transition to 708 board
In 1946, McLean County Health Department and BOH was established by referendum under 55 ILCS 5/Div. 5-25 (Appendix A) with the ability to levy up to $.10. In 1989, a referendum was passed which allows for up to an additional $.05 for additional mental health services (55 ILCS 5/5-25025).

A BOH has broad latitude in providing or contracting for mental health services. The broad latitude can range from solely contracting for mental health services, as the BOH currently does in McLean County, to the BOH operating as the direct provider of behavioral health services, including but not limited to, psychiatric services, case management, vocational training, and housing.

A 708 board is created by referendum according to 405 ILCS 20/ (Appendix B) as a separate governmental unit with taxing authority to levy up to $.15. In 1972, a referendum to create a 708 board failed. There is a currently a state task force led by the Lieutenant Governor looking into local

government consolidation. Given the current funding and political climate, it is beyond the scope of this report to speculate on potential system structure, funding, costs, and benefits.
Funding, information sharing, and EMS options must to be addressed at higher levels of government. "McLean County needs to advocate for more adequate funding for behavioral health services at the state and federal level and include mental health in the legislative agenda."

2. Continue to engage federal and state legislators regarding funding and explore alternative local revenue funding streams for Behavioral Health Services

The McLean County Board, community leaders, and others should work with state and federal lawmakers through various methods to improve funding for mental health initiatives in McLean County.

Local funding for mental health services within the community is almost entirely derived from property taxes. McLean County should work with its municipalities and other local government partners to jointly identify opportunities to diversify the revenue streams in a more equitable manner to fund mental health services.

McLean County needs to advocate for changes to the Illinois Mental Health and Developmental Disabilities Code and the Illinois Mental Health and Developmental Disability Confidentiality Act in order to share core information between agencies who are providing services to the behavioral health clients.

3. Engage state legislators regarding information

In order to better provide a continuum of care and to aid those mentally ill patients navigate the system, allowances in the law should be made to share information as much as possible.

4. Engage state legislators regarding EMS

While mostly a crisis issue, on 8/14/14 the Illinois statue regarding EMS transport only to a hospital was changed to allow for transport to locations other than a hospital. However, implementation is still being worked out regarding reimbursement for services. With the opening of the crisis stabilization unit, options for transportation should exist to divert from EDs or from EDs to a more appropriate setting. This would reduce costs not only to the patient but also to hospitals, insurance/Medicaid, and taxpayers. "McLean County needs to ensure that an array of behavioral health services are available and readily accessible to that population of individuals who confront mental health issues that are not yet chronic and persistent, so that their mental health issues can be timely addressed to reduce the prospect of decompensation resulting in long-term care and hospitalization." **Peer support** is getting help from someone who has been there. Some types of peer providers undergo training and certification to qualify. Medicaid and public mental health systems increasingly pay for services provided by certified peer support specialists as part of the service delivery team.

"McLean County needs to seek a central point of intake and provide wrap around services, which include basic needs with natural and creative supports along with follow up services."

5. Evaluate centralized intake and WRAP teams

Centralized intake is considered a best practice along with no wrong door. In order to move from no wrong door to centralized intake, many changes would have to be made to the system structure, service delivery approach, along with the funding to do so.

WRAP teams consist of multiple supports from providers to fully cover a variety of services utilizing a single, individualized, integrated plan resulting in long term stability.

COORDINATION

For this report, the term coordination is in reference to case management and the definition of Case Management as defined by the Medicaid Rule 132:

Mental health case management services include assessment, planning, coordination and advocacy services for clients who need multiple services and require assistance in gaining access to and in using mental health, social, vocational, educational, housing, public income entitlements and other community services to assist the client in the community. Case management activities may also include identifying and investigating available resources, explaining options to the client and linking them with necessary resources.

SHORT TERM OBJECTIVES

1. Utilize PATH services

Notify all agencies that they have free electronic access to the PATH Directory by going to: www.findhelp211.org.

Encourage all agencies to have their newly recruited case managers and those involved in case management services attend the PATH Community Services training as part of their initial orientation.

Encourage all agencies to have their ongoing case managers and those involved in case management services attend a PATH Community Services Update every three years.

*NOTE: 3 month lead time required by PATH

“McLean County needs to entice, retain, and cross train case managers to aid in expanding efficiency.”

2. Create interagency training

Encourage various agencies providing case management services to coordinate community based "lunch and learn trainings" by their staff on best practices and evidence based case management issues. Based upon the scope of the training and the credentials of the staff presenters, continuing education might be provided to attendees.

“McLean County needs a community wide support system for case managers and families that would include (but not limited to) the faith based community, volunteers, peer support, businesses and private organizations that would provide resources to the diverse segment of the behavioral health population.”

3. Educate public about PATH training

Encourage the faith-based communities to participate in the PATH Community Services Training.
“McLean County needs a case management system to work within existing structures or to engage new structures to minimize the duplication of services and to meet behavioral health needs with support at the leadership level.”

4. Explore technology to enhance services between agencies
Ensure the client's case manager from the lead agency coordinates the case and has access to documentation with additional providers. “McLean County needs to evaluate the current/active case management system and effectiveness of previous case management services.”

5. Examine data requirements
Develop a common set of data that will be contained in notes for all agencies providing case management services.

6. Create reports for review by agency managers
Develop an evaluation process for the case management system (similar to data link) that includes data from items listed below.

- Clients served
- The community
- Progress made by the client
- Timeliness to linkage for critical services
- Engagement and follow through
- Case manager efficiency and productivity

LONG TERM OBJECTIVES

While the need “McLean County needs a case management system to work within existing structures or to engage new structures to minimize the duplication of services and to meet behavioral health needs with support at the leadership level” was stated above in the short term, there is also a long-term component.

1. Utilize technology
Develop a process to allow appropriate information on individuals being served by multiple agencies to be shared among these case management providers, HIPAA and other privacy issues must be addressed.

2. Continue to expand existing case management cooperation
Expand case management cooperation among agencies (two examples of this ongoing cooperation are Mental Health First Aid and the CHS Crisis Note.

- Ongoing Mental Health First Aid training is being provided through a collaboration of multiple county/community organizations.
- The CHS Crisis note was developed in collaboration with various community stakeholders and becomes part of the ongoing clinical record. Multiple community stakeholders were involved with its development but CHS is the only provider that completes the note in its entirety for data collection when documenting contact of clients in crisis.
  Continued efforts/no specific timeline.

“McLean County needs integrated, inclusive collaboration for case managers from local agencies working with behavioral health clients, including homeless, developmental disabilities, adolescents, substance abuse, family, school, etc. in a proactive manner.”

3. Develop inclusive best practice case management system
Encourage agencies to provide evidence based case management services.

Focus Area	Recommended Next Steps & Time Frames			
	Action	**Who**	**When**	**Goals/Metrics to Identify Positive Change**
Education	Notify agencies of PATH Directory		Begin in 1-3 mos.	
Education	PATH Community Services Training	New case managers, involved with case management services	Begin in 6-9 mos.(3 month lead time)	PATH reporting
Education	PATH training update	Every 3 years for all involved in case management	Begin in 6-9 mos.	PATH reporting
Education	Interagency training	Various providers	Begin in 6-9 mos.	Reporting from hosting agency
Pubic	PATH Community Services Training	faith community, volunteers, businesses, private organizations	Begin in 9-12 mos.	Reporting from PATH
Data	Explore technology – create similar to “Crisis Note” for case management	Major case management providers	Begin in 6 mos.	Usage of “Case Note” among providers
Data	Create common data set		Begin in 9-12 mos.	Document in all provider training material

Focus Area	Recommended Next Steps & Time Frames			
	Action	Who	When	Goals/Metrics to Identify Positive Change
Reporting	Create standardized reports for evaluation of services	All case management providers	Begin in 9-12 mos.	Reports on demand
Data	Utilize technology/software to share information	Service Providers	Begin in 12 mos.	Sharing information
Integrated Supports	Develop inclusive evidence based case management	Service Providers	Begin in 18 mos.	
Medical	List of EMR implementations for critical agencies	All agencies	Complete by 12/15	
Leadership	Complete MCDF EMR timeline	MCDF	Complete by 12/15	
Leadership	Formalize working agreements for EMR sharing	All agencies	Complete by 7/16	
Leadership	Appoint MHAB	BOH	July 2015	
	Grant writer	County Administration	As Needed	Contracts executed, grants applied for, grants awarded

Focus Area	Recommended Next Steps & Time Frames			
	Action	Who	When	Goals/Metrics to Identify Positive Change
Leadership	BH/DD coordinator	MCHD	April 2015	
Community	List of all mental health providers considered critical to service delivery as it relates to the McLean County Jail and hospital systems.		Dec. 2015	This list should include each organization's progress of EMR implementation.
Leadership	McLean County Jail complete an initial EMR implementation timeline to coordinate with jail expansion plan timeline.	Sheriff, County Administration	Dec. 2015	Report to County Board Oversight committee
Intgrated Leadership	Critical mental health service organizations have formalized working agreements as they relate to sharing patients' protected health information.	Hospitals, MCDF, CHS	July 2016	
Integrated Leadership	All organizations considered critical to mental health service delivery as it relates to MCDF and hospital systems provide regular progress reporting related to EMR implementation to an oversight group.		July 2016	

ACCESS TO MEDICAL SERVICES

AND

MEDICAL MANAGEMENT

ACCESS TO MEDICAL SERVICES AND MEDICAL MANAGEMENT

Medication and Medical Community Concerns in McLean County, IL:

1. Lack of access to medication and/or medication management for the mentally ill in McLean County
2. Lack of availability of timely services following release from hospitals or jail
3. Acute lack of prescribers for psychotropic medication

Specific County-wide needs as assessed and listed by the County Board Mental Health Advisory Committee on Needs:

1. McLean County needs the local medical community to increase efforts to develop a multi-disciplinary approach to behavioral health care.

2. McLean County needs to ensure that an array of behavioral health services are available and readily accessible to that population of individuals who confront mental health issues that are not yet chronic and persistent, so that their mental health issues can be timely addressed to reduce the prospect of decompensation resulting in long-term care and hospitalization.

3. McLean County needs to recruit a minimum of (3) three full-time equivalent behavioral health professionals, including psychiatrists and advanced practice nurse prescribers for children and adolescents. Their service must include public practice.

4. McLean County needs to recruit three-to-four full-time equivalent behavioral health professionals, including psychiatrists and advanced practice nurse prescribers for adults in both public and private practice.

5. McLean County, recognizing that 65-70% of psychotropic medication prescriptions written nationally are ordered by primary care physicians and pediatricians, needs to provide consultation and support to help and encourage them to enhance their knowledge of behavioral health issues.

6. McLean County Jail needs to be able to provide for an increasing number of incarcerated individuals access to psychiatrists and counseling, currently 28% diagnosed as mentally ill with 10% receiving psychotropic medication.

The County Board Mental Health Advisory Committee on Best Practices found the following to be Best Practices in Medication and Mental-Health Related Medical Services:

A system of Behavioral/Primary Health Care Services which include:

1. Electronic Medical Records (EMR) provide McLean County to opportunity to needs to integrate and encourage shared release of information for the mentally ill in order to provide holistic care, where able for core information

2. Health Care Teams at shared locations which provide comprehensive community-based medical, dental and mental health screenings, assessments, evaluation, treatment and rehabilitation services to all clients regardless of their ability to pay for such services, and to be cultural and linguistically competent

3. Primary Care Homes at locations throughout the community where client services are based on an integrated care management system and follow-up ranging from wellness to adequate handling of complex patients[1]

4. Services including the following:
    - Geriatric Psychiatric Services
    - Intensive Case Management Teams
    - Inpatient care and treatment

5. No appointment model for behavioral health services

[1] Evaluation at all locations of services to include: trauma, depression, anxiety, substance abuse and primary health screening as well as psychological and developmental assessments

Current Accomplishments

1. **Electronic medical records are being adopted by a wide variety of providers within the community**
2. **Under a recent HRSA grant, the Community FQHC can add a behavioral health professional for service to underserved community residents**

SHORT TERM OBJECTIVES

1. **Develop plan for EMR implementation**

to have all McLean County mental health service providers develop a plan for electronic health records implementation. In addition, under the structure of the current working committees under the Mental Health Advisory Group to the Executive Committee for the McLean County Board, committee members seek ongoing ways to enhance collaboration and care coordination through structured information sharing (working/business agreements, patient releases, processes for information sharing, etc.). It is recommended organizations consider the following to be important information to include in data sharing:

a. Patient Demographics
b. Diagnosis/Problem List
c. Medications (both current and discontinued)
d. Allergies
e. Hospital/Residential Admissions (if applicable)
f. Treatment Planning/Discharge Report
g. Pending Appointments
h. seek funding sources for social service agencies to convert records to an electronic system

2. **Initiating a trial using a no appointment model**
for behavioral health services provides access to clients who may be challenged because of medical condition to meet their scheduled appointment parameters and reduces the complication that no-shows create for providers.

LONG TERM OBJECTIVES

1. As McLean County progresses to improve its mental health services, it should not ignore the importance of Electronic Medical Records (EMR). Across the country, healthcare systems, both large and small, have migrated to EMR systems. The benefits of which mirror the goals of the McLean County's Mental Health Advisory Group on Coordination and Collaboration. Benefits of Electronic Medical Records include:

- Improved Patient Care
- Improved Coordination
- Increased Patient Participation
- Improved Diagnostics & Patient Outcomes
- Practice Efficiencies & Cost-Savings

While behavioral health is one of the most varied healthcare settings, encompassing a wide range of services from outpatient substance abuse treatment to full-time, residential psychiatric care, its services can also be enhanced with the use of EMR systems. Within local mental health services, the type of care provided also differs. For instance, a single organization may offer group therapy, one-on-one counseling, crisis stabilization and community outreach. Compounding the diversity is the fact that each area has significant sensitivities in terms of both treatment approach and client privacy. While these services may differ from traditional healthcare services, it does not exclude them from benefitting from EMR implementation.

Some McLean County mental health providers have implemented EMR's. This committee feels it is imperative for all healthcare providers develop a plan for EMR implementation in order to gain the benefits listed above. This will not only improve the care delivery for each organization, but will improve the collaborative efforts of the entire care delivery system.

For the need "McLean County needs a public model of the DataLink system for all agencies", exploration of the current DataLink system being utilized by some local service providers was conducted. The electronic database system is helpful for some organizations that use it, but there are several reasons why this system should not be explored further. DataLink is a program implemented through the Illinois Department of Human Services and only programs funded by IDHS can access DataLink. While this is a statewide database, programs that use it can only access records and information to the patients they serve.

While in a perfect world, all healthcare delivery organizations would share the same software and have integrated capabilities; this is not realistic for many reasons. Both hospitals current operate on different EMR platforms and organizations that have implemented or are looking to implement EMR will select a vendor based on the specific needs of their organization. Therefore, it is not the recommendation of this sub-committee that the County move toward an integrated EMR platform, but that each organization implement an EMR system and that organizations utilize their EMR systems to their fullest potential to better coordinate service delivery with shared populations.

Agencies that could not absorb the cost of their own EMR system should investigate vendors who may be able to provide for shared resources and database management systems spreading the initial cost and continuing maintenance over a larger number of providers.

McLean County

JUVENILE
(21 AND UNDER)

JUVENILES (21 and under)

McLean County should design a comprehensive, accessible, affordable, state-of-the-art behavioral health care system, integrated with primary health, education, social supports, and employment. Planning must begin by creating a system framework that includes a convener/leadership team (oversight group); a robust, shared data system; political support and policies that support coordination and collaboration; funding/grant writing; shared training and coaching to build critical skills; intra-agency policies and procedures that support coordination and collaboration, leading to an openness to organizational change for all stakeholders; and an evaluation system that demands ongoing accountability and reporting of results (movement toward designated outcomes) at regular intervals. Determining how desired outcomes will be measured will be critical to the success of the plan. The decision about creating a 708 board vs. our current system will need to be resolved with a goal to merge the infrastructure, oversight and funding for behavioral health (mental health and substance use) and intellectual disabilities/developmental disabilities to facilitate integrated cross-systems planning, service delivery, and accountability in an effective manner.

SHORT TERM OBJECTIVES

1. Develop a system framework (infrastructure) that includes political support/advocacy, policies that support integration, blended funding/grant writing, shared professional development/ coaching/consultation, and an evaluation system to track and report outcomes at regular intervals (aligned with federal and state initiatives)

2. Establish a Convener and Leadership Team to oversee work of action planning teams and to implement planning grants for team members

3. Develop/implement a "Call to Action" focusing on
    - ACES—Adverse Childhood Experiences Study
    - Youth Mental Health First Aid/Mental Health First Aid
    - Strengthening Families Approach
    - Stigma reduction for behavioral health challenges
    - Organization and mobilization of natural community-based supports (i.e. social networks) and services (i.e. transportation)

Guiding Principles of Behavioral Health Care for Juveniles (21 and under)

1. Use a System of Care (SOC) model, aligned with current federal and state behavioral health/integrated care initiatives, ensuring that the county/community work toward the following:
    - An integrated network offering a broad array of services and supports funded from multiple sources
    - Delivery of trauma-informed, evidence-based behavioral health and developmental disabilities services and supports in the least restrictive setting needed. Ensure that evidence-based, trauma-informed practices are being utilized by personnel in programs/agencies such as child welfare, home visiting, public health, child abuse and neglect prevention, early care and education, mental health, substance use, primary care, special education, and juvenile justice
    - Utilization of an individualized Wraparound practice approach (i.e. Person-Centered Planning). The wraparound process aims to achieve positive outcomes by providing a structured, creative, and individualized team planning process that, compared to traditional treatment planning, results in plans that are more effective and more relevant to the child and family. Through the team-based planning and implementation process, wraparound also aims to develop the problem-solving skills, coping skills, and self-efficacy of the young people and family members. The intensity and individuals participating in this process will be different based on the level of need of the identified young person
    - Family and Youth Partnerships and Leadership Development - opportunities with attention to cultural and linguistic needs
    - Cross-system "Planning and Thinking"-- Service coordination
    - Integrated Systems Framework—Cross-Agency Teaming, Training, and Collaboration
    - Community of Practice model that offers sufficient, effective, and ongoing professional development, supervision and consultation for providers, care-givers, family support specialists, and administrators
    - Services for Young Children and Their Families
        - Services for Youth in Transition to Adulthood (rehabilitation, empowerment, natural supports, education, work)
    - Collaboratively "develop outcomes and indicators to be measured, establishing a data collection process, collecting outcome and cost data, and developing an impact map". *(Return on Investment in Systems of Care for Children with Behavioral Health Challenges)*
    - Data-Informed Decision Making
        - Trend identification leading to concurrent planning for prevention and early intervention
        - Continuous assessment and improvement of services/models of treatment/fidelity to EBT
        - Accountability and Systemic Assessment

2. Adopt a philosophy and practices in support of diversion and/or return of youth from inpatient and residential treatment settings, decreased use of emergency rooms, and decreased use of juvenile correction by investing resources in cost-effective home and community-based services. Critical practices include a coordinated system of crisis response and intensive case coordination at low ratios for youth with intensive behavioral health and substance use challenges

3. Execute "A Call to Action" involving education, engagement, and mobilization of the community and its resources regarding:
    - ACES—Adverse Childhood Experiences Study
    - Youth Mental Health First Aid/Mental Health First Aid

- Strengthening Families Approach
- Stigma reduction for behavioral health challenges
- Organization and mobilization of natural community-based supports (i.e. social networks) and services (i.e. transportation)

4. Utilize higher education resources in the community to engage in evaluation of systems, practices, and outcomes associated with behavioral health/developmental disabilities services for juveniles.

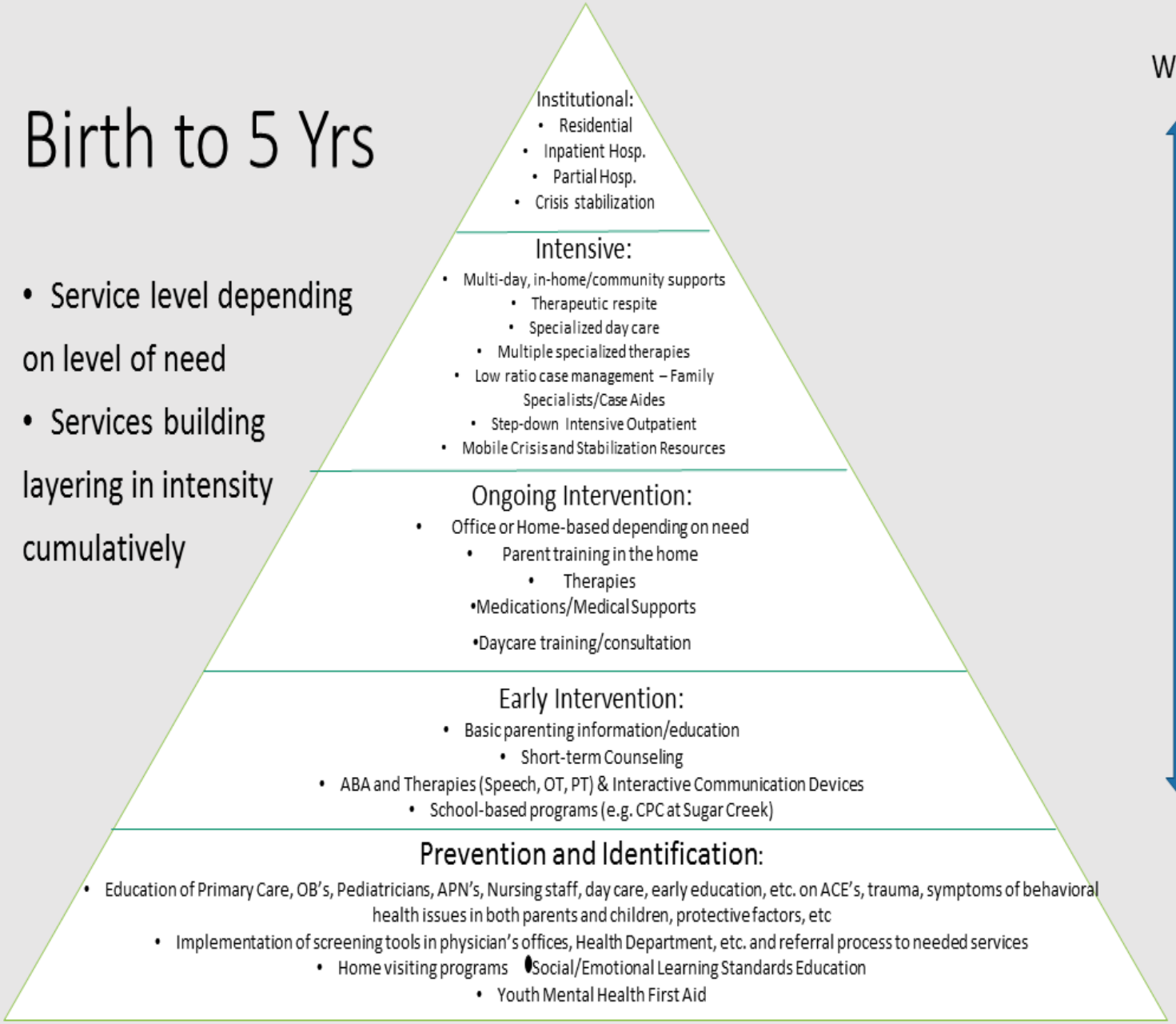
5. Coordinate a crisis response system/network for youth overseen by a single provider to streamline referrals, response, follow-up, etc. This system will include a mobile crisis team, therapeutic respite, a crisis stabilization unit, child and adolescent psychiatric beds, and step-down intensive outpatient services and supports. This needs to be integrated with state-proposed regional crisis stabilization/detox centers.

6. Create/expand gainful employment opportunities, in keeping with the Workforce Innovation and Opportunity Act (a blended funding framework and a "quality career pathways" model). This model includes a continuum of work-based learning experiences to include career exploration, career planning and management, job shadowing, job/work sampling, service learning, job development and coaching, internships, apprenticeships, paid employment, and mentoring. This model should be "job-driven"-responding to the needs of employers and preparing workers for jobs that are available now and in the future.

7. Enhance the current transportation system to provide access to behavioral health and developmental disabilities services, resources and supports and access to education/training and employment.

Birth to 5 Yrs

- Service level depending on level of need
- Services building layering in intensity cumulatively

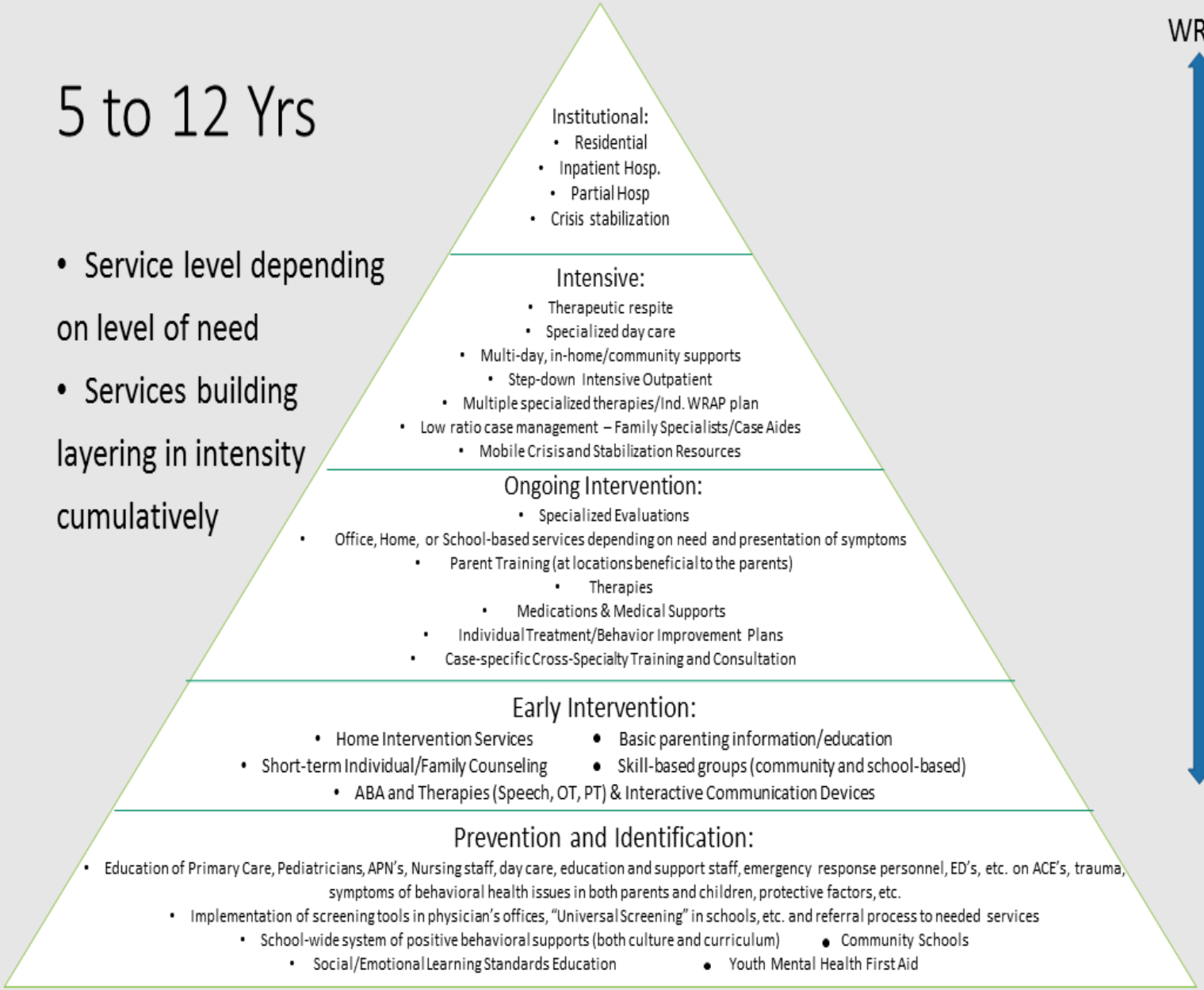


WRAP

- WRAP Teams
- WRAP-around Resources for Needs (e.g. housing, utilities, safety, transportation, recreation, social/emotional, child care, vocational, natural supports, nutrition, etc.)
- Parent Mentoring
- Consultation amongst providers w/ shared, ongoing service planning
- Cross-system training and coaching for/among providers, day care and early education, and juvenile justice
- Parent Partnerships & Leadership Development
- Family Navigators/Care Managers

5 to 12 Yrs

- Service level depending on level of need
- Services building layering in intensity cumulatively

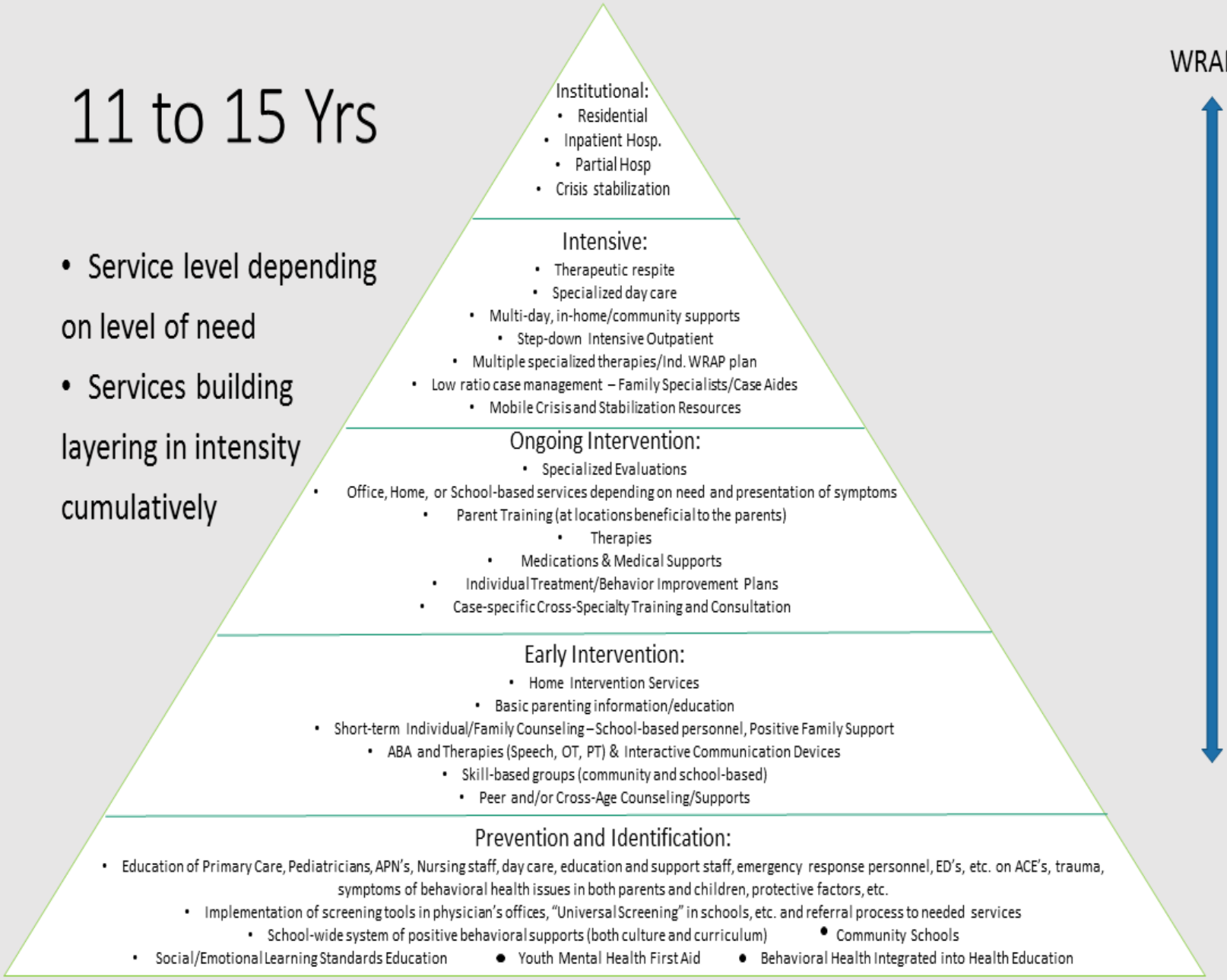


WRAP

- WRAP Teams
- WRAP-around Resources for Needs (e.g. housing, utilities, safety, transportation, recreation, social/emotional, child care, vocational, natural supports, nutrition, etc.)
- Parent Mentoring
- Consultation amongst providers w/ shared, ongoing service planning
- Cross-system training and coaching for/among providers, day care and early education, and juvenile justice
- Parent Partnerships & Leadership Development
- Family Navigators/Care Managers

11 to 15 Yrs

- Service level depending on level of need
- Services building layering in intensity cumulatively

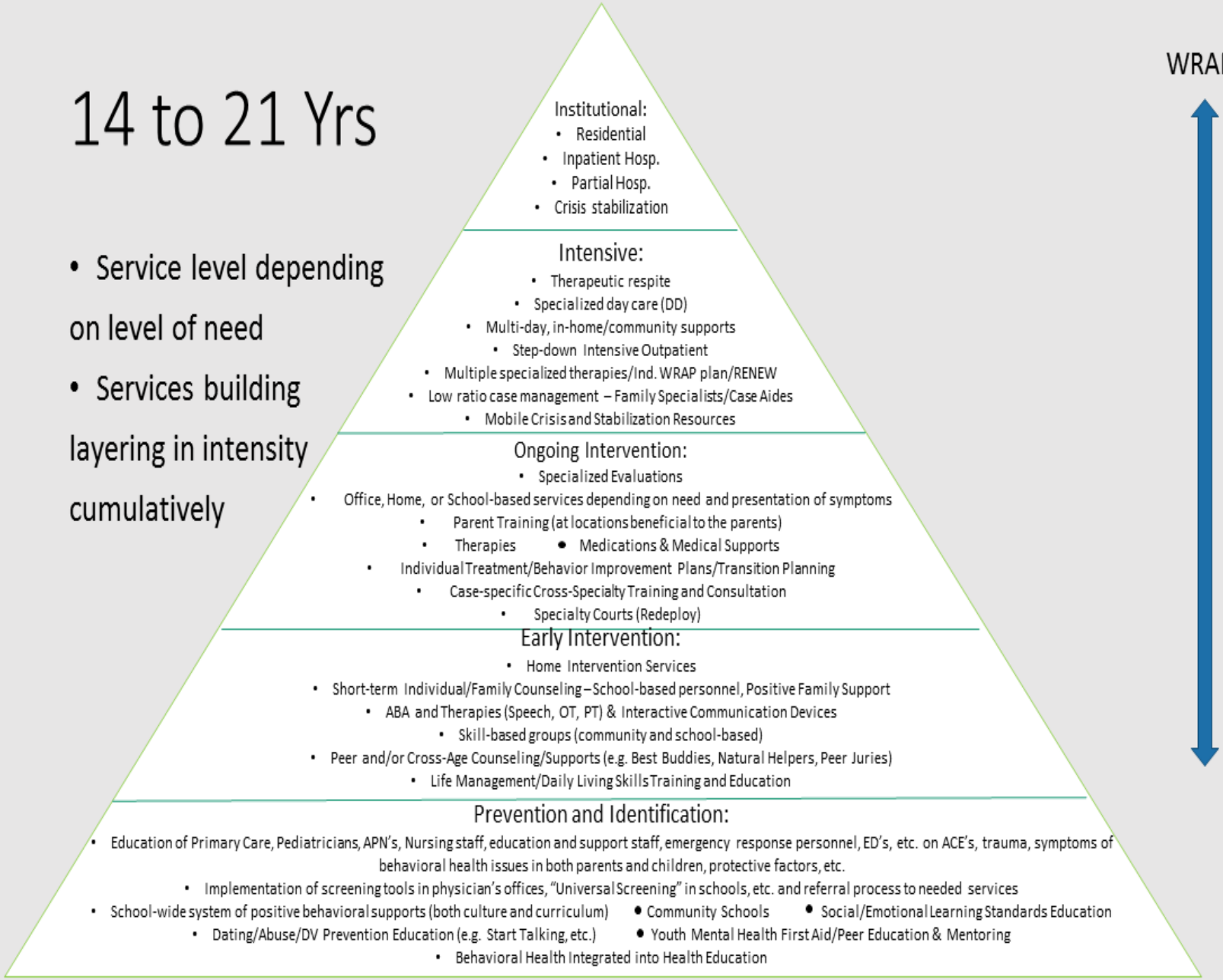


WRAP

- WRAP Teams
- WRAP-around Resources for Needs (e.g. housing, utilities, safety, transportation, recreation, social/emotional, child care, vocational, natural supports, nutrition, etc.)
- Parent Mentoring
- Consultation amongst providers w/ shared, ongoing service planning
- Cross-system training and coaching for/among providers, day care and early education, and juvenile justice
- Parent Partnerships & Leadership Development
- Family Navigators/Care Managers

14 to 21 Yrs

- Service level depending on level of need
- Services building layering in intensity cumulatively

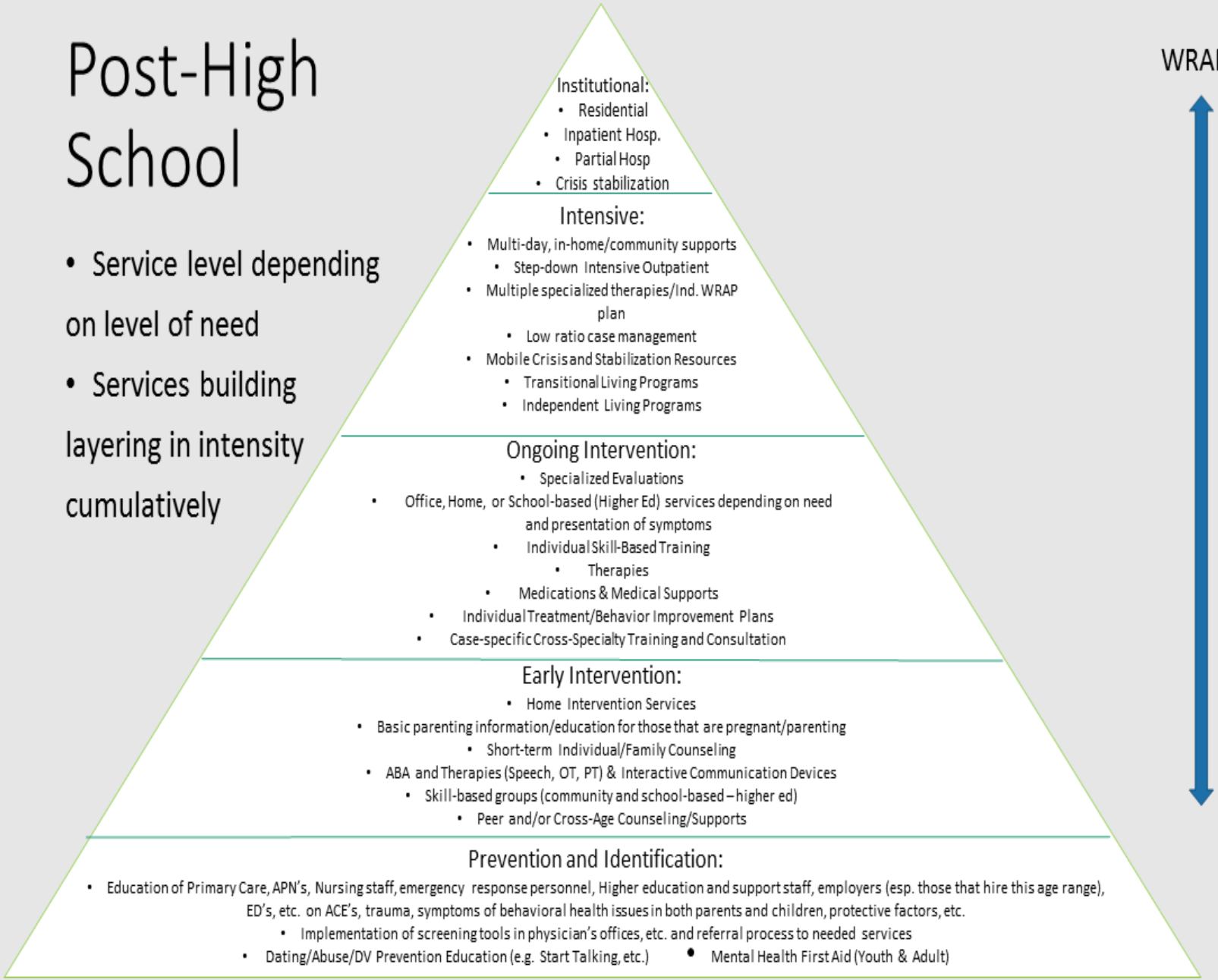


WRAP

- WRAP Teams
- WRAP-around Resources for Needs (e.g. housing, utilities, safety, transportation, recreation, social/emotional, child care, vocational, natural supports, nutrition, etc.)
- Parent/Peer Mentoring
- Consultation amongst providers w/ shared, ongoing service planning
- Cross-system training and coaching for/among providers, day care and early education, and juvenile justice
- Parent Partnerships & Leadership Development
- Family Navigators/Care Managers

Post-High School

- Service level depending on level of need
- Services building layering in intensity cumulatively



WRAP

- WRAP Teams
- WRAP-around Resources for Needs (e.g. housing, utilities, safety, transportation, recreation, social/emotional, child care, vocational, natural supports, nutrition, etc.)
- Peer Mentoring
- Consultation amongst providers w/ shared, ongoing service planning
- Cross-system training and coaching for/among providers, day care and early education, and justice
- Leadership Development
- Care Managers
- Specialty Courts

Focus Area	Recommended Next Steps & Time Frames			
	Action	**Who**	**When**	**Goals/Metrics to Identify Positive Change**
Convener and Leadership	Develop a system framework (infrastructure) that includes political support/advocacy, policies that support integration, blended funding/grant writing, shared professional development/ coaching/consultation, and an evaluation system to track and report outcomes at regular intervals (aligned with federal and state initiatives) Establish a Convener and Leadership Team to oversee work of action planning teams and to implement planning grants for team members	County Board and designees with specialized expertise employ convener; appoint leadership group	0 months, Complete by 3 months	Design an evidence-based integrated primary health, behavioral health, and developmental disabilities system of care that is consumer driven, easily accessed, effective, cost efficient, and accountable Provide incentives for service providers to promote collaboration/ integration Impact legislation related to increasing blended and flexible funding for behavioral health and developmental disabilities services; advocate for integrated systems of support at all levels Apply for and obtain grants to fund systemic components
Community Initiative/ Call to Action and Mobilization of Natural Supports	Develop/implement a "Call to Action" focusing on ACES/Trauma-Informed Care, Mental Health First Aid, stigma reduction, Strengthening Families, Community Schools, Recovery and Resiliency, Person-Centered Planning with goal of mobilization/organization of natural supports/ volunteer/service contributions from entire community	County Board/designees and leadership group in conjunction with community members offering ***natural supports***; business and civic organizations; faith community; peer support groups; parents/family/ caregivers; early education and day care providers; youth groups; higher education; community shelters; employers/ businesses; schools; retired citizens; libraries, transportation networks, etc.	Begin by 3 months, Complete by 18 months	Increase number of youth and families seeking services by reducing stigma attached to behavioral health issues and developmental disabilities Create a cadre of natural supports/peer helpers to prevent/ minimize/intervene related to behavioral health issues and developmental disabilities
Screening and Assessment	Develop/expand an integrated service delivery/response system for the identification and early intervention of pregnant women and	Obstetricians, gynecologists as well as primary care providers, nurses, behavioral health and developmental disability professionals,	Complete by 18 months	Develop a system of universal screening/assessment for behavioral health issues and

Focus Area	Recommended Next Steps & Time Frames			
	Action	**Who**	**When**	**Goals/Metrics to Identify Positive Change**
	parents/children dealing with trauma, depression, anxiety, substance use, domestic violence, developmental delays, and primary health issues	school personnel, day care providers, health department personnel, pregnant women and parents/families		developmental delays as early as possible Impact legislation to sufficiently fund screening and assessment services
Integrated Agency, School and Community Behavioral Health/ Developmental Disabilities ***Prevention and Early Intervention (Interconnected Systems Framework)***	Develop/expand an integrated system for delivering "best practices" wellness, prevention, and early intervention behavioral health and developmental disabilities services, resources, and supports in homes, schools, and community locations	Primary care providers, nurses, behavioral health and developmental disability professionals, school personnel/administrators, day care providers, health department personnel, social service agency administrators, youth and families, and potential funders	Complete by 18 months	Develop an integrated evidence-based system for prevention and early identification of primary health and behavioral health issues and developmental disabilities to minimize impact on infants, children, and families Identify current and potential sources to fund integrated prevention and early intervention services
Integrated Agency, School and Community Behavioral Health/ Developmental Disabilities ***Intervention and Intensive Intervention (Interconnected Systems Framework)***	Develop/expand an integrated system for delivering a continuum of high quality, solution-focused, and evidence-based behavioral health and developmental disability services in homes, schools and community locations. Integrate teaming, co-training, cross training, co-facilitation, and ongoing consultation/supervision of community and school behavioral health providers as a part of service delivery across agencies and entities involved. Integrate service planning across providers. Integrate daily living and employment services with clinical treatment.	Clinical practitioners, school leaders, school practitioners (school psychologists, school social workers, and school counselors), administrators and practitioners from social service agencies, juvenile justice personnel, youth and families, and potential funders	Complete by 18 months	Develop an integrated evidence-based, multi-disciplinary, easily accessed and affordable system to deliver a continuum of primary care, behavioral heath care and developmental disabilities services with level/intensity of intervention matched to level/intensity of need for youth and families in McLean County Identify current and potential sources to fund integrated intervention services

Focus Area	Recommended Next Steps & Time Frames			
	Action	**Who**	**When**	**Goals/Metrics to Identify Positive Change**
Capacity Building for Psychiatric, Developmental Pediatrician, and Advanced Practice Nursing Services (Diagnostic and Medication)	Develop/implement comprehensive plan for recruiting psychiatrists, advanced practice nurses, and developmental pediatricians for integrated community care and to empower/train/coach/recruit primary care physicians and clinical psychologists to address more of the diagnostic, specialized evaluations, and medication needs of those with behavioral health challenges and developmental disabilities *(OSF Resource Link and Consulting Psychiatrist/Physician Models)*	Administrators of hospitals and agencies, physicians, psychiatrists, physician organizations, advanced practice nurses, behavioral health and developmental disabilities professionals, youth and families, etc.	Complete by 18 months	Increase timely and affordable access to diagnostic services, ongoing care, and needed medication from psychiatrists, developmental pediatricians, and advanced care nurses Increase recruitment, training and consultation for primary care physicians to address behavioral health and developmental disabilities needs
Diversion from Residential/ Inpatient Treatment Integrated Crisis Response System	a) Develop/expand systemic components (intensive low-ratio case coordination and provision of evidence-based therapies, resources and supports) to divert youth with mental health/substance use and/or developmental disabilities from residential/inpatient treatment, and juvenile facilities. b) Develop/expand the overall comprehensive youth crisis response system overseen by a single provider. System would include mobile crisis team, crisis stabilization unit, therapeutic respite, child/adolescent psychiatric beds, and step-down intensive outpatient services, integrated with proposed regional crisis stabilization centers	a) Treatment facilities/providers and juvenile justice administrators/staff, psychiatrists, physicians, hospital administrators, youth and families, etc. b) Treatment facilities/providers administrators/staff, first responders, psychiatrists, physicians, hospital administrators, youth and families, etc.	Complete by 18 months Begin by 3 months, Complete by 18 months	Decrease number of youth needing emergency room care, hospitalization, and/or residential/ inpatient treatment, and incarceration related to behavioral health and developmental disabilities issues Develop an integrated, evidence-based continuum of crisis services for youth from crisis stabilization through follow-up Impact legislation related to sufficient, blended, and flexible funding for diversion and crisis services

Focus Area	Recommended Next Steps & Time Frames			
	Action	**Who**	**When**	**Goals/Metrics to Identify Positive Change**
Supportive Housing	Develop/expand network and implementation plan for increasing number of Supportive Housing Units for youth/families with behavioral health and developmental disabilities and those youth transitioning to independent living.	Bloomington Housing Authority, City of Bloomington, City of Normal, local property owners, youth and families, agency personnel, government employees in charge of funding and regulatory policies	Complete by 18 months	Increase number of families and youth with behavioral health and developmental disabilities with access to supportive, safe, and affordable housing
Education, Training, and Employment	Develop/expand the continuum of education, training, and employment supports and increase the number of supported, subsidized, and competitive employment positions for youth with behavioral health and developmental disabilities	Transition Planning Committee members Parents/ Families/Care-givers; Youth; Agency and School Administrators and Personnel, Juvenile Justice, Government and Business Leaders (Chamber of Commerce/McLean County Community Compact)	Complete by 18 months	Increase number of transition age youth with behavioral health and developmental disabilities involved in education/training ***leading to employment*** Increase number of businesses and entities offering employment supports and long term employment for those with behavioral health and developmental disabilities Impact legislation related to increased blended and flexible funding for employment services, work incentives, and tax incentives for employers
Transportation	Develop/expand current transportation services/options to allow affordable access to behavioral health and developmental disabilities services and to education/training, employment, and social supports	Staff/owners/managers from public and private transportation entities, youth and families	Complete by 18 months	To increase availability of safe, affordable transportation to allow access to needed supports, services, and employment

McLean County

HOUSING

HOUSING

There are two general concerns for housing in McLean County. These are: 1) access to clean safe, sanitary housing on a transitional/temporary, seasonal, or permanent basis, and 2) availability of supportive housing.

Of these general categories of need, County-wide needs as assessed and listed by the County Board Mental Health Advisory Committee on Needs were broken down as follows:

1. McLean County Jail needs specialized housing within the jail to provide a therapeutic environment for those incarcerated who cannot tolerate placement within the general population.

2. McLean County needs step-down housing to those individuals diagnosed with mental illness released from corrections facilities (Crisis Stabilization unit opening April 1 – 14 beds /initially 6 In lieu of jail/hospital – maximum stay 14 days – 4 beds for detox – 24/7 APN)

3. McLean County needs to increase the number of supportive housing beds from 84 beds to an estimated 180 based on the currently available data on the homeless population in the community , which housing needs to include step-down, transitional, and permanent types. (Need 54 beds for the chronically homeless)

4. McLean County needs to engage the Bloomington Housing Authority, the City of Bloomington, the Town of Normal, and local property owners to insure that there is adequate clean, safe, sanitary, affordable housing alternatives that meet minimum housing code standards.

5. McLean County needs to advocate for clients who are in housing that is unsafe, is of poor quality, or does not meet code. (Call PATH – works closely with COB)

6. McLean County needs to ensure that housing is accessible to those with disabilities, chronically mentally ill, veterans, and homeless populations needing continuous care.

7. McLean County needs to integrate and collaborate with housing providers and incentivize the collaboration based upon data driven outcomes.

The County Board Mental Health Advisory Committee on Best Practices identified the following to be Best Practices in Housing:

1. A continuum of housing options:
    a. Transitional Housing
    b. Emergency Shelter
    c. Recovery Housing
    d. Permanent Supported Housing
    e. Seasonal housing for the homeless population

2. Housing based services to assist individuals in remaining in the community/least restrictive environment which could include elements of the following:
    a. Intensive Case Management (homemaker assistance, transportation, medication management, recreational services, etc.)
    b. Intensive Home-Based Treatment (How is this different from "a")
    c. Supported Education
    d. Transportation
    e. Interactive Communication Devices
    f. Peer Support
    g. Recovery Support Coaching
    h. Job Training
3. Establish relationships with landlords for housing
        i. Rent Guarantees
        ii. Support for maintenance of housing

CURRENT ACCOMPLISHMENTS

There are a number of different agencies that provide housing assistance to homeless and mentally ill individuals. The services and work these agencies perform is summarized below.

1. PATH continues to work with the homeless population in the area. There are two main shelters in the community; however, some of the mentally ill may not be eligible for those beds as they are reserved families or there may be restrictions on client eligibility).
2. Chestnut Health Systems currently has twenty people in scattered site housing. This is permanent housing as opposed to transitional housing. These units are not Section 8 housing. They have worked to develop rapport with landlords. Chestnut's involvement allows landlords to know that rent will be paid. Case managers meet with regularly to assist with life skills. They continue to work to secure funds for additional housing.
3. The Salvation Army continues to house up to forty men and eighteen women at Safe Harbor. Over two-thirds have a mental illness or substance abuse issues. They provide case management, job development, and spiritual development. Clients typically stay for 8 weeks. Residents receive case management. There is also a warming center during the winter months (73-80 in the warming center average). SSVF – supportive services for veteran families. Pathway to Hope – case management program – families with children under 18 – goal to break the cycle of poverty/no longer relying on agencies for support.
4. Genesis House – HUD funded transitional housing –chronically homeless (maximum two (2) years/try to transition out after a year). Transitional Housing through COB. (Not restricted to HUD requirements)
5. There is FEMA money for short-term hotels – preference to families with children. (Through PATH)
6. Home Sweet Home provides shelter for up to 90 men, women, and children of all ages. They feed an additional 40-50 people at meals and over 350 food co-op members. (Low income food co-op – working a couple of hours in exchange for a shopping trip (100-150 dollars – Started in July) Residents receive case management while at the shelter. The goal is to get clients to the place where they can function in their own homes. As they leave the agency, they are connected with other supports in the community. A variety of classes are offered. Rapid re-housing program called Bridge of Hope for single moms.

    a. Working with CHCC – Mobile Health Project (at least once a month – goal is to get up to weekly)
        i. Providing medical services – Tent city
        ii. Strategic locations in the community
7. Center for Human Services operates several different types of housing:
    a. There is an 8 bed rooming house for those who are chronically mentally ill. This is staffed 24/7. Case managers work with clients on all types of life skills and the hope is that clients may eventually move to transitional housing.
    b. There is a 12 unit supportive housing program where case managers are on-site a minimum of twice a day. (Intensive case management)
    c. There are 5 transitional units where the average stay is 6 months. They receive case management, are checked on twice a day, receive aid in applying for benefits and accessing services from other agencies, and are assisted in finding supportive permanent placements.
    d. There are also 30 Section 8 vouchers. These clients receive a minimum of weekly case management.
8. Project Oz provides transitional housing for up to two years for teens/young adults. An estimated 75% of their clients have a mental illness.
9. Labyrinth provides outreach services to women who are transitioning out of jail or prison or who are on parole or probation. They provide assistance in many areas such as transportation, housing, counseling, case management, and education. Currently, they are raising matching funds to purchase transitional housing properties. As of January 5, 2015, they were $7,794 away from their matching grant goal of $48,000.
10. Jail study has been completed and the County is reviewing options for increasing appropriate housing for inmates with mental illness.

Some more recent accomplishments are:

1. The Community Health Care Clinic and Home Sweet Home have partnered to sponsor the Mobile Health Project. Home Sweet Home owns the vehicle, handles the logistics of the program (drivers, supplies, coordinating site locations) and provides linkage, referral, and follow up contact with patients for other needs they may have (housing, transportation, dental care, clothing, employment assistance). The Community Health Care Clinic provides the medical treatment. Currently, services are offered once a month. The goal is to move to weekly services. The clinic provides medical services at "Tent City" and strategic locations in the community to serve the homeless and other underserved populations.
2. Home Sweet Home began a low-income food co-op started in July 2014. There are now 350 food co-op members and others on a waiting list to participate. Co-op members work a couple of hours in exchange for a shopping trip in which they are allocated $100 to $150 to spend.
3. Veterans Affairs, PATH, The Salvation Army, and HUD collaborated on the goal of "finding mainstream housing for 10 chronically homeless veterans in 100 days." The collaboration resulted in mainstream housing (apartments with local landlords) for 11 veterans.
4. The jail study has been completed and McLean County Government is reviewing options for increasing appropriate housing for inmates with mental illness

SHORT TERM ACTION PLAN

1. Seek additional Federal housing vouchers for behavioral health clients.
2. Seek housing funding for construction of new subsidized housing units or scattered site leasing (Federal Government preference – scattered site is more cost effective)
3. Form a coordinated system for reviewing applications for housing assistance to maximize resources (Township, Veteran's Assistance, etc.)
4. Establish ties with rental groups, Bloomington Housing Authority
5. Develop a database of addresses/locations of people in scatter site housing/private housing to allow organizations to reach out to these individuals.

LONG RANGE PLAN

1. Construction of sufficient number of housing units – permanent and transitional to meet different levels of need.
2. Conduct a full inventory of all public and private housing units available for individuals with behavioral health issues to identify the location, rent and availability of supportive services for each housing unit.
3. Increase the level of services delivered by mobile units that bring services to locations with a high population of individuals with behavioral health issues.

McLean County

CRISIS

CRISIS

Definitions:

Crisis: An event that includes any or all of the following: a loss of function, ideation/intent/plans that present a danger to the individual or others, sharp and/or sudden increase in psychiatric symptoms, or any other situation requiring urgent care to restore the individual's previous level of functioning.

Crisis Intervention Services: – Actions designed to help an individual experiencing a crisis event avoid more restrictive levels of treatment (such as hospitalization) when possible and to assist in the prevention of future events. The primary goal of these actions is to stabilize and improve psychological symptoms of distress, allowing referral to and/or linkage with other ongoing mental health services to address issues that led to the crisis. These actions include, but are not limited to: safety/harm evaluation, mental health assessment, brief/immediate mental health services, therapeutic support, hospitalization, and case management services.

Crisis Stabilization: Crisis stabilization is defined as "a direct service that assists with deescalating the severity of a person's level of distress and/or need for urgent care associated with a substance use or mental health disorder. Crisis stabilization services are designed to prevent or improve a behavioral health crisis and/or reduce acute symptoms of mental illness by providing continuous 24-hour observation and supervision for persons who do not require inpatient services" (SAMHSA 2012).

County-wide needs as assessed and listed by the County Board Mental Health Advisory Committee on Needs:

1. McLean County needs enhanced crisis services with crisis response team members who are knowledgeable about available community services, able to make appropriate cross-agency referrals, and able to assist clients in navigating the behavioral health delivery system.

2. McLean County needs a mobile response team which is the front door of an integrated community-wide system that thoughtfully directs clients to needed services, monitors compliance, and assesses changing needs.

3. McLean County needs crisis response team members who have the necessary skills, training, education, experience, and confidence to provide an initial therapeutic response to a crisis situation.

4. McLean County needs a minimum of (3) crisis counselors available at any one time to travel, provide walk in service, or over-the-telephone intervention seven days a week, twenty-four hours a day.

5. McLean County needs a (10-14) bed crisis stabilization program for adults.

Best Practices – A System of Behavioral/Primary Health Care Services which include a Crisis Stabilization Unit (CSU) which provides stabilization and treatment services to persons who are in psychiatric crisis. CSU can serve as a step down from a higher level of care (i.e. inpatient hospitalization for state operated hospitalization). In many cases, mental illness can be treated in the unit and returned to the community without an inpatient admission to a hospital. The purpose is to treat crisis immediately; avoiding the wait or services that typically see the presenting condition worsen. The CSU should be connected to the integrated system in the event hospitalization is required. Best practices include:

1. Mobile Crisis Stabilization
2. Relapse Prevention
3. Follow-up
4. Outreach
5. Recovery Support Coaching
6. Crisis Residential Stabilization
7. Medically-monitored intensive inpatient
8. Urgent Care
9. Peer Support
10. 24/7 Crisis Hotline
11. 23 Hour Crisis Stabilization

CURRENT ACCOMPLISHMENTS

The McLean County Board has initiated and supported action to meet the needs for enhanced crisis stabilization and treatment services. As a result, and with the help of monetary support from grants and actions taken by related community service provider organizations, the following has occurred:

1. It is important to note that many of the accomplishments are a direct result of collaborative efforts overseen by the McLean County Health Department. Together, County Board Members, Board of Health Members, the League of Women Voters, County employees, community providers and entities have made significant progress this past year, but without this funding and approval from the Board of Health, many of the accomplishments could not have occurred. The coordination between the jail and community crisis planning group, the improved reporting, and improvements in data collection are all a direct result of priorities of BOH and MCHD.

2. Chestnut Health System has applied for, and received grant funding which has allowed for a development and opening of a short-term, crisis stabilization unit.

3. The Center for Human Services (CHS) has enhanced its data collection and reporting processes regarding crisis services (For an example, see Attachment A). CHS has shared this information with other community stakeholders as part of its ongoing collaborative efforts to improve the provision of crisis intervention and related services in the county. This has allowed for better analysis of trends and needs by all parties. CHS has increased the number of crisis counselors on staff. Using the enhanced data, CHS has

also been able to identify times of peak demand for services and allocate staff accordingly. These two factors have resulted in 2-3 crisis staff being available for calls during such time periods, increasing the number of persons served and improving response times. The Center has continued to provide quality crisis services and has improved training while working with other community stakeholders to increase awareness of community resources. CHS has approached other agencies/entities (BPD, NPD, McLean County Sheriff, Advocate, OSF, PATH, Chestnut and others) to develop a direct means of communication and collaboration.

4. A Community Crisis Planning Committee has been formed consisting of members from PATH, Chestnut Health Services, Advocate Bromenn, OSF, SASS and Center for Human Services (and other key leaders in crisis care services) which is now working and meeting regularly to provide co-ordination and integration of services (see Attachment B for sample meeting notes). As a result of their action, a crisis response action plan has been developed which will help to deal with any adult person in crisis in a more immediate and precise manner (see diagram on following page). Through the committee's efforts immediate improvement in services already in place have been provided as evidenced by:

    1) Crisis response times showing actual response times.
    2) The CHS crisis note (7-page crisis assessment form) has been developed and its information is now being shared with some agencies, including the hospitals. NOTE: Pages 1 and 2 of the Plan are consequently sent to PATH and include a safety plan and an action plan developed with and for the client.

5. In January 2015 a person was hired by PATH for up to 5 clinical follow-up services for cases presented by the crisis team (Attachment C).

6. Law enforcement has gained new solutions within the Jail environment Inmates at the Jail have 24/7 services for crisis response. The Jail is working with CHS and local providers to insure proper planning for ongoing care after discharge. Weekly contact is maintained between the Jail and MCCHS staff to make sure that timely screening appointments are scheduled upon release.

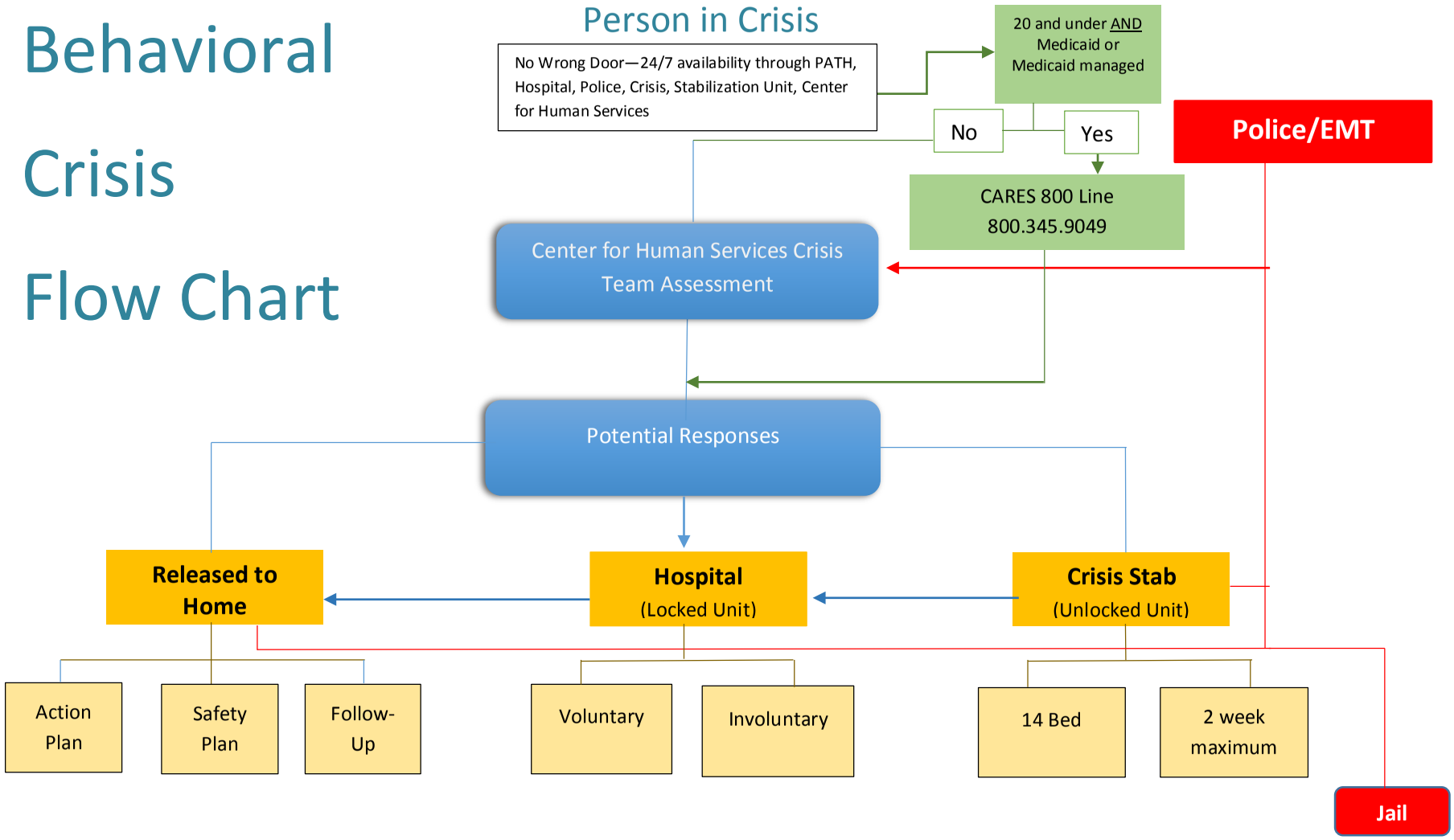
7. The McLean County Board Property Committee is continuing to work with consultants and architects to find a solution to providing improved capacity for the jail and facilities that will allow for better services to those in crisis.

8. Efforts are continuing to guarantee that all first responders receive CIT (Crisis Intervention Training).

9. Efforts are currently being undertaken for hospitals and responders to improve provision of data-keeping for use by all involved agencies.

10. Development of the following Continuity of Care model:

Behavioral Crisis Flow Chart



No Wrong Door: A person seeking help can be referred to crisis services through any organization (not limited to examples provided below).

Doctors | Employers | Churches | Family/Friends | Hospitals | Schools | Agencies

Vision: Continuity of Care

SHORT TERM ACTION PLAN

1. Expand follow-up services and funding to provide an array of services and necessary personnel for Chestnut, Center for Human Services, hospitals and the Jail.

2. Increase funding for clinical treatment and follow-up services.

3. Continue to improve the plan for follow-up services being coordinated by PATH. Through the follow-up services under the direction of PATH, linkages will be made to community resources to help clients (e.g. emergency funds, transportation, etc.).

4. Investigate the development of a Volunteer Peer Mentoring Recovery Support System that could be utilized and encouraged by all agencies. This would greatly help for prevention of relapse and wellness recovery.

5. Adopt trauma informed intervention to assist the individual and families.

6. Continue to improve the plan for follow-up services being coordinated by PATH.

7. Provide crisis intervention services in the least restrictive environment to reduce trauma, emergency room visits, and incarceration.

8. Improve crisis outcomes by utilizing national standards to assess individuals in the most comfortable setting possible, such as at home, community, or in a 'living room' type of environment including a stabilization unit.

9. Develop protocols for all integration/coordination efforts which include addressing legal methods to handle confidentiality.

10. Initiate and continue crisis intervention training for all first responders.

LONG RANGE ACTION PLAN

1. McLean County Board will annually convene a public forum on the state of Mental Health in the County designed to evaluate the progress of Mental Health plan in McLean County.

2. McLean County Board will establish a Mental Health Coordinating Council with community wide representation including both representatives of the mental health delivery system and community members.

3. The Community Crisis Planning Committee will continue to meet to collaborate between various agencies.

4. The McLean County Board will establish a full-time, working Health and Human Services Committee to provide oversight for County Mental Health Services, the McLean County Department of Health, and the McLean County Nursing Home.

5. Work towards a countywide commitment to diversified funding of Community Mental Health – including crisis services.

6. Expand community mental health services in all McLean County Detention Facilities.

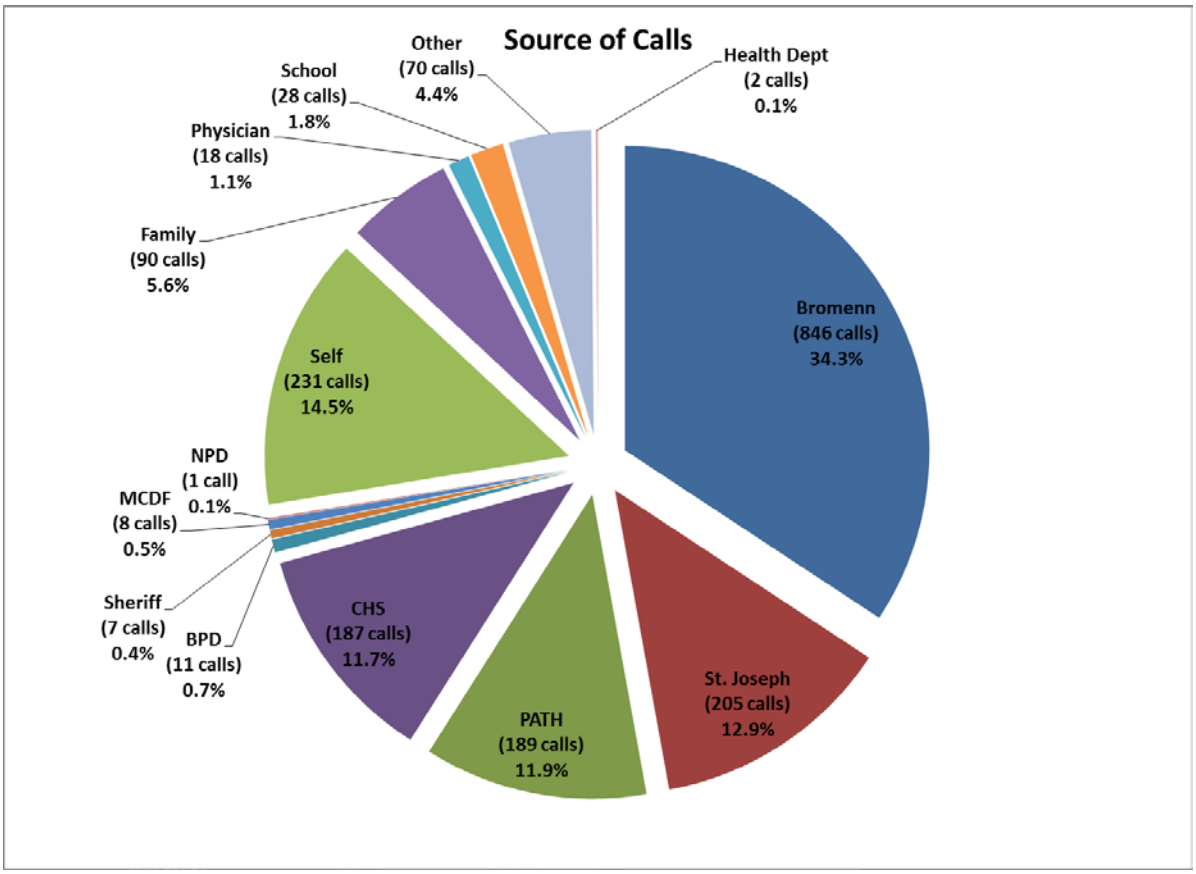
7. Continue to encourage and provide ongoing mental health training (PATH, Crisis Team, schools, churches, families, etc.) in a variety of formats (in person, web based, etc.).

Attachment A

MCLEAN COUNTY CENTER FOR HUMAN SERVICES
EMERGENCY CRISIS INTERVENTION CALL DATA
JULY 1ST – DECEMBER 31ST, 2014

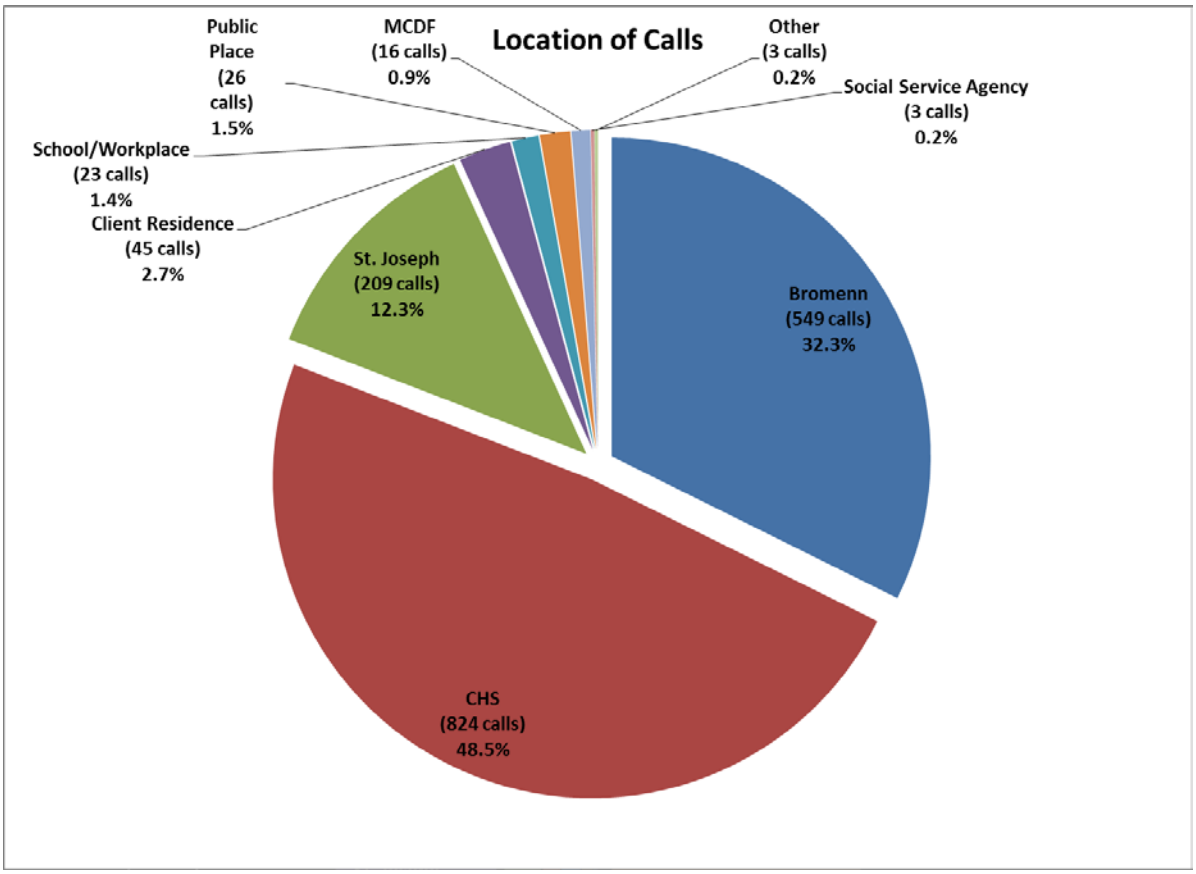
Source of Calls

- The source of the call is the person or place that initiates the Crisis intervention.
- At times, individuals seen at hospitals present with other medical symptoms, however during screening and triage the hospital staff request crisis services due to the presence of some psychiatric symptoms.
- Referrals from hospitals may be a mix of clients that were sent by other referral sources to the emergency department for assessment.
- 53% were community based with 47% generated at hospitals
- During the first quarter of FY 2015, there were certain circumstances in which this data was not collected (105 calls), particularly regarding calls in which services related to interventions (such as follow up calls) were provided or when scheduled welfare checks were performed. The gathering of this type of information began in in the second quarter and will continue into the future.



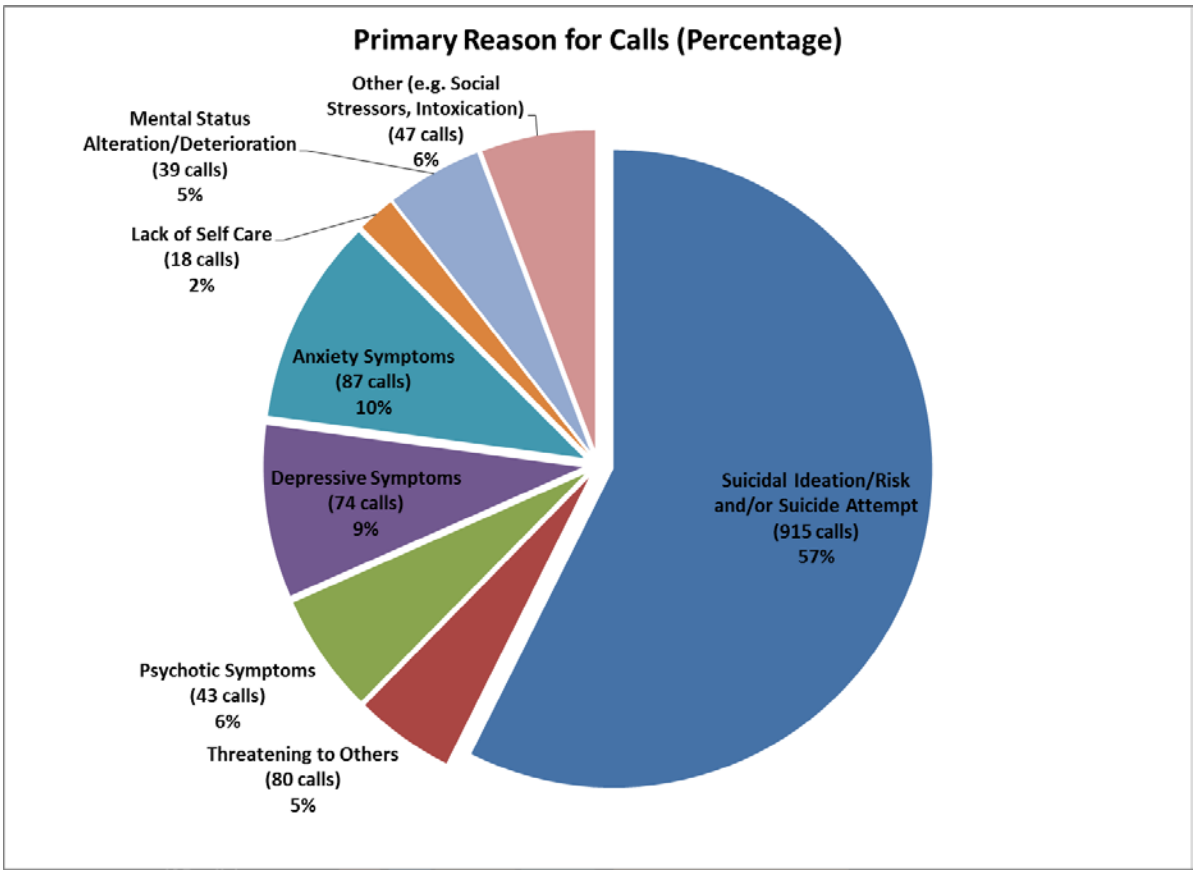
Location of Calls

- Location of calls indicates where services are given to clients. As certain calls include services at multiple locations, the above graph denotes the location where the clinical intervention began.
    - This includes phone calls which primarily occur at McLean County Center for Human Services. This contributes to higher number of calls at this location.
- The public is encouraged to contact the McLean County Center for Human services to seek out crisis services directly either in person or over the phone.



Reason for Calls

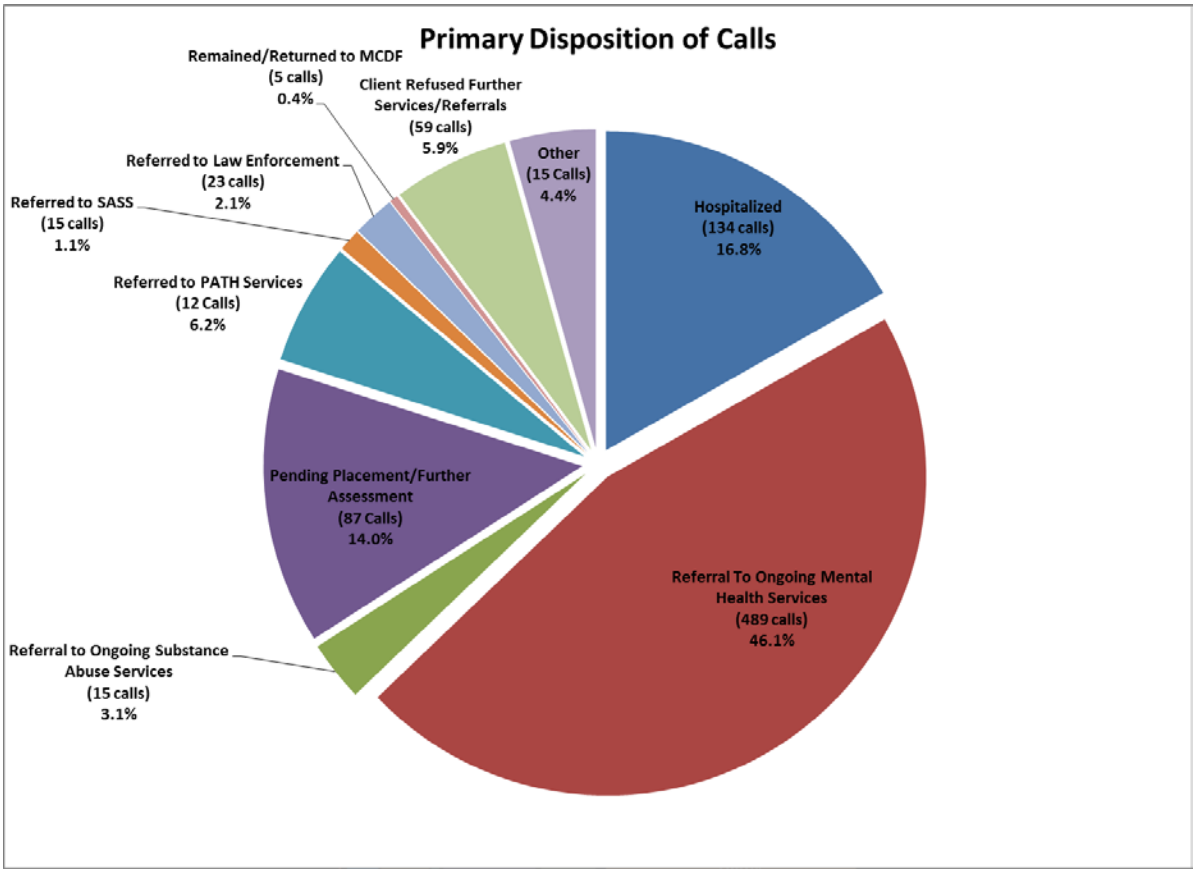
- The reason for the call is the most pressing symptom during the current crisis contact.
  - This includes calls handled by the crisis team due to the severity or complexity of mental health symptoms. This includes:
    - Calls transferred from PATH to the crisis team
    - Calls made directly to the crisis team
- During the first quarter of FY 2015, there were certain circumstances in which this data was not collected (103 calls), particularly regarding calls in which services related to interventions (such as follow up calls) were provided or when scheduled welfare checks were performed. The gathering of this type of information began in the second quarter and will continue into the future.



Disposition of Calls

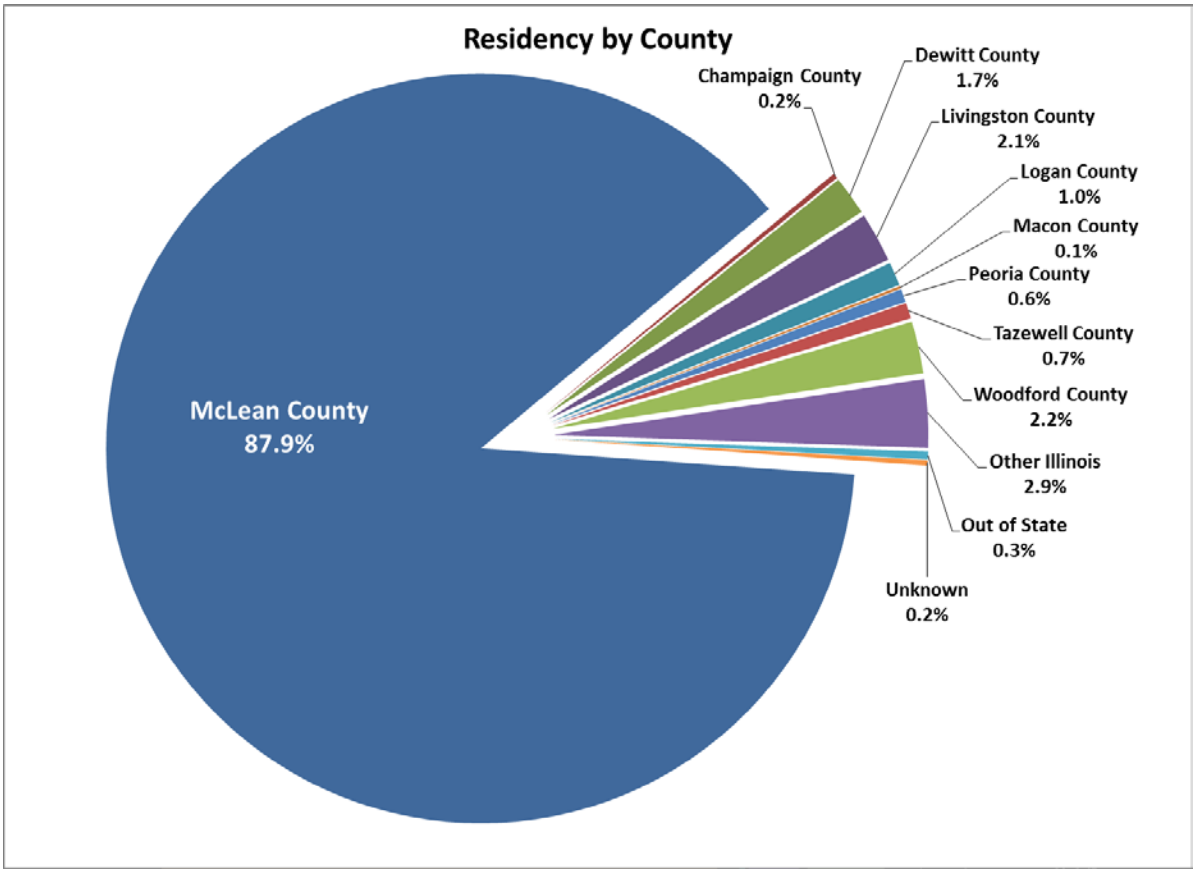
A primary disposition is the "next step" in the intervention. At times, this could be further evaluation. It can also represent a recommended course of treatment, which can include referrals to other community resources or providers as appropriate.

- The other category generally represents providers in primary care physician offices or out of county referrals.
- Referrals to services are based on information the client provides to staff. This can include what type of insurance they may have or funding source.
- As crisis staff cannot determine which services will be provided when requesting services via 911, requests through 911 are included in referrals to law enforcement.
- Pending placement/further assessment refers to instances in a psychiatric bed is not available or an individual may need further medical assessment/clearance. At times during such instances, a call will end. The individual may be discharged by medical or other clinical personnel prior to reassessment by CHS crisis staff
- The other category generally represents providers in primary care physician offices or out of county referrals.
- PATH's phone line and suicide prevention line are not listed in the above chart but are generally given as a resource to all clients to call when appropriate. PATH services that are included in the chart refer to other PATH services (e.g. emergency housing, transportation vouchers, elderly services, etc.).



Residency

All services took place within McLean County. Residence data is based upon addresses given to staff by clients/collaterals at the time of service. Thus, individuals designated as out of county residents may have been visiting or have temporary housing (such as students who provide their permanent address rather than their local address) in McLean County at the time of service. Residency is also categorized by zip codes, thus certain areas may appear to be out of county, when they are in fact in McLean County. For example, El Paso is primarily located in Woodford County (although part of it crosses into McLean County); however, the zip code designated for El Paso covers a larger portion of both Woodford and McLean Counties.



FY 2015 SECOND QUARTER REPORT FOR MCLEAN COUNTY HEALTH DEPARTMENT

NARRATIVE ATTACHMENT

CRISIS INTERVENTION PROGRAM

The purpose of this report is to provide information regarding crisis intervention services delivered by the McLean County Center for Human Services. Information contained in this report reflects services provided by crisis team members. Services were defined as any crisis intervention, assessment, and related services provided by either the mobile or in-house crisis team.

While this report focuses on program objectives, it also contains other information not required for this purpose in order to better understand the needs and trends of the community. In order to reflect the extensive crisis services in the community and provide accurate information to other entities involved with the provision of mental health services in the county, The Center for Human Services continues to enhance its data gathering and reporting processes. Although information gathered and subsequent reports may seem similar from one quarter to another, such data cannot always be directly compared. Explanations of such information are contained in the narrative sections below.

PRIMARY PROBLEM AREA(S) OF CLIENTS SERVED

Crisis Assessment and Stabilization

- A mental illness or emotional disruption so severe that it incapacitates an individual to the extent that he/she is unable to perform activities of daily life effectively (e.g., schizophrenia, bipolar disorder, intermittent explosive disorder, etc.)
- Suicidal or homicidal ideation, impulses, gestures
- Behavior disruptive to the community for an unknown reason
- Individuals experiencing their first psychiatric symptoms

SUMMARY OF PROGRAM ACTIVITIES

- Stabilization of individuals in crisis so that they can remain safe and function better in the least restrictive environment.
- Referral to appropriate next step following stabilization (e.g. hospitalization, counseling, case management)
- Screening and crisis counseling for walk-in and emergency Medicaid and non-Medicaid referrals.
- Screening individuals who present for psychiatric hospitalization at Advocate BroMenn or St. Joseph's Regional Medical Center.

- Conduct welfare checks on individuals identified as high-risk by other professionals. Welfare checks are often planned assessments that are non-urgent in nature. The goal of these services is to provide support and early intervention to those at risk before their symptoms become exacerbated.
- Consultation with law enforcement, educational personnel, and other medical professionals in determining the most appropriate response to mental health issues they encounter in the community.

CLIENT/SERVICE INFORMATION

Unduplicated Clients Served: 485

Residence Status:

All services took place within McLean County. Residence data is based upon addresses given to staff by clients/collaterals at the time of service. Thus, individuals designated as out of county residents may have been visiting or have temporary housing (such as students who provide their permanent address rather than their local address) in McLean County at the time of service.

RESIDENCE					
Location	New Clients	Total Clients	Location	New Clients	Total Clients
McLean County	350	429	Peoria County	2	2
Champaign County	1	1	Tazewell County	6	6
Dewitt County	9	10	Woodford County	9	9
Livingston County	8	8	Other Illinois	4	5
Logan County	2	4	Out of State	1	1
Macon County	0	0	Unknown	2	10
			Total:	394	485

MCLEAN COUNTY DETAILED RESIDENCE								
Location	New	Total		New	Total		New	Total
Anchor	0	0	Colfax	2	2	Leroy	1	2
Arrowsmith	0	0	Cooksville	0	0	Lexington	4	5
Bellflower	0	0	Cropsey	0	0	McLean	3	2
Bloomington	211	264	Danvers	2	3	Merna	0	0
61701	*145*	*185*	Downs	0	0	Normal	94	115
61702	*1*	*1*	El Paso	8	8	Saybrook	4	4
61704	*54*	*62*	Ellsworth	0	0	Shirley	1	1
61705	*11*	*16*	Gridley	1	1	Stanford	1	2
Carlock	0	0	Heyworth	9	11	Towanda	0	0
Chenoa	4	4	Hudson	5	5	Other	0	0
						Total:	350	429

CALL SUMMARY

Total Calls: 854

- The number of times that the crisis team was requested to intervene with an individual. This intervention could be over the phone or face-to face. Clients may have multiple calls during the quarter.

Total Client Services Provided: 1,268 **Total Client Service Hours Provided:** 1,323

- It is important to distinguish a call from a service. Within a single call, multiple service events may occur. An example could be the crisis assessment, collaboration with a family member, and coordination with other service providers all being provided in a single crisis call.

Average Client Services (in minutes) Provided Per Call: 93 minutes

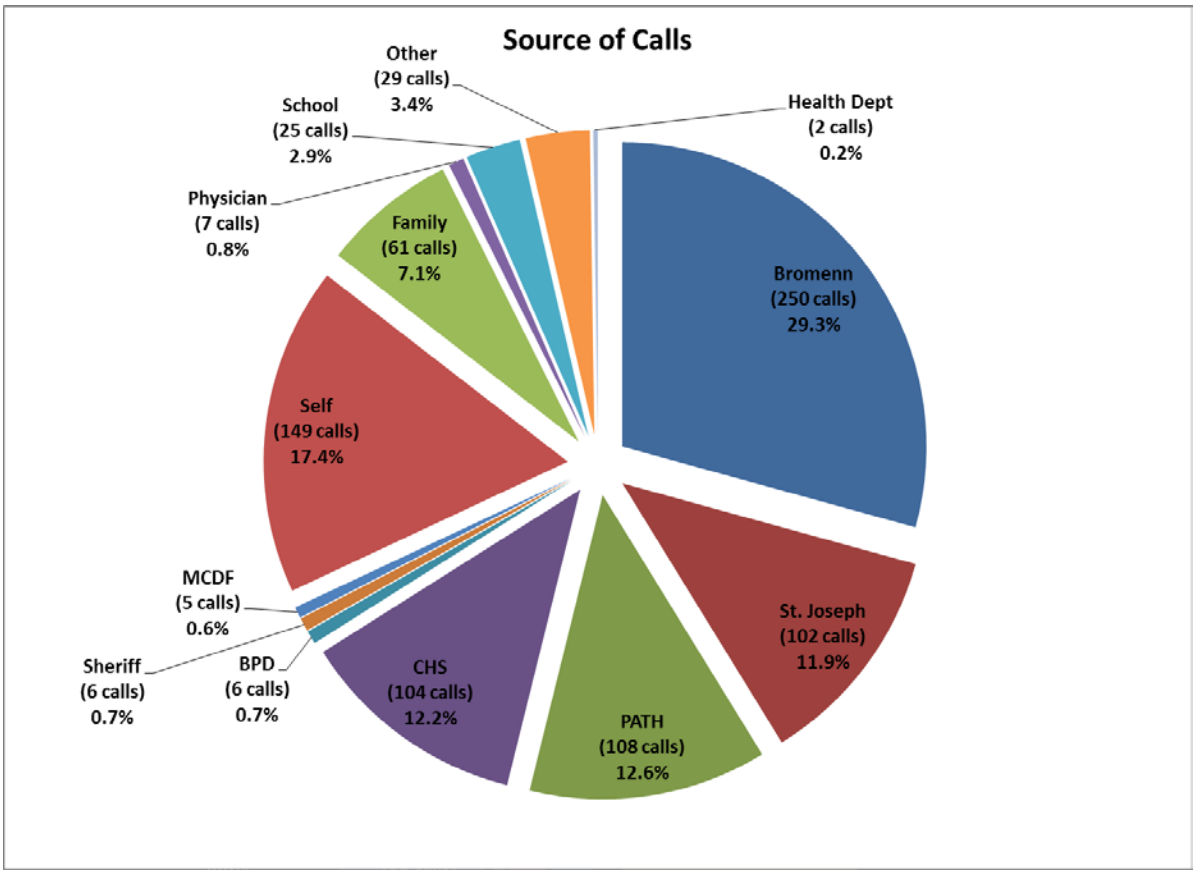
This number represents the total number of client service hours provided divided by the number of calls. This number reflects the time spent in the direct provision of service to/on behalf of an individual.

Average Call Duration: 139 minutes

- Duration was measured from the time of the initial contact to the end of the last service. In prior reports, this measurement varied as periodically, the start time began with the beginning of the first service rather than the first contact.
    - This time period includes not only the client service time mentioned above, but also the time spent on other aspects of delivering crisis intervention. These aspects consist of both systemic and internal factors that contribute to the overall duration of the call.
        - Examples include: Time spent waiting on the client and/or collaterals, staff time spent on another call, time spent waiting on other professionals, time spent gathering information, time spent waiting for medical tests/clearance, travel time, and the time the individual was intoxicated.
- Calls can consist of phone calls, face-to face interventions, and hospitalization placements. Hospitalizations can take several hours to facilitate thus causing the average duration of calls to increase.

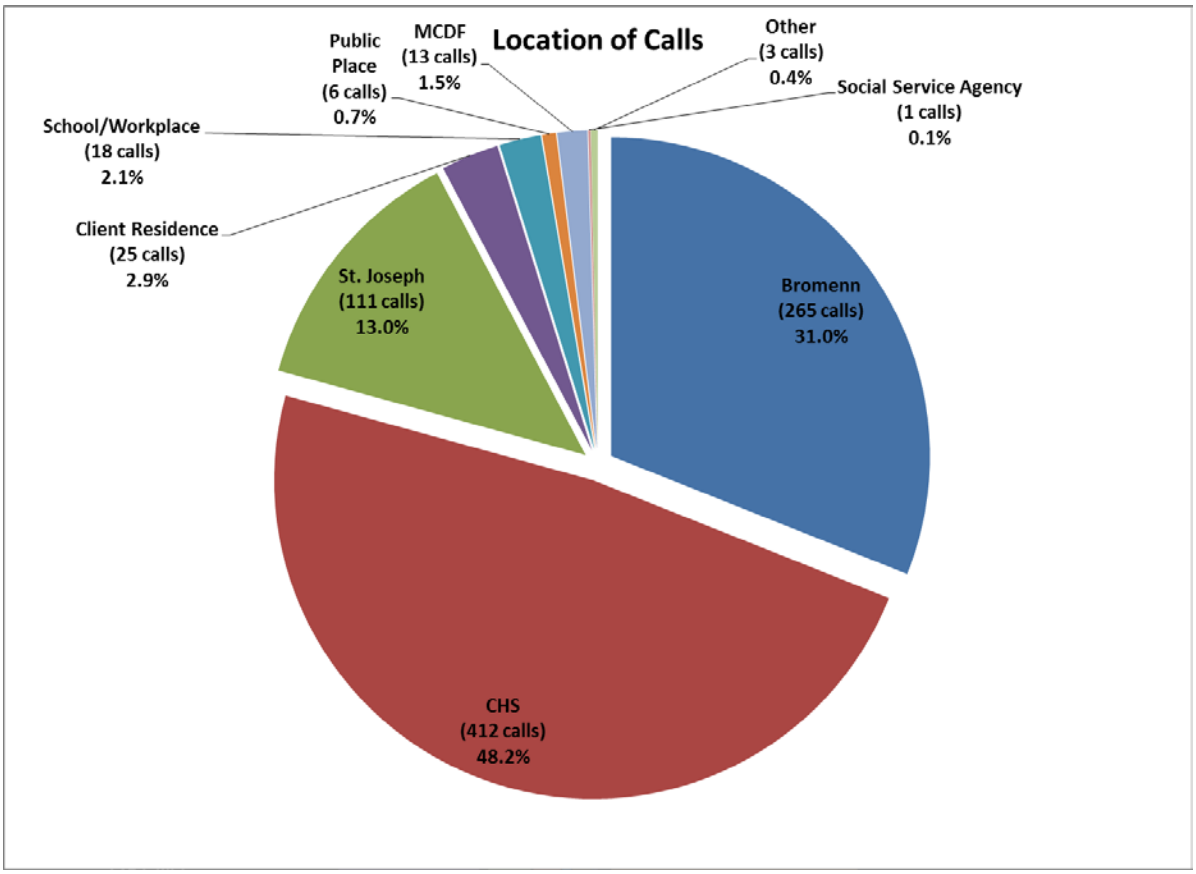
Referral Sources of Calls

- The source of the call is the person or place that initiates the Crisis intervention.
- At times, individuals seen at hospitals present with other medical symptoms, however during screening and triage the hospital staff request crisis services due to the presence of some psychiatric symptoms.
- Referrals from hospitals may be a mix of clients that were sent by other referral sources to the emergency department for assessment.
- 58.8% were community based with 41.2% generated at hospitals



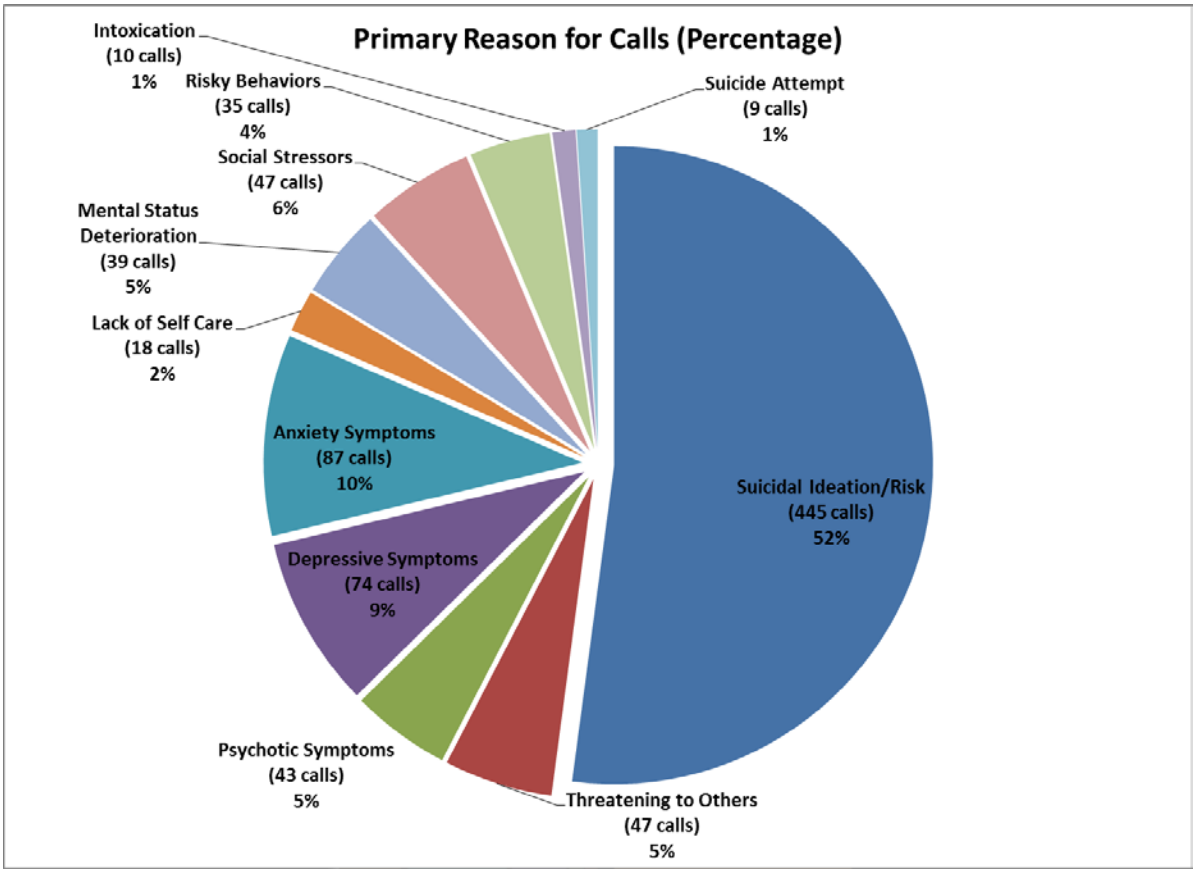
Locations of Calls

- Location of calls indicates where services are given to clients. As certain calls include services at multiple locations, the above graph denotes the location where the clinical intervention began.
    - This includes phone calls which primarily occur at McLean County Center for Human Services. This contributes to higher number of calls at this location.
- The public is encouraged to contact the McLean County Center for Human services to seek out crisis services directly either in person or over the phone.



Reasons for Calls

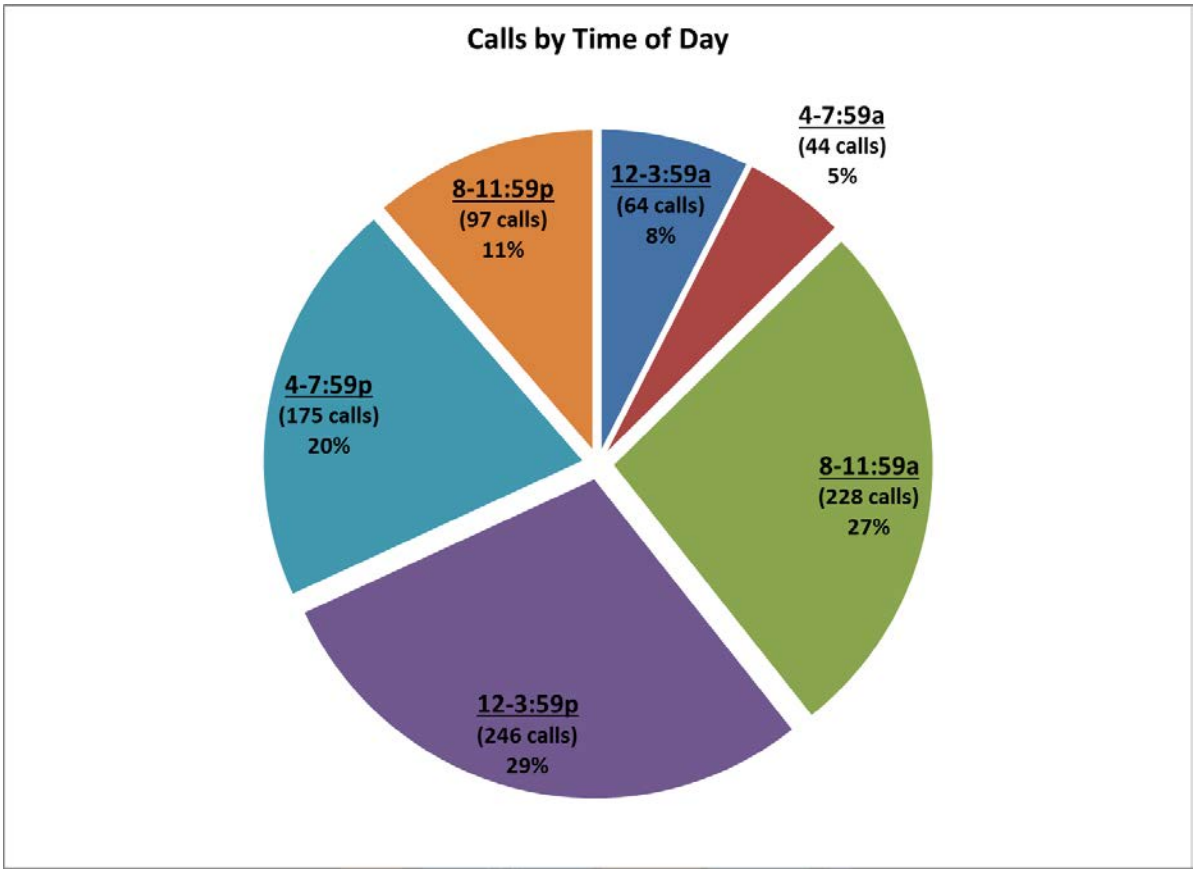
- The reason for the call is the most pressing symptom during the current crisis contact.
- 52% of calls were in response to suicidal ideation or risk of suicide.
  - This includes calls handled by the crisis team due to the severity or complexity of mental health symptoms. This includes:
    - Calls transferred from PATH to the crisis team
    - Calls made directly to the crisis team

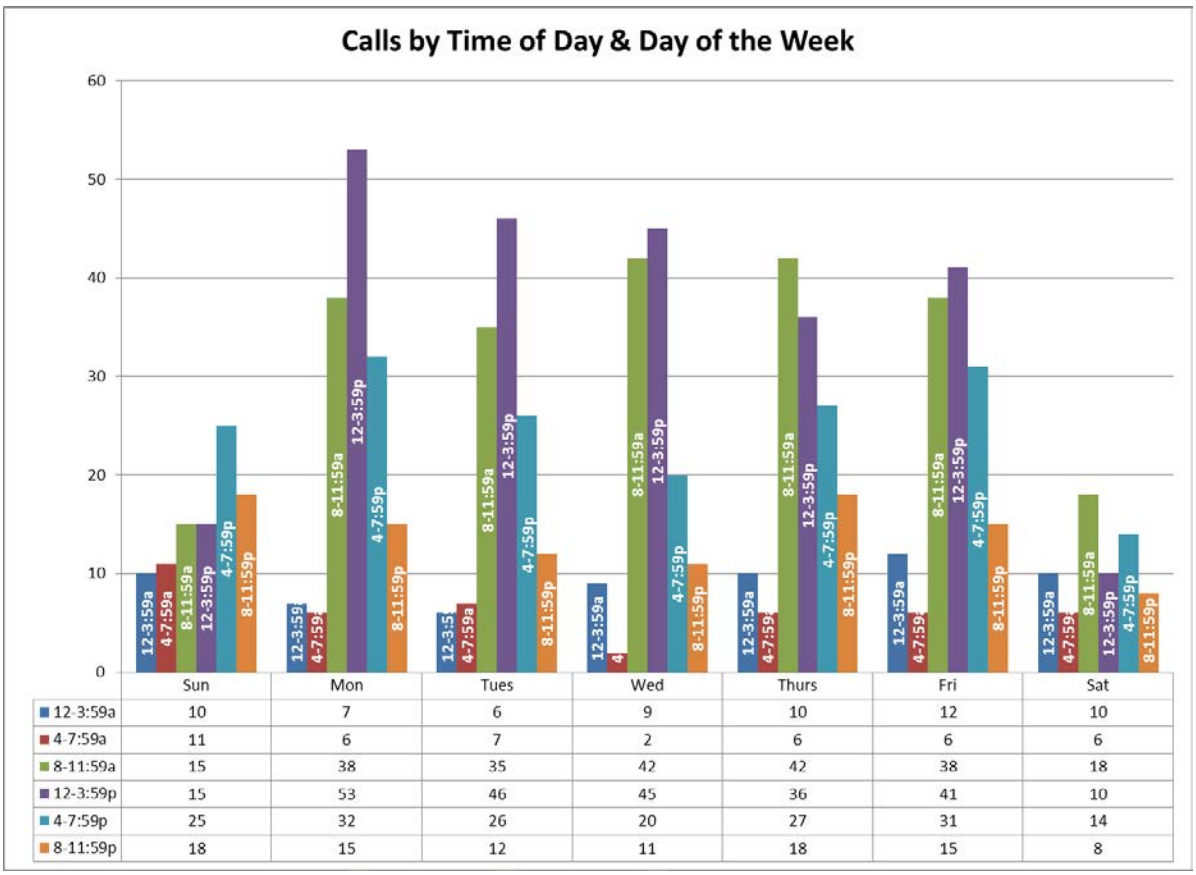


Times of Calls

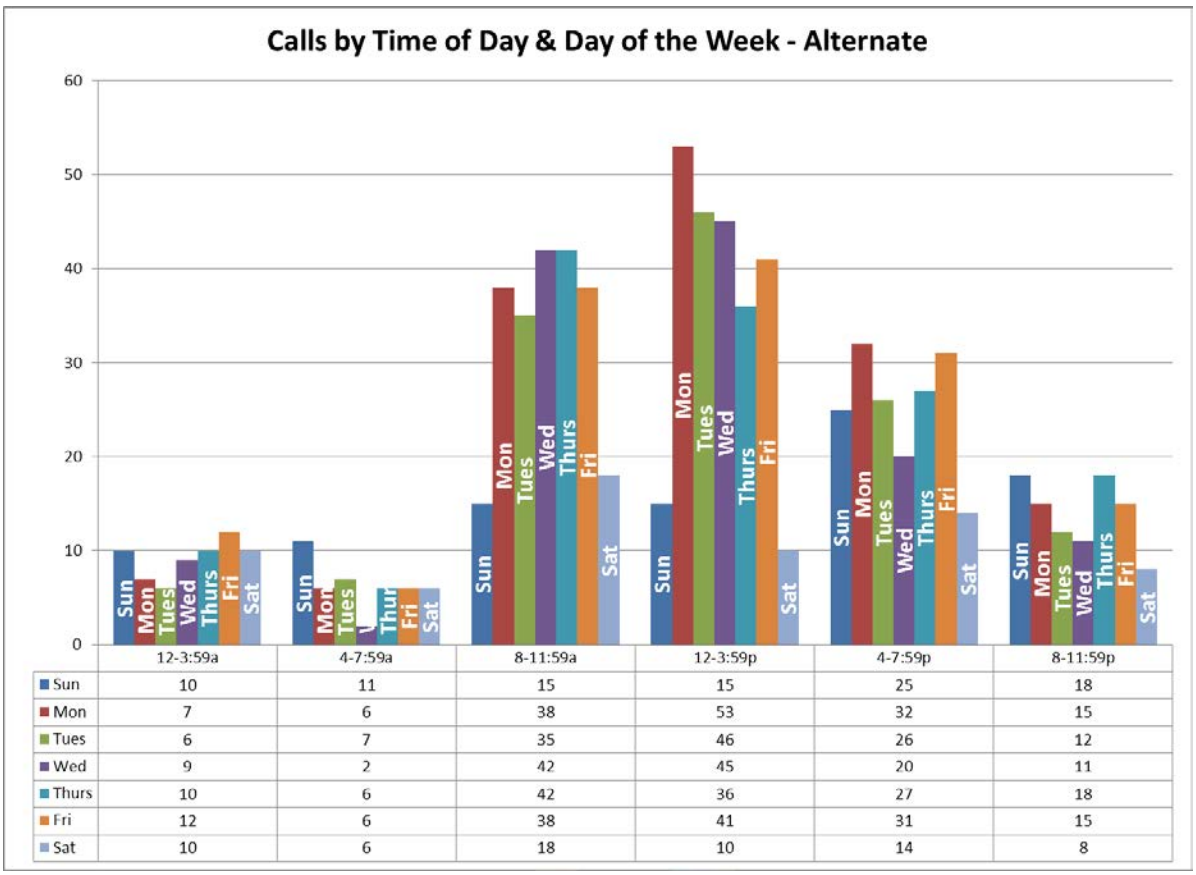
The following charts represents the time periods when calls occurred.

- Times listed denote the time the call started (time of first contact), not when the intervention started
- Starting with this report, start times of calls will be reflected in four hour time periods as opposed to eight hour periods presented in past reports. This allow for better refinement in the determination of call times.





	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
12-3:59a	10	7	6	9	10	12	10
4-7:59a	11	6	7	2	6	6	6
8-11:59a	15	38	35	42	42	38	18
12-3:59p	15	53	46	45	36	41	10
4-7:59p	25	32	26	20	27	31	14
8-11:59p	18	15	12	11	18	15	8



	12-3:59a	4-7:59a	8-11:59a	12-3:59p	4-7:59p	8-11:59p
Sun	10	11	15	15	25	18
Mon	7	6	38	53	32	15
Tues	6	7	35	46	26	12
Wed	9	2	42	45	20	11
Thurs	10	6	42	36	27	18
Fri	12	6	38	41	31	15
Sat	10	6	18	10	14	8

RESPONSE TIME OVERVIEW

CHS Average Response Time (Average Time from Initial Call Seeking Assessment to Preliminary Response from Crisis)**:**

- **12 Seconds**

Percentage of Response Times (Preliminary Responses) **within 15 Minutes:**

- **The Crisis Team responded to 99.9% of initial crisis requests within 15 minutes.**

Response times refer to how quickly crisis team members respond to the request for intervention, not the start of the intervention. Response time represents the time between when someone initiates a crisis contact and the crisis worker responds to that person whether that is face-to-face or over the phone.

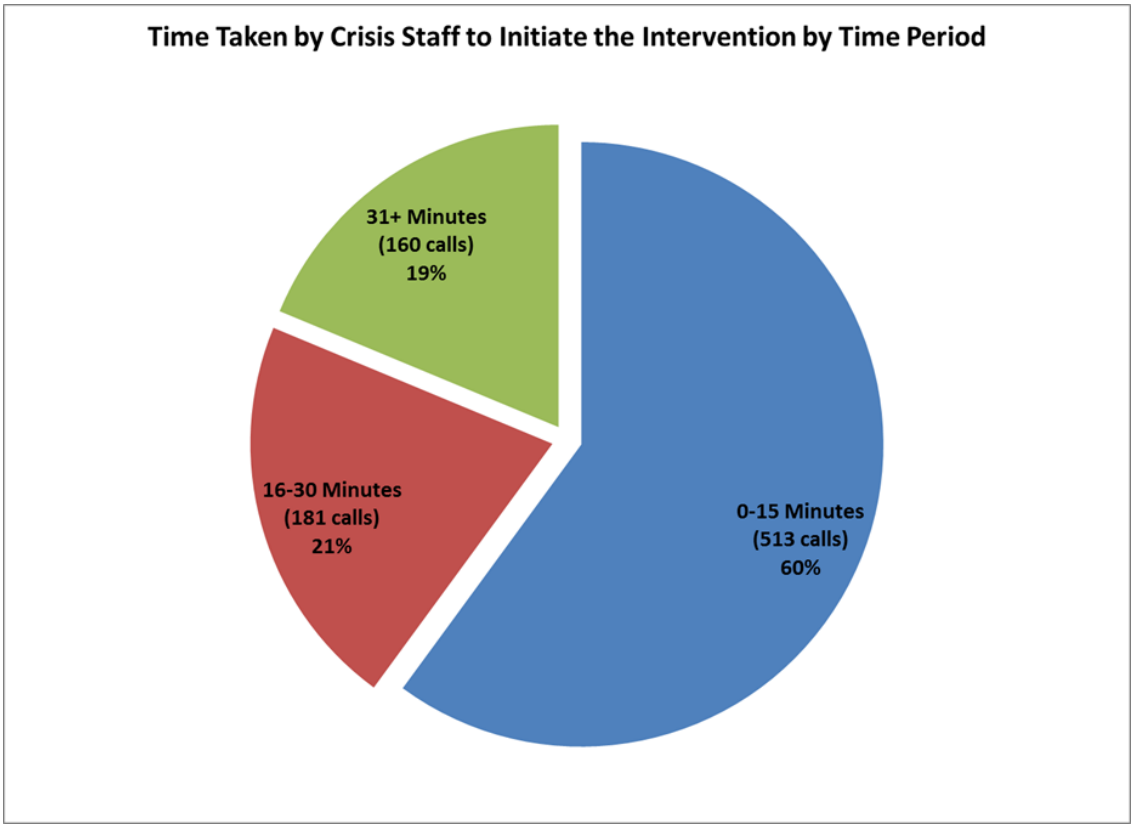
- The crisis worker is gathering information and planning for the crisis intervention at this time either face to face or over the phone.
- The benefit of this is that the person initiating or referring a crisis contact speaks directly with a crisis staff member to develop a plan of action.

- At times, crisis workers may be completing a crisis assessment and have to find the appropriate time to excuse themselves from that assessment in order to respond to the call. This is done as quickly as possible.

Average Time Taken by Crisis Staff to Initiate the Intervention:

- **20 Minutes**

The graph below represents time taken by crisis staff to initiate the intervention by time period:



Intervention start times refer to the time period from the initial crisis request to the start of the clinical intervention with the individual. Delays in intervention start times in this category include events related to CHS staff including: travel time, time spent on another call, time gathering information, etc. Delays in intervention start times caused by factors such as client intoxication and/or staff waiting on medical clearance, other professionals, family members, etc. are excluded from this calculation.

- Due to the unpredictable nature of crisis, there are periods of high demand during which multiple clients initiate crisis contact in the same time period. This can cause increased response times.
- Our team makes every effort to respond as quickly as possible to community calls outside of the hospitals due to hospitals being considered a secure monitored setting.

Average Time Taken By Other Factors Prior to the Initiation of the Intervention

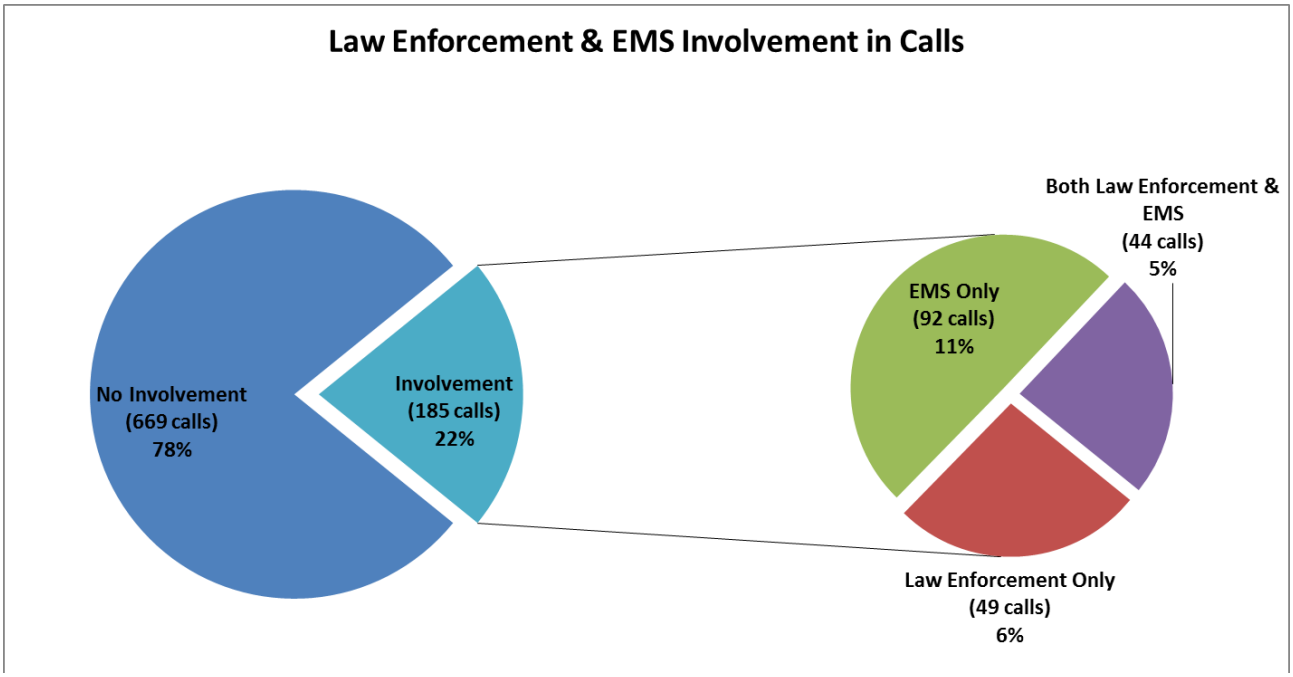
- **11 minutes**

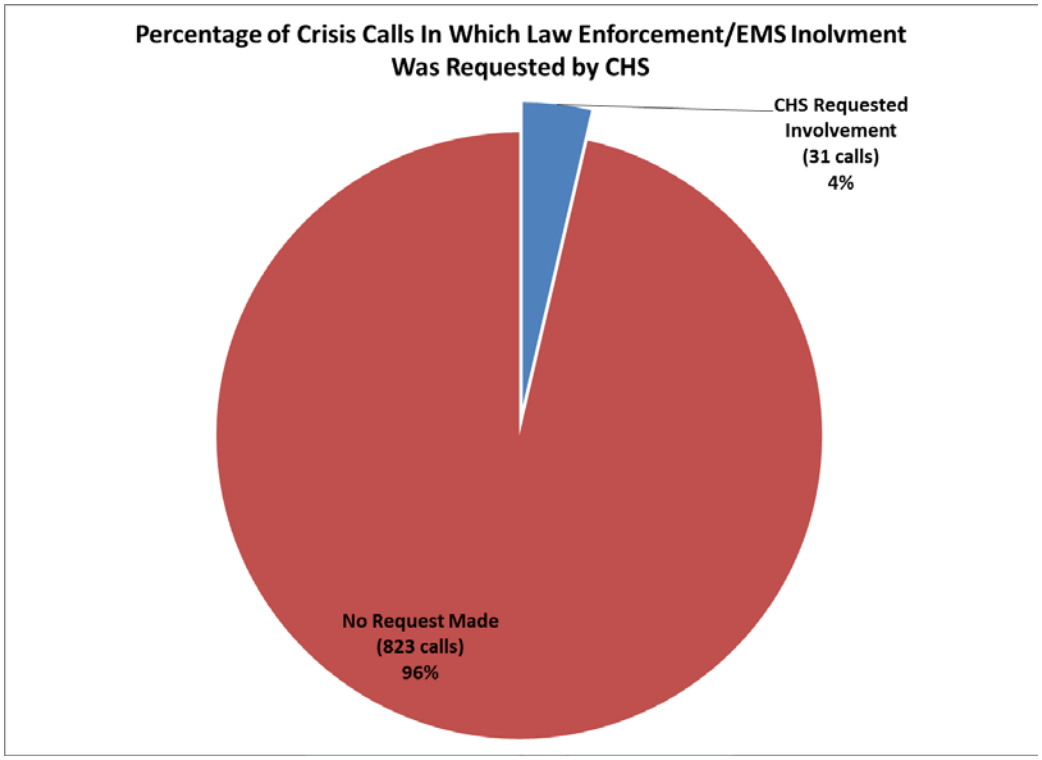
Intervention start times may also be delayed by such other factors as: time spent waiting on client/collaterals, waiting on other professionals, waiting on medical tests/clearance, time client spent intoxicated, etc. In such circumstances, crisis staff may be ready and present to start the invention, but it cannot be started due to these items. Such factors are included in this category. Delays in intervention start times caused by events related to CHS staff (travel, time spent on another call, etc.) are excluded from this calculation.

CALLS INVOLVING LAW ENFORCEMENT AND/OR EMERGENCY MEDICAL SERVICES (EMS)

At times, law enforcement and EMS are involved with crisis interventions when there is risk involving a possibly unstable individual (homicidal intent, psychosis, history of violence, etc.). The crisis team may request law enforcement assistance if the safety of the client or others is in imminent or likely danger. Alternatively, the crisis team may be called to situations by law enforcement or to situations in which law enforcement/EMS is already present.

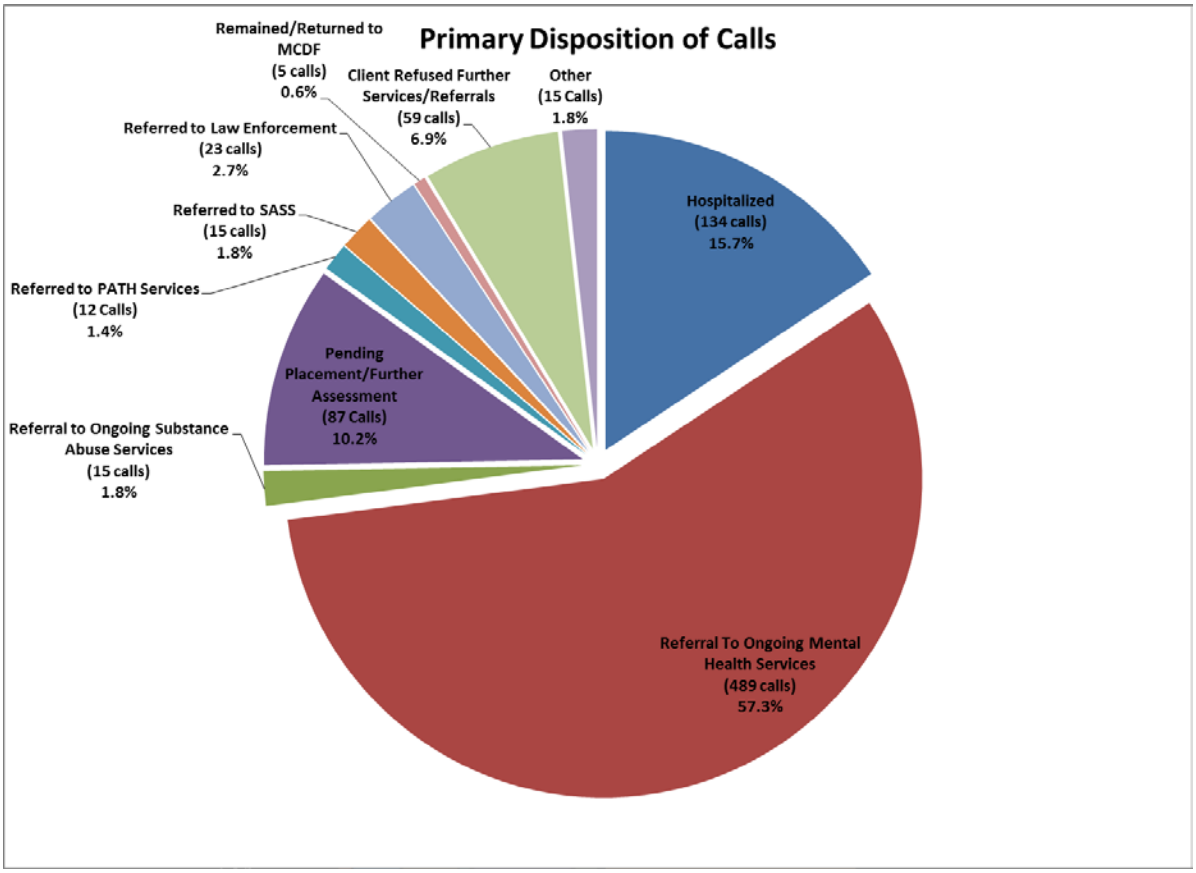
The following charts represent law enforcement/EMS involvement with calls. The first chart represents the percentage of calls in which these entities were involved. The second represents the percentage of calls in which the crisis team requested involvement. As indicated, CHS requested law enforcement/EMS assistance on 4% of all calls.





DISPOSITION OF CALLS

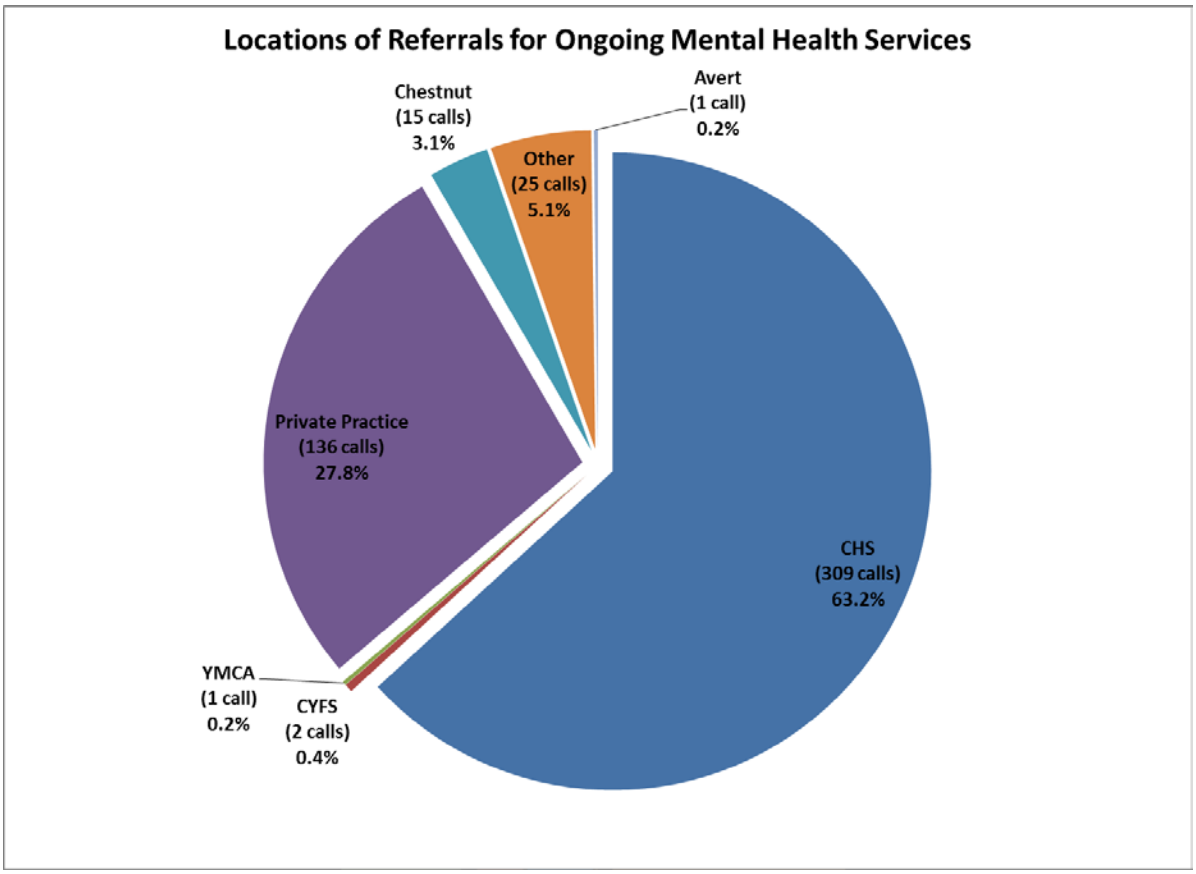
A primary disposition is the "next step" in the intervention. At times, this could be further evaluation. It can also represent a recommended course of treatment, which can include referrals to other community resources or providers as appropriate.

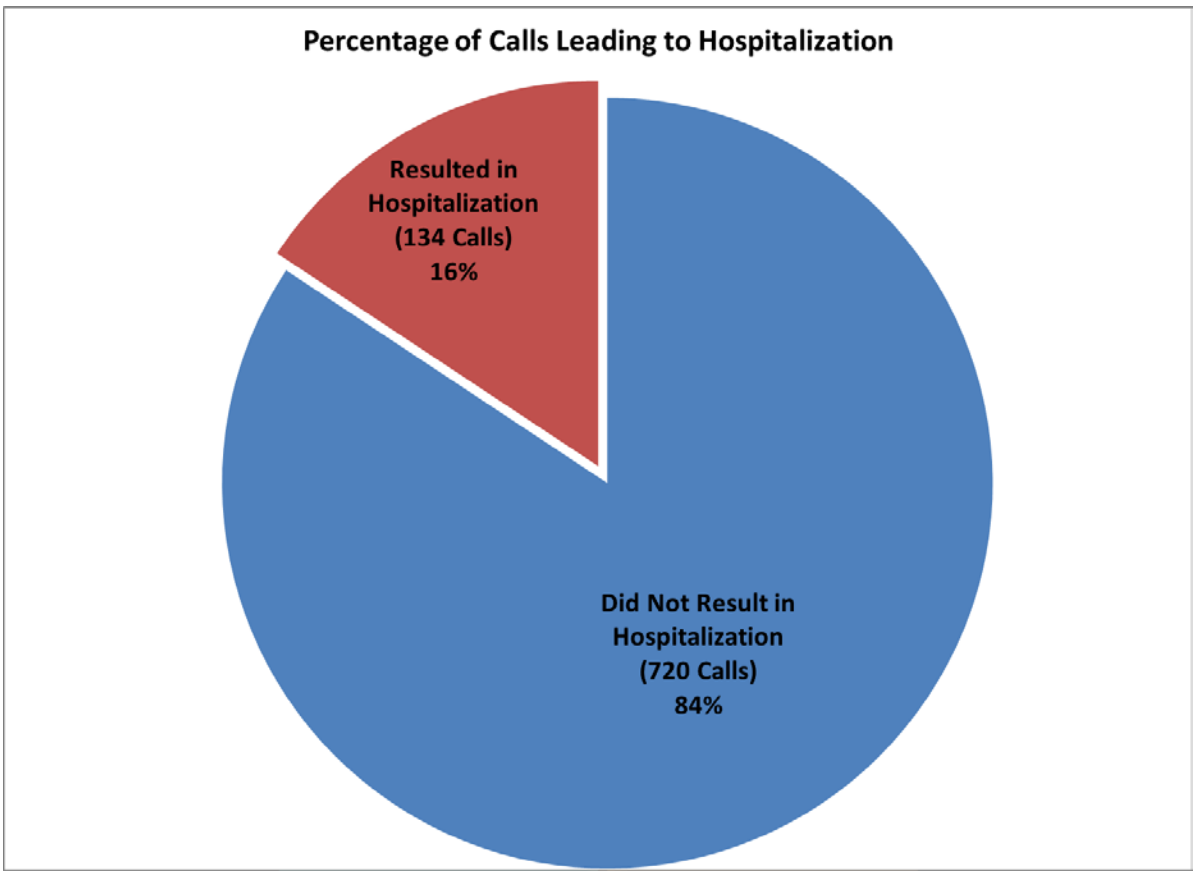


NOTE: In addition to the primary disposition, 11 calls had ongoing mental health services as a secondary referral, whereas 13 calls had ongoing substance abuse services as a secondary referral.

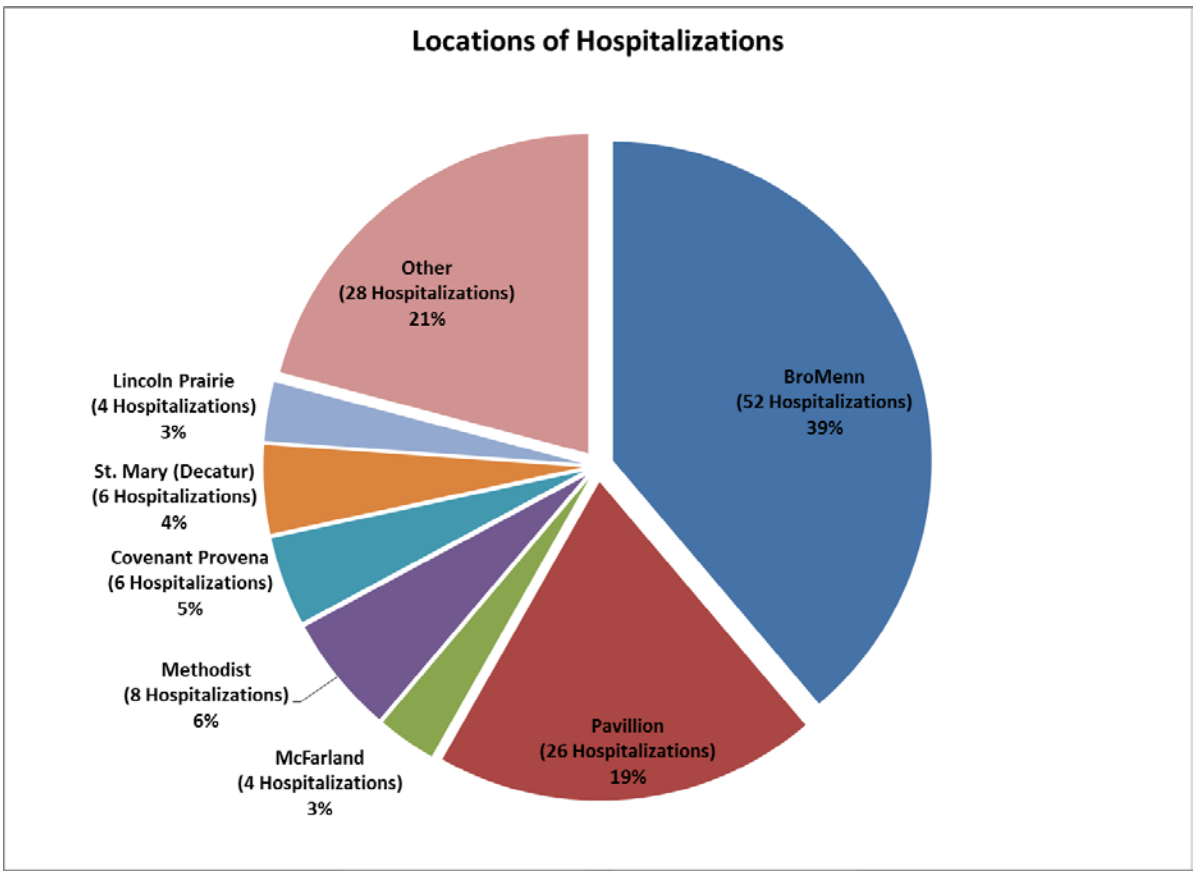
- 57.3% of calls resulted in a referral for ongoing mental health services
- Referrals to services are based on information the client provides to staff. This can include what type of insurance they may have or funding source.
- As crisis staff cannot determine which services will be provided when requesting services via 911, requests through 911 are included in referrals to law enforcement.
- Pending placement/further assessment refers to instances in a psychiatric bed is not available or an individual may need further medical assessment/clearance. At times during such instances, a call will end. The individual may be discharged by medical or other clinical personnel prior to reassessment by CHS crisis staff
- The other category generally represents providers in primary care physician offices or out of county referrals.

- PATH's phone line and suicide prevention line are not listed in the above chart but are generally given as a resource to all clients to call when appropriate. PATH services that are included in the chart refer to other PATH services (e.g. emergency housing, transportation vouchers, elderly services, etc.).
- As a large number of dispositions resulted in referral to ongoing mental health services or hospitalizations, the following charts illustrate further detail regarding these categories.





For calls in which inpatient hospitalization was recommended, the following chart indicates which hospitals were utilized for placement.



PROGRESS IN ACHIEVING PROGRAM OBJECTIVES

FY 2015 Objectives included the following:

1.) 99.9% of all individuals assessed by the Crisis Team will remain safe and alive for the 24 hour period following the intervention.

- **2nd Quarter Result:** 100% of assessed individuals were safe and alive within the given time period.

2.) The Crisis Team will respond to 90% of all calls seeking assessment within 15 minutes of the initial contact.

- **2nd Quarter Result:** 99.9% of calls received a preliminary response (how quickly the crisis team responded to the request for intervention) within 15 minutes

3.) 75% of crisis intervention services provided by CHS staff will not result in psychiatric hospitalizations for the individual served.

- **2nd Quarter Result:** 89.4% of all services (84% of calls) did not result in hospitalization for the individual served.

PROBLEMS ENCOUNTERED AND HOW THEY WERE HANDLED/PROGRAM UPDATES

- Crisis Team Staffing Patterns/Processes
  - Lack of Access to Inpatient Psychiatric Facilities (During a time when the number of individuals needing inpatient care is increasing.)
    - Clinical staff attempt to place individuals in other hospitals throughout the state when local facilities are not available.
    - Clinical Staff are reassessing and offering support that might allow for any change that would defer a client from hospitalization to a less restrictive program
  - Coordination with Medical Facilities
    - MCCHS reached out to medical facilities to clarify procedures for working with clients in the emergency departments
    - MCCHS partnered with the Mental Health Unit at Advocate BroMenn to continue coordinating standard documentation methods for crisis interventions
  - Previous Community Concerns Regarding the Amount of Crisis Staff
    - MCCHS now has 2-3 staff available for mobile calls during peak times
    - MCCHS approached other agencies/entities (e.g. law enforcement/emergency departments) to develop a more direct means of communication and collaboration with the crisis team
- Collaboration with Community Partners
  - MCCHS has continued to collaborate with several community stakeholders (including the McLean County Health Department, the McLean County Board, PATH, Chestnut Health Systems, OSF Saint Joseph, and Advocate BroMenn) to discuss community needs regarding crisis intervention services
  - CHS continues its collaborative efforts with the McLean County Health Department and other entities to implement Mental Health First Aid in the community. This is a nationally known program designed to increase education and awareness about mental health issues, including crisis recognition and intervention.

Attachment B

Community Crisis Planning Meeting
March 5, 2015

Attendance: Susan Schafer, Laura Beavers, Meghan Moser, Mary Young, Renee Donaldson, Stephanie Barisch, Karen Zengerle, Larry Cleer, Jodi Vedra, Michael Brantley, Phaedra Morris

Introductions: Meeting began with around the table introductions. Laura Beavers introduced Phaedra Morris. She is new to Laura's team and will be taking minutes for all future meetings. Please forward all meeting agenda items to Phaedra.

Handouts: Karen – Crisis Definition
Laura – Draft of Descriptive Services

Description of Services Draft: Discussion

- In draft stage/tweaked from ideas given at last meeting
  - Starting point is to meet with Fire Department Chiefs, School Administrators and RN's to get input
  - Put into terms to be brief description of spectrum of care – community of practice
  - Karen suggested adding suicidal/psychiatric situations
  - Suicidal/mental health crisis also suggested
  - Removing Area Hospitals section
  - Removing Advocate BroMenn and OSF information
  - Discussion to remove Marcfirst – determined not necessary to list them because residents have 310-7706 number and this is not given to public

Flow Chart of Crisis Services Draft – Discussion

- Draft stage
  - Suggested committee create additional flow chart for adolescents – Meghan and Stephanie volunteered to create
- Cares LIne
  - Members in agreement to add Cares Line to flow chart and to use Cares Line for children under 21
    - Acuity screening
    - Financial Eligibility
    - Link between Cares Line/Crisis Team – has to be secondary call
    - Where additional services available?
    - Multiple layers – No Wrong Door!
    - Numbers are not broken down by county per Stephanie
  - Stephanie to send Laura a description of Cares Line
- It was decided that Marcfirst should be removed from chart
- Area hospitals addressed?
  - Need to address scenario if person can't be kept safe for assessment to be done (health & safety risk) first responders need to take to nearest ER
  - Hospitals on Flow Chart?
  - Start discussion with fire chiefs about hospital protocol – when to take? Where?
  - Michael stated average ER visit across US for 2014 was 4.3 hours
  - Hopefully live with Telepysch within next 45 days

Updates Given:

- CYFS - Stephanie
  - Stephanie and Meghan have been talking. Crisis Team and some Outreach team will join SASS meeting next week
  - Stephanie and Meghan will tackle Superintendents in the future – with ROE support – Karen would like list of schools with crisis person on site
- Mobile Crisis Team – Meghan
  - Meeting with Mary periodically to collaborate
- PATH – Karen
  - Follow up with 38 people – see attached
- Chestnut Stabilization Unit - Mary
  - Staff starting March 16th – will be in orientation until opening
  - Stephanie and Meghan will be collaborating
  - Opens April 9th
  - Open House April 8th from 1-3pm
  - Was suggested to create education brochure from Chestnut to send to Police and Fire

Meeting adjourned

Next meeting is Tuesday, March 31st from 1-3 pm at PATH

Laura will bring another draft version of Services to next meeting to discuss.

If you have updates before the next meeting, please feel free to email the group

Attachment C

PATH, Inc.

Statistical Report

Client Form - Totals and Client's Gender

1/1/2015 to 3/5/2015

Total Calls in Date Range: 9286

38 (0.409%) Follow Up 1 CHS
- 38 (100%) Action Plan
  - 36 (94.737%) Will use
  - 1 (2.632%) Will not use action plan
  - 1 (2.632%) Will use part
  - 38 TOTAL
- 38 (100%) Place of Assessment
  - 18 (47.368%) Adv BroMenn
  - 9 (23.684%) OSF
  - 8 (21.053%) Other Community Outreach
  - 3 (7.895%) Home
  - 38 TOTAL
- 38 (100%) Safety Plan
  - 36 (94.737%) Will use
  - 1 (2.632%) Will not use
  - 1 (2.632%) Will use part
  - 38 TOTAL
- 37 (97.368%) Crisis Team
  - 34 (91.892%) ECI CompetenUProfessional
  - 34 (91.892%) ECI Understanding
  - 31 (83.784%) Addressed past history
  - 31 (83.784%) More Stable
  - 130 TOTAL
- 37 (97.368%) Current State
  - 29 (78.378%) No Suic Risk
  - 24 (64.865%) Less Agitated
  - 17 (45.946%) High Stress
  - 13 (35.135%) High hopes
  - 12 (32.432%) Hope
  - 11 (29.73%) Low Stress
  - 10 (27.027%) Still agitated
  - 9 (24.324%) Little hope
  - 8 (21.622%) Some suicidal Ideation
  - 8 (21.622%) Stressed
  - 3 (8.108%) High agitation
  - 3 (8.108%) No suicide thoughts
  - 1 (2.703%) Low hopelessness
  - 148 TOTAL
- 16 (42.105%) Barriers to Treatment

15 (93.75%) No barriers
1 (6.25%) Other Financial Concerns
1 (6.25%) Other
Referrals 17 TOTAL

2 {5.263%) Medication
1 (50%) No access
1 (50%) No funds
1 (50%) No Script
3 TOTAL

McLean County

Appendix

APPENDIX A

(55 ILCS 5/Div. 5-25 heading)

Division 5-25. County and Multi-county Health Departments

(55 ILCS 5/5-25001) (from Ch. 34, par. 5-25001)

Sec. 5-25001. County and multiple-county health departments. Any county or two or more adjacent counties may, by resolution of the county board or county boards of the respective counties, as the case may be, or upon approval by referendum as hereinafter provided, establish and maintain a full-time health department; provided, that four or more counties must obtain the approval of the State Department of Public Health prior to establishing a multiple-county health department. The approval may be obtained upon application by the county board of any county, containing such information as may be required by the State Department. Approval shall be granted if the State Department determines that the establishment of the multiple-county health department is essential to the health requirements of the area affected.

A "consolidated health department" shall mean a health department which has resulted from the merging of two or more adjacent existing county or multiple-county health departments, as provided in Section 5-25019.

A full-time health department is one whose personnel, other than consultants and clinicians, devote their full time during regular, standard working hours to health department duties. Reference hereinafter made to health departments means full-time health departments unless otherwise specified.

(Source: P.A. 86-962.)

(55 ILCS 5/5-25002) (from Ch. 34, par. 5-25002)

Sec. 5-25002. Classification of departments. County and multiple county health departments established under this Division may be classified by the Director of Public Health in accordance with standards relating to programs, and performance. The State Department of Public Health is authorized to promulgate rules and regulations setting forth minimum standards for programs and performance, including regulations in which the State Department of Public Health shall require provision of home visitation and other services for pregnant women, new mothers and infants who are at risk as defined by that Department that encompass but are not limited to consultation for parental and child development, comprehensive health education, nutritional assessment, dental health, and periodic health screening, referral and follow-up; the services shall be provided through programs funded by grants from the Department of Public Health from appropriations to the Department for that purpose. The Department is further authorized to prescribe minimum qualifications for the professional, technical, and administrative staff.

(Source: P.A. 86-962; 86-1377; 87-395.)

(55 ILCS 5/5-25003) (from Ch. 34, par. 5-25003)

Sec. 5-25003. Election on establishment of county health department and annual levy of additional tax. Whenever a petition signed by voters representing not less than 10% of the votes cast at the last preceding general election of any county is presented to the county clerk requesting the establishment and maintenance of a county health department and the levy therefor, in excess of the statutory limit, of an additional annual tax of not to exceed .1% of the value, as equalized or assessed by the Department of Revenue, of all taxable property of the county, the county clerk shall certify the proposition for submission at an election in accordance with the general election law, and the proposition shall be so submitted. The proposition shall be in substantially the following form:

```
-------------------------------------------------------------
   Shall.... county levy
an annual tax of not to            YES
exceed .1% for the purpose      -----------------------------
of providing community health       NO
facilities and services?
-------------------------------------------------------------
```

If a majority of all votes cast upon the proposition is in favor thereof, the county board shall immediately proceed to establish a health department. In any county in which a county health department was established by a referendum prior to January 1, 1970, the county board may, by resolution and without subsequent referendum, levy a tax at a rate not to exceed the rate set forth in Section 5-25010. However, any levy in excess of .05% shall be approved by at least a three-fifths vote of the county board. The foregoing limitations upon tax rates, insofar as they are applicable to counties of less than 1,000,000 population, may be increased or decreased under the referendum provisions of the General Revenue Law of Illinois.

(Source: P.A. 86-962.)

(55 ILCS 5/5-25004) (from Ch. 34, par. 5-25004)

Sec. 5-25004. Election on establishment of multiple-county health department and annual levy of additional tax. Whenever a petition signed by voters representing not less than 10% of the votes cast at the last preceding general election in each of two or more adjacent counties is presented to their respective county clerks requesting the establishment and maintenance of a multiple-county health department and the levy therefor, in excess of the statutory limit, of an additional annual tax in each county of not to exceed .1% of the value, as equalized or assessed by the Department of Revenue, of all taxable property of the county, each county clerk shall certify the proposition to the county clerk of each of the other counties mentioned in the petition. Each such county clerk in accordance with the general election law shall make certification to any board of election commissioners in his county and shall submit the proposition to the voters at an election. If the petitions are so presented in 4 or more

counties, the approval of the State Department of Public Health as provided in Section 5-25001, shall be obtained prior to the giving of notice. The proposition shall be in substantially the following form:

```
-------------------------------------------------------------
   Shall.... counties levy an
annual tax of not to exceed .1%         YES
for the purpose of providing health ---------------------------
facilities and services in their        NO
respective counties?
-------------------------------------------------------------
```

If a majority of all votes cast upon the proposition in each county is in favor thereof, the several county boards shall immediately proceed to organize a multiple-county health department and shall agree concerning the conditions governing the organization and operation of the department and for the apportionment of the cost thereof. In any county in which a multiple county health department was established and organized by a referendum prior to January 1, 1970, the county board may, by resolution and without subsequent referendum, levy a tax at a rate not to exceed the rate set forth in Section 5-25010. However, any levy in excess of .05% shall be approved by at least a three-fifths vote of the county board. The foregoing limitations upon tax rates, insofar as they are applicable to counties of less than 1,000,000 population, may be increased or decreased under the referendum provisions of the General Revenue Law of Illinois.

(Source: P.A. 86-962.)

(55 ILCS 5/5-25005) (from Ch. 34, par. 5-25005)

Sec. 5-25005. Canvass of votes. When the proposition is submitted to the voters of a county, the ballots shall be counted, the returns canvassed and the result declared as in the case of a regular county election.

(Source: P.A. 86-962.)

(55 ILCS 5/5-25006) (from Ch. 34, par. 5-25006)

Sec. 5-25006. Canvass of votes in several counties. When the proposition is submitted to the voters of two or more adjacent counties, the ballots shall be counted and the returns made to the county clerk of each county, respectively, in the same manner as in the case of returns to the county clerk in a general election. The returns shall be opened and canvassed by a committee made up of the county clerk of each county in which the vote on the proposition was cast, and the chairman of the county board of each county. The committee will convene at the request of the chairman of the county board of any one of the counties in which the vote on the proposition was cast. The committee shall elect a chairman whose duty it will be to see that the returns are opened and canvassed by the committee and that the result is declared.

(Source: P.A. 86-962.)

(55 ILCS 5/5-25007) (from Ch. 34, par. 5-25007)

Sec. 5-25007. County clerk to record vote. Each county clerk shall record the result of the vote upon the proposition in his county, and the result may be proved in all courts and in all proceedings by the record or by a certified copy thereof.

(Source: P.A. 86-962.)

(55 ILCS 5/5-25008) (from Ch. 34, par. 5-25008)

Sec. 5-25008. Jurisdiction of department. Each county and multiple-county health department has jurisdiction for the purposes of this Division throughout the entire county or multiple counties, except within:

1. Any public health district organized under "An Act to authorize the organization of public health districts and for the establishment and maintenance of a health department for the same," filed June 26, 1917, as amended;

2. Any city, village or incorporated town or combination thereof of less than 500,000 inhabitants which city, village, incorporated town or combination thereof or public health district maintains a local health department and employs a full-time health officer and other professional personnel possessing such qualifications as may be prescribed by the State Department of Public Health;

3. Any city, village or incorporated town of 500,000 or more inhabitants.

(Source: P.A. 86-962.)

(55 ILCS 5/5-25009) (from Ch. 34, par. 5-25009)

Sec. 5-25009. Abandonment of city, village or town department. Any city, village or incorporated town, or combination thereof or any public health district which maintains its own independent health department may abandon the same and become integrated in the county or multiple-county health department. The method of abandonment, unless otherwise prescribed by law, shall be the same as the method of adoption. Abandonment shall become effective at the end of the fiscal year of the city, village, incorporated town or public health district.

Any county which establishes a county health department may unite with other counties to organize a multiple-county health department, in which event the county health department shall be dissolved as soon as the multiple-county health department is organized and all of its records shall be transferred to the multiple-county health department.

(Source: P.A. 86-962.)

(55 ILCS 5/5-25010) (from Ch. 34, par. 5-25010)

Sec. 5-25010. Annual tax levy. The county board of any county which has established and is maintaining a county or multiple-county health department shall, when authorized as provided in

Sections 5-25003 or 5-25004, levy annually therefor, in excess of the statutory limit, a tax of not to exceed .1% of the value plus the additional tax, if applicable, provided for in Section 5-23002, or plus the additional tax, if applicable, provided for in Section 5.3 of "An Act to provide for the creation and management of tuberculosis sanitarium districts", approved May 21, 1937, as now or hereafter amended, as equalized or assessed by the Department of Revenue, of all taxable property of the county, which tax shall be levied and collected in like manner as general county taxes and shall be paid (except as provided in Section 5-25011) into the county treasury and held in the County Health Fund and shall be used only for the purposes of this Division. Where there is a county health department, the County Health Fund shall be drawn upon by the proper officers of the county upon the properly authenticated vouchers of the county health department. Where there is a multiple-county health department, the County Health Fund shall be drawn upon by the treasurer of the board of health of the multiple-county health department. In counties maintaining single county health departments, each county board shall appropriate from the County Health Fund such sums of money as may be sufficient to fund the approved budget of the county health department, so long as those sums have been set out in the annual budget submitted to the county board by the county board of health and that annual budget has been approved by the county board. In counties with a population between 700,000 and 3,000,000, the county board chairman has the power to veto or reduce any line item in the appropriation ordinance for the county or multiple-county health department as provided in Section 5-1014.5. Each county board of counties participating in the maintenance of a multiple-county health department shall appropriate from the County Health Fund and shall authorize the county treasurer to release quarterly or more often to the treasurer of the board of health of the multiple-county health department such sums of money as are in accordance with the budget submitted by the multiple-county board of health and approved by the county board of each of the participating counties as may be necessary to pay its agreed share for the maintenance of the multiple-county health department. The treasurer of the board of health of the multiple-county health department shall request by voucher, quarterly or more often such sums of money from the county treasurers of the respective member counties, and shall support such requests with estimates of anticipated receipts and expenditures for the period for which sums of money are requested and with statements of receipts and expenditures for the preceding period. In addition, that treasurer shall support the requests to the annual budget submitted by the multiple-county public health board and approved by the county board of each of the participating counties. No payment may be made from a County Health Fund except on the basis of a budget item in a budget submitted by the appropriate public health board and approved by the county board or boards concerned; however, amended or supplemental budgets may be submitted and approved and thereby be the basis for such a payment.

(Source: P.A. 89-402, eff. 8-20-95.)

(55 ILCS 5/5-25011) (from Ch. 34, par. 5-25011)

Sec. 5-25011. Disposition of taxes collected. The entire amount collected from taxes levied under this Division on property subject to the general corporate tax of any city, village or incorporated town or combination thereof or public health district which maintains its own local health department as provided in this Division, less the amount allowed for collecting the same, shall be paid over by the

county treasurer to the treasurer of the public health district, city, village or incorporated town to be used for the maintenance of its local health department.

(Source: P.A. 86-962.)

(55 ILCS 5/5-25012) (from Ch. 34, par. 5-25012)

Sec. 5-25012. Board of health. Except in those cases where a board of 10 or 12 members is provided for as authorized in this Section, each county health department shall be managed by a board of health consisting of 8 members appointed by the president or chairman of the county board, with the approval of the county board, for a 3 year term, except that of the first appointees 2 shall serve for one year, 2 for 2 years, 3 for 3 years and the term of the member appointed from the county board, as provided in this Section, shall be one year and shall continue until reappointment or until a successor is appointed. Each board of health which has 8 members, may have one additional member appointed by the president or chairman of the county board, with the approval of the county board. The additional member shall first be appointed within 90 days after the effective date of this amendatory Act for a term ending July 1, 2002.

The county health department in a county having a population of 200,000 or more may, if the county board, by resolution, so provides, be managed by a board of health consisting of 12 members appointed by the president or chairman of the county board, with the approval of the county board, for a 3 year term, except that of the first appointees 3 shall serve for one year, 4 for 2 years, 4 for 3 years and the term of the member appointed from the county board, as provided in this Section, shall be one year and shall continue until reappointment or until a successor is appointed. In counties with a population of 200,000 or more which have a board of health of 8 members, the county board may, by resolution, increase the size of the board of health to 12 members, in which case the 4 members added shall be appointed, as of the next anniversary of the present appointments, 2 for terms of 3 years, one for 2 years and one for one year.

The county board in counties with a population of more than 100,000 but less than 3,000,000 inhabitants and contiguous to any county with a metropolitan area with more than 1,000,000 inhabitants, may establish compensation for the board of health, as remuneration for their services as members of the board of health. Monthly compensation shall not exceed $200 except in the case of the president of the board of health whose monthly compensation shall not exceed $400.

When a county board of health consisting of 8 members assumes the responsibilities of a municipal department of public health, and both the county board and the city council adopt resolutions or ordinances to that effect, the county board may, by resolution or ordinance, increase the membership of the county board of health to 10 members. The additional 2 members shall initially be appointed by the mayor of the municipality, with the approval of the city council, each such member to serve for a term of 2 years; thereafter the successors shall be appointed by the president or chairman of the county board, with the approval of the county board, for terms of 2 years.

Each multiple-county health department shall be managed by a board of health consisting of 4 members appointed from each county by the president or chairman of the county board with the approval of the county board for a 3 year term, except that of the first appointees from each county one shall serve for one year, one for 2 years, one for 3 years and the term of the member appointed from the county board of each member county, as hereinafter provided, shall be one year and shall continue until reappointment or until a successor is appointed.

The term of office of original appointees shall begin on July 1 following their appointment, and the term of all members shall continue until their successors are appointed. All members shall serve without compensation but may be reimbursed for actual necessary expenses incurred in the performance of their duties. At least 2 members of each county board of health shall be physicians licensed in Illinois to practice medicine in all of its branches and at least one member shall be a dentist licensed in Illinois. In counties with a population under 500,000, one member shall be chosen from the county board or the board of county commissioners as the case may be. In counties with a population over 500,000, two members shall be chosen from the county board or the board of county commissioners as the case may be. At least one member from each county on each multiple-county board of health shall be a physician licensed in Illinois to practice medicine in all of its branches, one member from each county on each multiple-county board of health shall be chosen from the county board or the board of county commissioners, as the case may be, and at least one member of the board of health shall be a dentist licensed in Illinois. Whenever possible, at least one member shall have experience in the field of mental health. All members shall be chosen for their special fitness for membership on the board.

Any member may be removed for misconduct or neglect of duty by the chairman or president of the county board, with the approval of the county board, of the county which appointed him.

Vacancies shall be filled as in the case of appointment for a full term.

Notwithstanding any other provision of this Act to the contrary, a county with a population of 240,000 or more inhabitants that does not currently have a county health department may, by resolution of the county board, establish a board of health consisting of the members of such board. Such board of health shall be advised by a committee which shall consist of at least 5 members appointed by the president or chairman of the county board with the approval of the county board for terms of 3 years; except that of the first appointees at least 2 shall serve for 3 years, at least 2 shall serve for 2 years and at least one shall serve for one year. At least one member of the advisory committee shall be a physician licensed in Illinois to practice medicine in all its branches, at least one shall be a dentist licensed in Illinois, and one shall be a nurse licensed in Illinois. All members shall be chosen for their special fitness for membership on the advisory committee.

All members of a board established under this Section must be residents of the county, except that a member who is required to be a physician, dentist, or nurse may reside outside the county if no physician, dentist, or nurse, as applicable, who resides in the county is willing and able to serve.

(Source: P.A. 94-457, eff. 1-1-06; 94-791, eff. 1-1-07.)

(55 ILCS 5/5-25013) (from Ch. 34, par. 5-25013)

Sec. 5-25013. Organization of board; powers and duties.

(A) The board of health of each county or multiple-county health department shall, immediately after appointment, meet and organize, by the election of one of its number as president and one as secretary, and either from its number or otherwise, a treasurer and such other officers as it may deem necessary. A board of health may make and adopt such rules for its own guidance and for the government of the health department as may be deemed necessary to protect and improve public health not inconsistent with this Division. It shall:

1. Hold a meeting prior to the end of each operating fiscal year, at which meeting officers shall be elected for the ensuing operating fiscal year;

2. Hold meetings at least quarterly;

3. Hold special meetings upon a written request signed by two members and filed with the Secretary or on request of the medical health officer or public health administrator;

4. Provide, equip and maintain suitable offices, facilities and appliances for the health department;

5. Publish annually, within 90 days after the end of the county's operating fiscal year, in pamphlet form, for free distribution, an annual report showing the condition of its trust on the last day of the most recently completed operating fiscal year, the sums of money received from all sources, giving the name of any donor, how all moneys have been expended and for what purpose, and such other statistics and information in regard to the work of the health department as it may deem of general interest;

6. Within its jurisdiction, and professional and technical competence, enforce and observe all State laws pertaining to the preservation of health, and all county and municipal ordinances except as otherwise provided in this Division;

7. Within its jurisdiction, and professional and technical competence, investigate the existence of any contagious or infectious disease and adopt measures, not inconsistent with the regulations of the State Department of Public Health, to arrest the progress of the same;

8. Within its jurisdiction, and professional and technical competence, make all necessary sanitary and health investigations and inspections;

9. Upon request, give professional advice and information to all city, village, incorporated town and school authorities, within its jurisdiction, in all matters pertaining to sanitation and public health;

10. Appoint a medical health officer as the executive officer for the department, who shall be a citizen of the United States and shall possess such qualifications as may be prescribed by the State Department of Public Health; or appoint a public health administrator who shall possess such qualifications as may be prescribed by the State Department of Public Health as the executive officer for

the department, provided that the board of health shall make available medical supervision which is considered adequate by the Director of Public Health;

10 1/2. Appoint such professional employees as may be approved by the executive officer who meet the qualification requirements of the State Department of Public Health for their respective positions provided, that in those health departments temporarily without a medical health officer or public health administrator approval by the State Department of Public Health shall suffice;

11. Appoint such other officers and employees as may be necessary;

12. Prescribe the powers and duties of all officers and employees, fix their compensation, and authorize payment of the same and all other department expenses from the County Health Fund of the county or counties concerned;

13. Submit an annual budget to the county board or boards;

14. Submit an annual report to the county board or boards, explaining all of its activities and expenditures;

15. Establish and carry out programs and services in mental health, including intellectual disabilities and alcoholism and substance abuse, not inconsistent with the regulations of the Department of Human Services;

16. Consult with all other private and public health agencies in the county in the development of local plans for the most efficient delivery of health services.

(B) The board of health of each county or multiple-county health department may:

1. Initiate and carry out programs and activities of all kinds, not inconsistent with law, that may be deemed necessary or desirable in the promotion and protection of health and in the control of disease including tuberculosis;

2. Receive contributions of real and personal property;

3. Recommend to the county board or boards the adoption of such ordinances and of such rules and regulations as may be deemed necessary or desirable for the promotion and protection of health and control of disease;

4. Appoint a medical and dental advisory committee and a non-medical advisory committee to the health department;

5. Enter into contracts with the State, municipalities, other political subdivisions and non-official agencies for the purchase, sale or exchange of health services;

6. Set fees it deems reasonable and necessary (i) to provide services or perform regulatory activities, (ii) when required by State or federal grant award conditions, (iii) to support activities delegated to the board of health by the Illinois Department of Public Health, or (iv) when required by an

agreement between the board of health and other private or governmental organizations, unless the fee has been established as a part of a regulatory ordinance adopted by the county board, in which case the board of health shall make recommendations to the county board concerning those fees. Revenue generated under this Section shall be deposited into the County Health Fund or to the account of the multiple-county health department.

7. Enter into multiple year employment contracts with the medical health officer or public health administrator as may be necessary for the recruitment and retention of personnel and the proper functioning of the health department.

(C) The board of health of a multiple-county health department may hire attorneys to represent and advise the department concerning matters that are not within the exclusive jurisdiction of the State's Attorney of one of the counties that created the department.

(Source: P.A. 97-227, eff. 1-1-12.)

(55 ILCS 5/5-25014) (from Ch. 34, par. 5-25014)

Sec. 5-25014. Prompt payment. Purchases made pursuant to this Division shall be made in compliance with the "Local Government Prompt Payment Act".

(Source: P.A. 86-962.)

(55 ILCS 5/5-25015) (from Ch. 34, par. 5-25015)

Sec. 5-25015. Officers and employees. Each county or multiple-county health department shall have the exclusive right to employ and discharge its officers and employees, except as otherwise provided in Section 5-25013; provided that in counties having a civil service system, the employees of the health department shall be subject to the rules and regulations of such system.

(Source: P.A. 86-962.)

(55 ILCS 5/5-25016) (from Ch. 34, par. 5-25016)

Sec. 5-25016. Lease or acquisition of property for department. The board of health of each county or multiple-county health department is authorized to lease or to acquire by purchase, construction, lease-purchase agreement or otherwise and take title in its name and to borrow money, issue debt instruments, mortgages, purchase money mortgages and other security instruments, maintain, repair, remodel or improve such real estate as may be reasonably necessary for the housing and proper functioning of such health department. Money in the County Health Fund may be used for such purposes.

Upon the discontinuance of a single county health department any such real estate shall become the property of and title shall be transferred to the county.

Upon the discontinuance of a multiple-county health department any such real estate shall be sold and the proceeds distributed pro-rata to the several counties as their agreed share of the maintenance of such department may indicate.

(Source: P.A. 86-962.)

(55 ILCS 5/5-25017) (from Ch. 34, par. 5-25017)

Sec. 5-25017. Discontinuance of department. Any health department may be discontinued; 1 - by resolution of the county board or county boards, if established in such manner; or, 2 - if established by referendum, then by a referendum initiated by petition and submitted to vote in the same manner as for adoption. The proposition shall be stated "For the discontinuance of the county (or multiple-county) health department" and "Against the discontinuance of the county (or multiple-county) health department." If a majority of the votes cast upon the proposition in any county is for discontinuance, the board of health shall proceed at once to close up the affairs of the department. After the payment of all obligations, the money in the "County Health Fund" shall become a part of the general funds in the county treasury. All other property shall be devoted to such county purpose as the county board or boards determine.

(Source: P.A. 86-962.)

(55 ILCS 5/5-25018) (from Ch. 34, par. 5-25018)

Sec. 5-25018. Board of Health in counties having civil service qualifications and appointment. When this Division is adopted by resolution in counties over 500,000 population where Civil Service Qualifications and appointment on all employees prevail, and where all funds expended are approved by budget of the County Board of Commissioners and so paid after approval, by the County Treasurer, the County Board of Commissioners shall constitute the Board of Health to carry out the provisions of this Division in a similar manner to other acts and duties of the County.

(Source: P.A. 86-962.)

(55 ILCS 5/5-25019) (from Ch. 34, par. 5-25019)

Sec. 5-25019. Formation of consolidated health department. Any county which has established a county health department or any counties which have established a multiple-county health department may unite with one or more adjacent counties which have established county or multiple-county health departments, for the purpose of maintaining and operating a consolidated health department subject to the approval of the county boards involved and the Director of the Illinois Department of Public Health. In the event of approval by the county boards involved and the Director of Public Health, the chairman or president of each county board and of each board of health shall meet and immediately proceed to organize the consolidated health department. At such time as they shall agree concerning the conditions governing organization and operation, and the apportionment of the costs thereof, they shall select a date within 60 days on which the consolidated health department shall be established, and its operation and maintenance shall be in accordance with all provisions of this Division relating to county health

departments except where otherwise prescribed for multiple-county health departments. The county or multiple-county health departments in counties joining together to operate and maintain a consolidated health department shall cease to function as independent health departments so long as the consolidation shall exist; shall transfer all records to the consolidated health department; and shall not withdraw from this union except in accordance with the provisions of Section 5-25020.

The board of health of each consolidated health department shall consist of the members of the boards of health of the county and multiple-county health departments involved except that members from counties which have previously established single county health departments shall be reduced to four, including at least one physician and one member of the county board. New appointments and reappointments shall be made in accordance with the provisions of Section 5-25012 relating to boards of health of multiple-county health departments. The consolidated board of health shall hold its first meeting no later than seven days after the date of establishment, for the purpose of organizing, electing officers, and carrying out its responsibilities in connection with the consolidated health department. Its subsequent meetings shall be held as prescribed in this Division for multiple-county health departments. Membership and actions of the consolidated board of health shall become official at its first meeting or on the date of establishment of the consolidated health department, whichever occurs at the earlier date. After a consolidated health department has begun operation, addition of other health departments to the consolidation may be accomplished with consent of all county boards of supervisors or commissioners concerned and the Director of Public Health; participation by such additional counties will be under the conditions selected in the original consolidation agreement, and date of entry into the consolidation and other relevant details will be arranged between the board of health of the consolidated health department, and the president of the county board and the chairman or president of the board of health of each county requesting admission to the consolidated health department.

(Source: P.A. 86-962.)

(55 ILCS 5/5-25020) (from Ch. 34, par. 5-25020)

Sec. 5-25020. Withdrawal from consolidated health department. Any county which has established a county health department or counties which have established a multiple-county health department may withdraw from a consolidated health department for the purpose of maintaining and operating an independent county or multiple-county health department, as the case may be, or for the purpose of joining with another adjacent county or other adjacent counties in maintaining and operating a consolidated health department. Withdrawal for such purposes may be effected by majority vote of the county board of the withdrawing county which had established a county health department, or by a majority vote of each county board of the withdrawing counties which had established a multiple-county health department, before joining the consolidated health department. In all withdrawals from consolidated health departments, the county board of each county proposing withdrawal shall seek the advice and concurrence of the Director of the Illinois Department of Public Health before taking action effecting withdrawal. The effective date of withdrawal shall be June 30 following completion of the withdrawal agreements. The board of health of the consolidated health department shall meet and the members of the withdrawing and the remaining counties shall agree upon removal of records, supplies,

equipment and personnel by the withdrawing county or counties. Withdrawal of any county or counties from the consolidated health department does not alter the consolidation if the county or multiple-county health departments remaining party to the union are two or more. Discontinuance of any county or multiple-county health department effected under the provisions of Section 5-25017 constitutes withdrawal from a consolidated health department.

Any county which is a member county of a consolidated health department may also withdraw from the consolidated health department upon approval by referendum, the proposition for which shall be placed on the ballot at any general election by the county clerk on receipt of a petition signed by not less than 10 per cent of the registered voters of the county. The proposition shall be certified to the proper election officials, who shall submit the proposition to the voters at an election in accordance with the general election law. The proposition shall read substantially as follows:

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-------------------------------------------------------------
   Shall .... county withdraw the county       YES
health department from the .............    ------------------
consolidated health department?                NO
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If a majority of voters favor withdrawal the county shall arrange its withdrawal effective June 30 following the referendum and shall settle its affairs in the consolidated health department and resume operation in the manner hereinbefore prescribed in this section.

(Source: P.A. 86-962.)

(55 ILCS 5/5-25021) (from Ch. 34, par. 5-25021)

Sec. 5-25021. Bonds for permanent improvements; referendum. Whenever the county board determines that it is necessary to issue bonds to enable it to provide buildings for or to make permanent improvements in the community health facilities, the county board shall so instruct the county clerk. Thereupon, such clerk shall certify such determination to the proper election officials, who shall submit the proposition at an election in accordance with the general election law.

(Source: P.A. 86-962.)

(55 ILCS 5/5-25022) (from Ch. 34, par. 5-25022)

Sec. 5-25022. Form of proposition. The proposition pursuant to Section 5-25021 shall be in substantially the following form:

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-------------------------------------------------------------
   Shall.... county issue bonds
to the amount of.... dollars for the          YES
purpose of enabling the county to....
(purpose to be stated, which shall be    ---------------------
either to provide buildings for or to
```

make permanent improvements in the community health facilities)? NO

In case a majority of the votes cast upon the propositions shall be in favor of the issuance of such bonds, the county board shall issue the bonds not exceeding the amount authorized at the referendum. Such bonds shall become due not more than 20 years after their date, shall be in denominations of $100 or any multiple thereof, and shall bear interest, evidenced by coupons, at a rate not exceeding the maximum rate authorized by the Bond Authorization Act, as amended at the time of the making of the contract, payable semi-annually, as shall be determined by the county board.

With respect to instruments for the payment of money issued under this Section or its predecessor either before, on, or after the effective date of Public Act 86-4, it is and always has been the intention of the General Assembly (i) that the Omnibus Bond Acts are and always have been supplementary grants of power to issue instruments in accordance with the Omnibus Bond Acts, regardless of any provision of this Division or "An Act in relation to the establishment and maintenance of county and multiple-county public health departments", approved July 9, 1943, that may appear to be or to have been more restrictive than those Acts, (ii) that the provisions of this Section or its predecessor are not a limitation on the supplementary authority granted by the Omnibus Bond Acts, and (iii) that instruments issued under this Section or its predecessor within the supplementary authority granted by the Omnibus Bond Acts are not invalid because of any provision of this Division or "An Act in relation to the establishment and maintenance of county and multiple-county public health departments", approved July 9, 1943, that may appear to be or to have been more restrictive than those Acts.

(Source: P.A. 86-962; 86-1028.)

(55 ILCS 5/5-25023) (from Ch. 34, par. 5-25023)

Sec. 5-25023. Sale of bonds. The bonds authorized by this Division shall be sold and the proceeds thereof used solely for the specified purpose. At or before the time of delivery of any bond, the county board shall file with the county its certificates, stating the amount of bonds to be issued, or denominations, rate of interest, where payable, and shall include a form of bond to be issued. The county board shall levy a direct tax upon all of the taxable property within the county sufficient to pay the principal and interest on the bonds as and when the same respectively mature. Such tax shall be in addition to all other taxes and shall not be within any rate limitation otherwise prescribed by law.

The proceeds received from the sale of the bonds shall be placed in a special fund in the county treasury to be designated as the "Bond Community Health Fund" and thereafter the county shall appropriate from such funds such sum or sums as may be necessary to carry out the provisions of this Section.

(Source: P.A. 86-962.)

(55 ILCS 5/5-25024) (from Ch. 34, par. 5-25024)

Sec. 5-25024. Submission at same election. Both the proposition for the levy of an annual tax pursuant to Sections 5-25003 or 5-25004 and the proposition for issuance of bonds pursuant to Section 5-25021 may be submitted to the electors at the same election.

(Source: P.A. 86-962.)

(55 ILCS 5/5-25025) (from Ch. 34, par. 5-25025)

Sec. 5-25025. Mental health program. If the county board of any county having a population of less than 1,000,000 inhabitants and maintaining a county health department under this Division desires the inclusion of a mental health program in that county health department and the authority to levy the tax provided for in subsection (c) of this Section, the county board shall certify that question to the proper election officials, who shall submit the proposition at an election in accordance with the general election law. The proposition shall be in substantially the following form:

Shall .....County include a mental health program in the county health department, and levy an annual tax of not to exceed .05% of the value of all taxable property for use for mental health purposes by the county health department?	YES ---------- NO

If a majority of the electors voting at that election vote in favor of the proposition, the county board may include the mental health program in the county health department and may, annually, levy the additional tax for mental health purposes. All mental health facilities provided shall be available to all citizens of the county, but the county health board may vary any charges for services according to ability to pay.

When the inclusion of a mental health program has been approved:

(a) To the extent practicable, at least one member of the County Board of Health, under Section 5-25012, shall be a person certified by The American Board of Psychiatry and Neurology professionally engaged in the field of mental health and licensed to practice medicine in the State, unless there is no such qualified person in the county.

(b) The president or chairman of the county board of health shall appoint a mental health advisory board composed of not less than 9 nor more than 15 members who have special knowledge and interest in the field of mental health. Initially, 1/3 of the board members shall be appointed for terms of one year, 1/3 for 2 years and 1/3 for 3 years. Thereafter, all terms shall be for 3 years. This advisory board shall meet at least twice each year and provide counsel, direction and advice to the county board of health in the field of mental health.

(c) The county board may levy, in excess of the statutory limit and in addition to the taxes permitted under Sections 5-25003, 5-25004 and 5-25010, an additional annual tax of not more than .05% of the value, as equalized or assessed by the Department of Revenue, of all taxable property within the county which tax shall be levied and collected as provided in Section 5-25010 but held in the County Health Fund of the county treasury for use for mental health purposes. These funds may be used to provide care and treatment in public and private mental health facilities.

(d) When a mental health program has been included in a county health department pursuant to this Section, the county board may obtain the authority to levy a tax for mental health purposes in addition to the tax authorized by the preceding paragraphs of this Section but not in excess of an additional .05% of the value, as equalized or assessed by the Department of Revenue, of all taxable property in the county by following the procedure set out in Section 5-25003 except that the proposition shall be in substantially the following form:

Shall.... county levy, in excess of the statutory limit, an additional annual tax of not to exceed .05% for use for mental health purposes by the county health department?	YES --- NO

If the majority of all the votes cast on the proposition in the county is in favor thereof, the county board shall levy such tax annually. The levy and collection of this tax shall be as provided in Section 5-25010 but the tax shall be held in the County Health Fund of the county treasury for use, with that levied pursuant to paragraph (c), for mental health purposes.

(Source: P.A. 86-962; 86-1028.)

(55 ILCS 5/5-25026)

Sec. 5-25026. Locally grown foods. Except in emergency situations, including but not limited to a food-borne disease outbreak, the board of health of a county or multi-county health department may not discourage the purchase or consumption of locally grown foods in relation to foods that are not locally grown.

(Source: P.A. 96-620, eff. 8-24-09.)

(55 ILCS 5/5-25027)

(Section scheduled to be repealed on December 31, 2018)

Sec. 5-25027. Advisory committee.

(a) No later than December 31, 2011, the county board chairman in every county with a population of less than 3,000,000 shall appoint a volunteer 7 member mental health advisory committee composed of

members of the general public, if the county has established a county health department pursuant to this Act, but no mental health program has been approved by the county health department as provided in Section 5-25025 of this Act.

(b) The mental health advisory committee shall identify and assess current mental health services in its respective jurisdiction, monitor any expansion or contraction of such services, and, if deemed necessary, provide a report to the county board with recommendations for additional services.

(c) The mental health advisory committee shall have no taxing authority.

(d) This Section is repealed on December 31, 2018.

(Source: P.A. 97-439, eff. 8-18-11.)

APPENDIX B

MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES
(405 ILCS 20/) Community Mental Health Act.

(405 ILCS 20/0.1) (from Ch. 91 1/2, par. 300.1)

Sec. 0.1. This Act shall be known and may be cited as the "Community Mental Health Act".

(Source: Laws 1967, p. 3457.)

(405 ILCS 20/1) (from Ch. 91 1/2, par. 301)

Sec. 1. As used in this Act:

"Direct recipient services" means only those services required to carry out a completed individualized treatment plan that is signed by a service recipient or legal guardian. Crisis assessment and stabilization services are excluded, although these services may be anticipated in a treatment plan.

"Governmental unit" means any county, city, village, incorporated town, or township.

"Person with a developmental disability" means any person or persons so diagnosed and as defined in the Mental Health and Developmental Disabilities Code. Community mental health boards operating under this Act may in their jurisdiction, by a majority vote, add to the definition of "person with a developmental disability".

"Mental illness" has the meaning ascribed to that term in the Mental Health and Developmental Disabilities Code. Community mental health boards operating under this Act may in their jurisdiction, by a majority vote, add to the definition of "mental illness".

"Substance use disorder" encompasses substance abuse, dependence, and addiction, not inconsistent with federal or State definitions.

(Source: P.A. 97-813, eff. 7-13-12.)

(405 ILCS 20/2) (from Ch. 91 1/2, par. 302)

Sec. 2. Any county, city, village, incorporated town, township, public health district, county health department, multiple-county health department, school district or any combination thereof, in consultation with and being advised by the Department of Human Services, shall have the power to construct, repair, operate, maintain and regulate community mental health facilities to provide mental health services as defined by the local community mental health board, including services for, persons with a developmental disability or substance use disorder, for residents thereof and/or to contract therefor with any private or public entity which provides such facilities and services, either in or without such county, city, village, incorporated town, township, public health district, county health department, multiple-county health department, school district or any combination thereof.

(Source: P.A. 95-336, eff. 8-21-07.)

(405 ILCS 20/3) (from Ch. 91 1/2, par. 303)

Sec. 3. Any such county, city, village, incorporated town, township, public health district, county health department, multiple-county health department, school district, community mental health board or any combination thereof, may accept donations of property and funds for the purposes specified in this Act.

(Source: P.A. 81-898.)

(405 ILCS 20/3a) (from Ch. 91 1/2, par. 303a)

Sec. 3a. Every governmental unit authorized to levy an annual tax under any of the provisions of this Act shall, before it may levy such tax, establish a 7 member community mental health board who shall administer this Act. Such board shall be appointed by the chairman of the governing body of a county, the mayor of a city, the president of a village, the president of an incorporated town, or the supervisor of a township, as the case may be, with the advice and consent of the governing body of such county, city, village, incorporated town or the town board of trustees of any township. Members of the community mental health board shall be residents of the government unit and, as nearly as possible, be representative of interested groups of the community such as local health departments, medical societies, local comprehensive health planning agencies, hospital boards, lay associations concerned with mental health, developmental disabilities and substance abuse, as well as the general public. Only one member shall be a member of the governing body. The chairman of the governing body may, upon the request of the community mental health board, appoint 2 additional members to the community mental health board. No member of the community mental health board may be a full-time or part-time employee of the Department of Human Services or a board member, employee or any other individual receiving compensation from any facility or service operating under contract to the board. If a successful referendum is held under Section 5 of this Act, all members of such board shall be appointed within 60 days of the referendum.

Home rule units are exempt from this Act. However, they may, by ordinance, adopt the provisions of this Act, or any portion thereof, that they may deem advisable.

The tax rate set forth in Section 4 may be levied by any non-home rule unit only pursuant to the approval by the voters at a referendum. Such referendum may have been held at any time subsequent to the effective date of the Community Mental Health Act.

(Source: P.A. 95-336, eff. 8-21-07.)

(405 ILCS 20/3b) (from Ch. 91 1/2, par. 303b)

Sec. 3b. The term of office of each member of the community mental health board shall be for 4 years, provided, however, that of the members first appointed, 2 shall be appointed for a term of 2 years, 2 for a term of 3 years and 3

for a term of 4 years. All terms shall be measured from the first day of the year of appointment. Vacancies shall be filled for the unexpired term in the same manner as original appointments.
(Source: Laws 1965, p. 1037.)

(405 ILCS 20/3c) (from Ch. 91 1/2, par. 303c)
Sec. 3c.
Any member of the community mental health board may be removed by the appointing officer for absenteeism, neglect of duty, misconduct or malfeasance in office, after being given a written statement of the charges and an opportunity to be heard thereon.
(Source: P.A. 77-1500.)

(405 ILCS 20/3d) (from Ch. 91 1/2, par. 303d)
Sec. 3d.
The expenses incurred by any community mental health board in the performance of duties imposed upon it or its members shall be a charge on the board and shall be paid out of the "Community Mental Health Fund" hereinafter established. No member shall receive payment, except expenses, for service on the board.
(Source: P.A. 78-574.)

(405 ILCS 20/3e) (from Ch. 91 1/2, par. 303e)
Sec. 3e. Board's powers and duties.
(1) Every community mental health board shall, immediately after appointment, meet and organize, by the election of one of its number as president and one as secretary and such other officers as it may deem necessary. It shall make rules and regulations concerning the rendition or operation of services and facilities which it directs, supervises or funds, not inconsistent with the provisions of this Act. It shall:

(a) Hold a meeting prior to July 1 of each year at which officers shall be elected for the ensuing year beginning July 1;

(b) Hold meetings at least quarterly;

(c) Hold special meetings upon a written request signed by at least 2 members and filed with the secretary;

(d) Review and evaluate community mental health services and facilities, including services and facilities for the treatment of alcoholism, drug addiction, developmental disabilities, and intellectual disabilities;

(e) Authorize the disbursement of money from the community mental health fund for payment for the ordinary and contingent expenses of the board;

(f) Submit to the appointing officer and the members of the governing body a written plan for a program of community mental health services and facilities for persons with a mental illness, a developmental disability, or a substance use disorder. Such plan shall be for the ensuing 12 month period. In addition, a plan shall be developed for the ensuing 3 year period and such plan shall be reviewed at the end of every 12 month period and shall be modified as deemed advisable.

(g) Within amounts appropriated therefor, execute

such programs and maintain such services and facilities as may be authorized under such appropriations, including amounts appropriated under bond issues, if any;

(h) Publish the annual budget and report within 120 days after the end of the fiscal year in a newspaper distributed within the jurisdiction of the board, or, if no newspaper is published within the jurisdiction of the board, then one published in the county, or, if no newspaper is published in the county, then in a newspaper having general circulation within the jurisdiction of the board. The report shall show the condition of its trust of that year, the sums of money received from all sources, giving the name of any donor, how all monies have been expended and for what purpose, and such other statistics and program information in regard to the work of the board as it may deem of general interest. A copy of the budget and the annual report shall be made available to the Department of Human Services and to members of the General Assembly whose districts include any part of the jurisdiction of such board. The names of all employees, consultants, and other personnel shall be set forth along with the amounts of money received;

(i) Consult with other appropriate private and public agencies in the development of local plans for the most efficient delivery of mental health, developmental disabilities, and substance use disorder services. The Board is authorized to join and to participate in the activities of associations organized for the purpose of promoting more efficient and effective services and programs;

(j) Have the authority to review and comment on all applications for grants by any person, corporation, or governmental unit providing services within the geographical area of the board which provides mental health facilities and services, including services for the person with a mental illness, a developmental disability, or a substance use disorder. The board may require funding applicants to send a copy of their funding application to the board at the time such application is submitted to the Department of Human Services or to any other local, State or federal funding source or governmental agency. Within 60 days of the receipt of any application, the board shall submit its review and comments to the Department of Human Services or to any other appropriate local, State or federal funding source or governmental agency. A copy of the review and comments shall be submitted to the funding applicant. Within 60 days thereafter, the Department of Human Services or any other appropriate local or State governmental agency shall issue a written response to the board and the funding applicant. The Department of Human Services shall supply any community mental health board such information about purchase-of-care funds, State facility utilization, and costs in its geographical area as the board may request provided that the information requested is for the purpose of the Community Mental Health Board complying with the requirements of Section 3f, subsection (f) of this Act;

(k) Perform such other acts as may be necessary or proper to carry out the purposes of this Act.

(2) The community mental health board has the following powers:

(a) The board may enter into multiple-year contracts for rendition or operation of services, facilities and educational programs.

(b) The board may arrange through intergovernmental agreements or intragovernmental agreements or both for the rendition of services and operation of facilities by other agencies or departments of the governmental unit or county in which the governmental unit is located with the approval of the governing body.

(c) To employ, establish compensation for, and set policies for its personnel, including legal counsel, as may be necessary to carry out the purposes of this Act and prescribe the duties thereof. The board may enter into multiple-year employment contracts as may be necessary for the recruitment and retention of personnel and the proper functioning of the board.

(d) The board may enter into multiple-year joint agreements, which shall be written, with other mental health boards and boards of health to provide jointly agreed upon community mental health facilities and services and to pool such funds as may be deemed necessary and available for this purpose.

(e) The board may organize a not-for-profit corporation for the purpose of providing direct recipient services. Such corporations shall have, in addition to all other lawful powers, the power to contract with persons to furnish services for recipients of the corporation's facilities, including psychiatrists and other physicians licensed in this State to practice medicine in all of its branches. Such physicians shall be considered independent contractors, and liability for any malpractice shall not extend to such corporation, nor to the community mental health board, except for gross negligence in entering into such a contract.

(f) The board shall not operate any direct recipient services for more than a 2-year period when such services are being provided in the governmental unit, but shall encourage, by financial support, the development of private agencies to deliver such needed services, pursuant to regulations of the board.

(g) Where there are multiple boards within the same planning area, as established by the Department of Human Services, services may be purchased through a single delivery system. In such areas, a coordinating body with representation from each board shall be established to carry out the service functions of this Act. In the event any such coordinating body purchases or improves real property, such body shall first obtain the approval of the governing bodies of the governmental units in which the coordinating body is located.

(h) The board may enter into multiple-year joint agreements with other governmental units located within the geographical area of the board. Such agreements shall

be written and shall provide for the rendition of services by the board to the residents of such governmental units.

(i) The board may enter into multiple-year joint agreements with federal, State, and local governments, including the Department of Human Services, whereby the board will provide certain services. All such joint agreements must provide for the exchange of relevant data. However, nothing in this Act shall be construed to permit the abridgement of the confidentiality of patient records.

(j) The board may receive gifts from private sources for purposes not inconsistent with the provisions of this Act.

(k) The board may receive Federal, State and local funds for purposes not inconsistent with the provisions of this Act.

(l) The board may establish scholarship programs. Such programs shall require equivalent service or reimbursement pursuant to regulations of the board.

(m) The board may sell, rent, or lease real property for purposes consistent with this Act.

(n) The board may: (i) own real property, lease real property as lessee, or acquire real property by purchase, construction, lease-purchase agreement, or otherwise; (ii) take title to the property in the board's name; (iii) borrow money and issue debt instruments, mortgages, purchase-money mortgages, and other security instruments with respect to the property; and (iv) maintain, repair, remodel, or improve the property. All of these activities must be for purposes consistent with this Act as may be reasonably necessary for the housing and proper functioning of the board. The board may use moneys in the Community Mental Health Fund for these purposes.

(o) The board may organize a not-for-profit corporation (i) for the purpose of raising money to be distributed by the board for providing community mental health services and facilities for the treatment of alcoholism, drug addiction, developmental disabilities, and intellectual disabilities or (ii) for other purposes not inconsistent with this Act.

(Source: P.A. 97-227, eff. 1-1-12.)

(405 ILCS 20/3f) (from Ch. 91 1/2, par. 303f)

Sec. 3f. Annually, each community mental health board shall prepare and submit, for informational purposes in the appropriations process, to the appointing officer and governing body referred to in Section 3a: (a) an annual budget showing the estimated receipts and intended disbursements pursuant to this Act for the fiscal year immediately following the date the budget is submitted, which date must be at least 30 days prior to the start of the fiscal year, and (b) an annual report detailing the income received and disbursements made pursuant to this Act during the fiscal year just preceding the date the annual report is submitted, which date must be within 90 days of the close of that fiscal year. Such report shall also include those matters set forth in Section 8 of this Act.

(Source: P.A. 95-336, eff. 8-21-07.)

(405 ILCS 20/3g) (from Ch. 91 1/2, par. 303g)

Sec. 3g. Purchases made pursuant to this Act shall be made in compliance with the "Local Government Prompt Payment Act", approved by the Eighty-fourth General Assembly.

(Source: P.A. 84-731.)

(405 ILCS 20/4) (from Ch. 91 1/2, par. 304)

Sec. 4. In order to provide the necessary funds or to supplement existing funds for such community mental health facilities and services, including facilities and services for the person with a developmental disability or a substance use disorder, the governing body of any governmental unit, subject to the provisions of Section 5, may levy an annual tax of not to exceed .15% upon all of the taxable property in such governmental unit at the value thereof, as equalized or assessed by the Department of Revenue. Such tax shall be levied and collected in the same manner as other governmental unit taxes, but shall not be included in any limitation otherwise prescribed as to the rate or amount of governmental unit taxes, but shall be in addition thereto and in excess thereof.

When collected, such tax shall be paid into a special fund to be designated as the "Community Mental Health Fund" which shall, upon authorization by the appropriate governmental unit, be administered by the community mental health board and used only for the purposes specified in this Act. Nothing contained herein shall in any way preclude the use of other funds available for such purposes under any existing Federal, State or local statute. Interest earned from moneys deposited in this Fund shall only be used for purposes which are authorized by this Act.

In any city, village, incorporated town, or township which levies a tax for the purpose of providing community mental health facilities and services and part or all of such city, village, incorporated town, or township is in a county or township, as the case may be, which levies a tax to provide community mental health facilities and services under the provisions of this Act, such county or township, as the case may be, shall pay to such city, village, incorporated town, or township, as the case may be, the entire amount collected from taxes under this Section on property subject to a tax which any city, village, incorporated town, or township thereof levies to provide community mental health facilities and services.

Whenever any city, village, incorporated town, or township receives any payments from a county or township as provided above, such city, village, incorporated town, or township shall reduce and abate from the tax levied by the authority of this Section a rate which would produce an amount equal to the amount received from such county or township.

(Source: P.A. 95-336, eff. 8-21-07.)

(405 ILCS 20/5)(from Ch. 91 1/2, par. 305)

Sec. 5. (a) When the governing body of a governmental unit passes a resolution as provided in Section 4 asking that an annual tax may be levied for the purpose of providing such mental health facilities and services, including facilities and services for the person with a developmental disability or a substance use disorder, in the community and so instructs the clerk of the governmental unit such clerk shall certify the proposition to the proper election officials for submission at a regular election in accordance with the general election law. The proposition shall be in the following form:

Shall..... (governmental unit) levy an annual tax of not to exceed .15% for the purpose of providing community mental health facilities and services including facilities and services for the person with a developmental disability or a substance use disorder?	YES ---------- NO

(b) If a majority of all the votes cast upon the proposition are for the levy of such tax, the governing body of such governmental unit shall thereafter annually levy a tax not to exceed the rate set forth in Section 4. Thereafter, the governing body shall in the annual appropriation bill appropriate from such funds such sum or sums of money as may be deemed necessary, based upon the community mental health board's budget, the board's annual mental health report, and the local mental health plan to defray necessary expenses and liabilities in providing for such community mental health facilities and services.

(c) If the governing body of a governmental unit levies a tax under Section 4 of this Act and the rate specified in the proposition under subsection (a) of this Section is less than 0.15%, then the governing body of the governmental unit may, upon referendum approval, increase that rate to not more than 0.15%. The governing body shall instruct the clerk of the governmental unit to certify the proposition to the proper election officials for submission at a regular election in accordance with the general election law. The proposition shall be in the following form:

"Shall the tax imposed by (governmental unit) for the purpose of providing community mental health facilities and services, including facilities and services for persons with a developmental disability or substance use disorder be increased to (not more than 0.15%)?"

If a majority of all the votes cast upon the proposition are for the increase of the tax, then the governing body of the governmental unit may thereafter annually levy a tax not to exceed the rate set forth in the referendum question.

(Source: P.A. 95-336, eff. 8-21-07; 96-764, eff. 8-25-09.)

(405 ILCS 20/6)(from Ch. 91 1/2, par. 306)

Sec. 6. Whenever the governing body of any governmental unit has not provided the community mental health facilities and services provided in Section 2 and levied the tax provided in Section 4 and a petition signed by electors of the governmental unit equal in number to at least 10% of the total votes cast for the office which received the greatest total number of votes at the last preceding general governmental unit election is presented to the clerk of the governmental unit requesting the establishment and maintenance of such community mental health facilities and services, including facilities and services for the person with a developmental disability or a substance use disorder, for residents thereof and the levy of such an annual tax therefor, the governing body of the governmental unit, subject to the provisions of Section 7, shall establish and maintain such community mental health facilities and services and shall levy such an annual tax of not to exceed .15% upon all of the taxable property in such governmental unit at the value thereof, as equalized or assessed by the Department of Revenue. Such tax shall be levied and collected in the same manner as other governmental unit taxes, but shall not be included in any limitation otherwise prescribed as to the rate or amount of governmental unit taxes, but shall be in addition thereto and in excess thereof.

When collected, such tax shall be paid into a special fund to be designated as the "Community Mental Health Fund" which shall, upon authorization by the appropriate governmental unit, be administered by the community mental health board and used only for the purposes specified in this Act. Nothing contained herein shall in any way preclude the use of other funds available for such purposes under any existing Federal, State or local statute. Interest earned from moneys deposited in this Fund shall only be used for purposes which are authorized by this Act.

In any city, village, incorporated town, or township which levies a tax for the purpose of providing community mental health facilities and services and part or all of such city, village, incorporated town, or township is in a county or township, as the case may be, which levies a tax to provide community mental health facilities and services under the provisions of this Act, such county or township, as the case may be, shall pay to such city, village, incorporated town, or township, as the case may be, the entire amount collected from taxes under this Section on property subject to a tax which any city, village, incorporated town, or township thereof levies to provide community mental health facilities and services.

Whenever any city, village, incorporated town, or township receives any payments from a county or township as provided above, such city, village, incorporated town, or township shall reduce and abate from the tax levied by the authority of this Section a rate which would produce an amount equal to the

amount received from such county or township.
(Source: P.A. 95-336, eff. 8-21-07.)

(405 ILCS 20/7)(from Ch. 91 1/2, par. 307)

Sec. 7. When the petition provided for in Section 6 is presented to the clerk of the governmental unit requesting the establishment and maintenance of such mental health facilities and services for residents of the community and the levy of such an annual tax therefor, the clerk of the governmental unit shall certify to the proper election officials the proposition for the levy of such tax which shall be submitted at a regular election in accordance with the general election law. The proposition shall be in substantially the following form:

Shall..... (governmental unit) establish and maintain community mental health facilities and services including facilities and services for the person with a developmental disability or a substance use disorder and levy therefor an annual tax of not to exceed .15%?	YES --- NO

If a majority of all the votes cast upon the proposition are in favor thereof, the governing body of such governmental unit shall establish and maintain such community mental health facilities and services and shall annually levy such tax. Thereafter, the governing body shall in the annual appropriation bill appropriate from such funds such sum or sums of money as may be deemed necessary, based upon the community mental health board's budget, the board's annual mental health report, and the board's plan to defray necessary expenses and liabilities in providing for such community mental health facilities and services.
(Source: P.A. 95-336, eff. 8-21-07.)

(405 ILCS 20/8)(from Ch. 91 1/2, par. 308)

Sec. 8. The Secretary of Human Services may make grants-in-aid to such county, city, village, incorporated town, township, public health district, county health department, multiple-county health department, school district or any combination thereof in accordance with the provisions of Section 34 of the Mental Health and Developmental Disabilities Administrative Act. However, no such grants shall be made without first considering the review and comments made by the board as set forth in Section 3e and responding thereto. The Department shall make all rules necessary for carrying out the provisions of this Section, including the setting of standards of eligibility for state assistance.
(Source: P.A. 91-357, eff. 7-29-99.)

(405 ILCS 20/8.1)(from Ch. 91 1/2, par. 308.1)

Sec. 8.1. The provisions of the Illinois Administrative Procedure Act are hereby expressly adopted and shall apply to all administrative rules and procedures of the Department under this Act, except that in case of conflict between the Illinois Administrative Procedure Act and this Act the provisions of this Act shall control, and except that Section 5-35 of the Illinois Administrative Procedure Act relating to procedures for rule-making does not apply to the adoption of any rule required by federal law in connection with which the Department is precluded by law from exercising any discretion.
(Source: P.A. 88-45.)

(405 ILCS 20/8.5)

Sec. 8.5. (Repealed).
(Source: P.A. 92-159, eff. 1-1-02. Repealed by P.A. 95-336, eff. 8-21-07.)

(405 ILCS 20/9)(from Ch. 91 1/2, par. 309)

Sec. 9. Whenever electors, equal in number to at least 10% of the total votes cast for the office on which the greatest total number of votes were cast at the last preceding general governmental unit election, of a governmental unit which has adopted the taxing provisions of this Act, present a petition to the clerk of the governmental unit, requesting that the levying of a tax annually in such governmental unit for the purpose of providing community mental health facilities and services be discontinued, the clerk shall certify the proposition to the proper election officials for submission at a regular election in accordance with the general election law. The proposition shall be substantially in the following form:

Shall.... (governmental unit) discontinue the levying of an annual tax for the purpose of providing community mental health facilities and services including facilities and services for the person with a developmental disability or a substance use disorder?	YES ---------- NO

If a majority of all the votes cast upon the proposition are for the discontinuance of the levying of such tax, the governing body of the governmental unit shall not thereafter levy such a tax unless a proposition authorizing such levy again receives a majority of all the votes cast upon the proposition as provided in Sections 5 and 7 of this Act.
(Source: P.A. 95-336, eff. 8-21-07.)

(405 ILCS 20/10)(from Ch. 91 1/2, par. 310)

Sec. 10. Whenever the board and the governing body of a governmental unit by resolution determines that it is necessary to issue bonds of the governmental unit to enable it to provide buildings for or to make permanent improvements in the community mental health facilities, including facilities for the person with a developmental disability or a substance

use disorder, the governing body shall so instruct the clerk of the governmental unit. Thereupon, such clerk shall certify the proposition to the proper election officials who shall submit the proposition at a regular election in accordance with the general election law. However, before such resolution is adopted, a report must be filed with the board and the governing body by the Department of Human Services as to the advisability of any proposed building or of any proposed permanent improvements in existing facilities.
(Source: P.A. 95-336, eff. 8-21-07.)

(405 ILCS 20/11)(from Ch. 91 1/2, par. 311)
Sec. 11. The proposition pursuant to Section 10 shall be in the following form:

Shall the.... (governmental unit) issue bonds to the amount of.... dollars for the purpose of enabling the governmental unit to.... (purpose to be stated, which shall be either to provide buildings for or to make permanent improvements in the community mental health facilities including facilities for the person with a developmental disability or a substance use disorder)?	YES ---------- NO

In case a majority of the votes cast upon the propositions shall be in favor of the issuance of such bonds, the governing body of the governmental unit shall issue the bonds of the governmental unit not exceeding the amount authorized at the referendum. Such bonds shall become due not more than 40 years after their date, shall be in denominations of $100 or any multiple thereof, and shall bear interest, evidenced by coupons, payable semi-annually, as shall be determined by the governing body.
(Source: P.A. 95-336, eff. 8-21-07.)

(405 ILCS 20/12)(from Ch. 91 1/2, par. 312)
Sec. 12.
The bonds authorized by this Act shall be sold and the proceeds thereof used solely for the specified purpose. At or before the time of delivery of any bond, the governing body of the governmental unit shall file with the clerk of the governmental unit its certificates, stating the amount of bonds to be issued, or denominations, rate of interest, where payable, and shall include a form of bond to be issued. The governing body of the governmental unit shall levy a direct tax upon all of the taxable property within the governmental unit sufficient to pay the principal and interest on the bonds as and when the same respectively mature. Such tax shall be in addition to all other taxes and shall not be within any rate limitation otherwise prescribed by law.
The proceeds received from the sale of the bonds shall be placed in a special fund in the governmental unit treasury to be designated as the "Bond Community Mental Health Fund" and thereafter the governing body shall in the annual appropriation bill appropriate from such funds such sum or

sums as may be necessary to carry out the provisions of this section. Interest earned from moneys deposited in this Fund shall only be used for purposes which are authorized by this Act.
(Source: P.A. 78-574.)

(405 ILCS 20/13) (from Ch. 91 1/2, par. 313)
Sec. 13. Both the proposition for the levy of an annual tax pursuant to Section 5 of this Act and the proposition for issuance of bonds pursuant to Section 10 of this Act may be submitted to the electors at the same election.
(Source: Laws 1967, p. 1171.)

(405 ILCS 20/14)
(Section scheduled to be repealed on December 31, 2018)
Sec. 14. Advisory committee.
(a) No later than December 31, 2011, the county board chairman in every county with a population of less than 3,000,000, or the township supervisor of a township located in a county with a population of 3,000,000 or more, shall appoint a volunteer 7 member mental health advisory committee composed of members of the general public, if no community mental health board has been established in the county or township as provided under Section 3a of this Act. This subsection shall not apply to townships that currently monitor and address mental health needs of township residents by providing or funding mental health services available to individuals and families, and that include the following: psychiatric evaluation, therapy, crisis assessment and intervention, and case management.
(b) The mental health advisory committee shall identify and assess current mental health services in its respective jurisdiction, monitor any expansion or contraction of such services, and, if deemed necessary, provide a report to the county or township board with recommendations for additional services.
(c) The mental health advisory committee shall have no taxing authority.
(d) This Section is repealed on December 31, 2018.
(Source: P.A. 97-439, eff. 8-18-11; 97-1170, eff. 3-12-13.)

DATE: _____ **McLean County Center for Human Services** ID#: _____

108 West Market Street • Bloomington, IL 61701

CRISIS INTERVENTION NOTE

Communication Assistance Required for this Client:

☐ None ☐ Spoken Language Interpreter ☐ Sign Language Interpreter ☐ Other: _____

Historian (if other than client): *Name:* _____ *Relationship:* _____ *Phone #:* _____

SECTION A: IDENTIFYING DATA

Client Name: _____ Client SSN: _____

(Last, First, Middle I.)

Sex: ☐M☐F DOB: _____ Age: _____ # of Children: _____ Total # persons in household: _____

Address: _____ McLean

Street/Apartment *County*

_____ IL

City *State* *Zip Code*

Phone: (Main.) _____ (Alt.) _____ Email _____

Emergency Contact / Guardian: _____ Phone: _____

Name *Relationship*

Primary Care Physician: _____ Insurance: _____

Policy Number _____ Group Number _____

Ethnicity/Race: _____ Current Living Arrangement: _____

Primary Language: _____ Forensic/Court Status: _____ Military History?: ☐Yes ☐ No

Marital Status: _____ Education Status (Years): _____ Enrolled?: ☐ Yes ☐ No

Employment Status: _____ Occupation/Employment Details: _____

SECTIONS B-N MAY HAVE BEEN OMITTED DUE TO THE FOLLOWING (CHECK IF APPLICABLE):

- ☐ Information has been recorded by ECI staff within the previous 24 hours and is unchanged (See previous note. Section D & N required)
- ☐ Phone intervention with **current** client that did not lead to hospitalization/placement (Section D & N required)
- ☐ Face-to-Face intervention with **current** walk-in client that did not lead to hospitalization/placement (Sections B-I & N required)
- ☐ Planned community call on a **current** client that did not lead to hospitalization/placement (Section D & N required)
- ☐ Other services provided by in-house ECI staff not related to crisis intervention or assessment
- ☐ Other informational or preliminary services in which this information was unavailable or assessment unwarranted

SECTION B: WILLINGNESS FOR FOLLOW-THROUGH

➢ Client is utilizing current prescribed/recommended supports and medications? ☐Yes ☐ No

Please describe:

SECTION C: ALCOHOL/DRUG USE

➢ Do you drink and/or use drugs? ☐Yes ☐No If yes, please describe: _____

Substance Type	Date of Last Use	Frequency of Use	Amount Typically Used
1.)			
2.)			
3.)			

SECTION D: PRESENTING PROBLEMS (Describe sequence of events)

➢ **Current Behavioral Status:**

☐Cooperative ☐Defensive ☐Belligerent ☐Aggressive ☐Dramatic

☐Restless ☐Agitated ☐Manipulative ☐Withdrawn ☐Immature ☐Hyperactive ☐Hypoactive

☐Impulsive ☐Hostile ☐Relaxed ☐Demanding ☐Dependent ☐Tense/Rigid ☐Posturing ☐Tremulous

➢ **Signs/Symptoms of Chief Complaint:**

➢ **Impact of Symptoms on Functioning & Self-Management:**

Signature _____

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- **Onset, Progression, & Duration of Symptoms:**

- **Patient's Attempts/Coping Methods & Availability of Supports to Address Problem(s) & Outcome(s):**
  ☐ **See Client Safety Plan** ☐ **Other (If not able to safety plan):**

SECTION E: CLIENT SAFETY PLAN ☐ Sections E and F omitted due to client being admitted/Not Applicable

- **The one thing that is most important to me and is worth living for is**: _____
- **One thing that gives me hope is:** _____
- **Step One - Warning Signs** (thoughts, images, mood, situation, behavior) **that the immediate crisis may be developing:**
  1. _____
  2. _____
  3. _____
- **Step Two - Things I can do to redirect my thoughts without contacting another person** (relaxation/physical activities)**:**
  1. _____
  2. _____
  3. _____
- **Step Three - People and social settings that can provide positive support:**
  1. _____ 3. _____
  2. _____ 4. _____
- **Step Four - People whom I will ask for help:**
  1. _____ 3. _____
  2. _____ 4. _____
- **Step Five - Professionals or agencies I will contact during a crisis:**

Clinic/Clinician Name: _____ Phone: _____
Crisis / Center for Human Services Phone: *309-827-*
Other Contact: **PATH** Phone: ***211***
Urgent Care Services: _____ Address: _____ Phone: _____

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- **Step Six – Making the environment safer**
  1. _____
  2. _____
  3. _____

SECTION F: ACTION PLAN

- Best Times to Call for Follow-Up: _____
- Should we leave a message on your voice mail in the event you are not there? ☐ Yes ☐ No
- What is your plan to help alleviate the crisis in the next few days (List Specific Steps – As Many as Applicable)?
  1. _____ 6. _____
  2. _____ 7. _____
  3. _____ 8. _____
  4. _____ 9. _____
  5. _____ 10. _____
- What is the Crisis Counselor's Recommendation:

Client Signature: _____ Crisis Counselor's Signature: _____

☐ **Original of this page given to client.**

SECTION G: ACTIVITIES OF DAILY LIVING

- **Sleep Patterns:** # of hours: _____ **Use of Sleeping Aids?** ☐Yes ☐No
  Type:
  - **Recent Changes in Sleep Patterns?** ☐None ☐Increase in Amount ☐Decrease in Amount
    ☐Difficulty Falling Asleep ☐Nightmares ☐Early AM Wakening ☐Middle Night Wakening
    ☐Difficulty Arising ☐Sleepwalking ☐Frequent Awakening
- **Recent Changes in Appetite/Weight?** ☐Yes ☐No If yes, please describe:
  - **Disclosed Eating Disorder?** ☐Yes ☐No If yes, please describe:
- **Self-Care**
  - **Bath/Shower**: ☐Independent ☐Needs Supervision ☐Requires Assistance
  - **Dressing:** ☐Independent ☐Needs Supervision ☐Requires Assistance
  - **Bathroom Use**: ☐Independent ☐Needs Supervision ☐Requires Assistance
  - **Eating**: ☐Independent ☐Needs Supervision ☐Requires Assistance

SECTION H: CURRENT PSYCHIATRIC/CHEMICAL DEPENDENCY TREATMENT

(With whom, date last seen, current medications & compliance)

SECTION I: PAST PSYCHIATRIC/CHEMICAL DEPENDENCY TREATMENT

(Include previous hospitalizations/crisis interventions - where, when and reason, compliance, and previous outpatient treatment with outcome)

SECTION J: PAST OR CURRENT FAMILY HISTORY OF PSYCHIATRIC ILLNESS/CHEMICAL DEPENDENCY

SECTION K: LEGAL CONCERNS

Have/Do you had/have any legal involvement? ☐ No ☐ Yes
If yes, please describe:

SECTION L: Functional Limitations (Client/Patient's Self-Statement and/or Observation of any physical, developmental, or other issues that will influence the delivery of service or which warrant additional assessment)

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SECTION M: PHYSICAL/EMOTIONAL/SEXUAL ABUSE

➢ **History of Abuse/Trauma:** ☐Denies ☐Alleges ☐Victim ☐Perpetrator ☐ Recent Loss (Relationships, Death, Support, Job)
☐Witness to Violence ☐Medical Trauma ☐Community Violence ☐Disasters ☐Witness Criminal activity

If yes, please describe:

➢ Are you currently in a relationship in which your partner, caretaker, or someone important to you is:

- Verbally or emotionally abusing you? ☐Yes ☐No
- Physically threatening or harming you? ☐Yes ☐No
- Do you fear this/these individual(s)? ☐Yes ☐No
- Forcing you to engage in uncomfortable activities? ☐Yes ☐ No

➢ Has abuse/neglect been reported? ☐Yes ☐No If yes, to what agency:

SECTION N: CURRENT MENTAL STATUS

Affect	☐Normal Range	☐Incongruent	☐Constricted	☐Euphoric ☐Labile	☐Blunted ☐Broad	☐Flat
Orientation	☐Person	☐Place	☐Time	☐Situation		
Thoughts	☐Organized ☐Obsessive ☐Insertion ☐ Delusional (explain):	☐Logical ☐Illogical ☐Idiosyncratic	☐Tangential ☐Distorted ☐Phobic	☐Somatic ☐Flight of Ideas	☐Ruminating ☐Broadcasting ☐Loose Associations	
Hallucination(s)	☐Visual	☐Auditory	☐Olfactory	☐Tactile	☐Gustatory	
Risk of Harm	☐Active Intent/Plan Ideation: ☐Current ☐Recent ☐Prev	☐Previous Attempts #		☐Violence Hx **(Recent < 2 Week - Previous > 2 weeks)**	☐Agreed to Safety Plan ☐Self-Harm	
Appearance	☐ Normal Range	☐Disheveled	☐Inappropriate	☐Bizarre	☐Poor Hygiene	☐Unkempt
Attitude/Manner	☐Normal Range ☐Guarded	☐Uncooperative ☐Suspicious	☐Reticent ☐ Helpless	☐Resistive ☐Indifferent	☐Fearful ☐Argumentative	☐Evasive ☐Critical
Mood	☐Depressed ☐Expansive ☐Apathetic	☐Anxious ☐Euphoric ☐Worried	☐Irritable ☐Euthymic ☐Elated	☐Angry ☐Unpredictable	☐Silly ☐Calm	☐Sad ☐Fearful
Concentration	☐Focused	☐Distractible	☐Inattentive	☐Pre-occupied	☐Circular	
Memory	☐Immediate	☐Recent	☐Remote	☐Partial Amnesia	☐Full Amnesia	
Speech	☐Spontaneous ☐Blocking	☐Coherent ☐Rambling	☐Slurred ☐Loud	☐Incoherent ☐Soft	☐Rapid	☐Pressured
Motivation	☐Adequate	☐Intense	☐Vacillating	☐Questionable		
Judgment	☐No Impairment		☐Minimal Impairment ☐Moderate Impairment		☐Severe Impairment ☐Incapacitated	
Insight	☐Aware of Problem		☐Denies Problem ☐Minimizes Problem		☐Blames Others ☐Blames Self	

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SECTION O: REQUIRED INFORMATION FOR NEW CLIENTS
(Complete section if client needs to be opened or is seen in hospital)

ICD-9/DSM-IV Diagnosis:

Axis I: _____ Axis II: _____ Axis III: _____ Axis V: (GAF/CGAS) _____

_____ _____ _____ Diagnosis Help

_____ _____ _____

Axis IV: ☐ Primary Support Group ☐ Social Environment ☐ Educational ☐ Occupational ☐ Housing
☐ Economic ☐ Health Care Access ☐ Legal ☐ Other: _____

First Presentation Assessment:

- Primary diagnosis was obtained from a psychiatrist. ☐Yes ☐No
- Does the client have a hx of autism, PDD, mental retardation, or organic brain disease or trauma? ☐Yes ☐No
- Has the client had more than 16 weeks of antipsychotic medication treatment? ☐Yes ☐No

Functional Assessment/Treatment History (For McLean County Center for Human Services Agency Use Only):

☐ ***Meets none of the criteria below***.

For ALL Referrals (Adults, Children & Adolescents): Check all that apply.

☐ Continuous treatment of 6 months or more in one or a combination of the following treatment modalities: Inpatient, Day Treatment, Partial Hospitalization.
☐ Six months continuous residence in residential setting program.
☐ Two or more admissions to inpatient treatment, day treatment, partial hospitalization, or residential programming within a 12 month period.
☐ History of using the following outpatient services over a one-year period, either continuously or intermittently: Psychotropic Medication Management, Case Management, Outreach and engagement services (adult referrals only), SASS/Intensive Community Based Services (child/adolescent referrals only).
☐ Previous treatment in an outpatient modality and a history of at least one mental health psychiatric hospitalization.

For Adult Referrals Only: Check all that apply.

☐ Serious impairment in social, occupational, or school functions.
☐ Unemployed or working only part-time due to mental illness & not for reasons of physical disability or some other role responsibility (e.g., student; primary caregiver for dependent family); is employed in sheltered setting/ supportive work situation, or has markedly limited work skills.
☐ Requires help to seek public financial assistance for out-of-hospital maintenance (e.g., Medicaid, SSI, SSDI, other indicators).
☐ Does not seek appropriate supportive community services (e.g., recreational, educational, or vocational support without assistance).
☐ Lacks supportive social systems in the community (e.g., no intimate or confiding relationships with anyone in their personal life, no close friends or group affiliations, is highly transient or has inability to co-exist within family setting).
☐ Requires assistance in basic life and survival skills. (Must be reminded to take medications, must have transportation to mental health clinic and other supportive services, needs assistance in self-care, household management, food preparation or money management, etc., is homeless or at risk of becoming homeless.)
☐ Exhibits inappropriate or dangerous social behavior resulting in demand for intervention by mental health and/or judicial/legal system.
☐ Currently receiving treatment, has a history within the past 5 years of functional impairment meeting two of the functional criteria listed above which persisted for at least 12 months, and there is documentation supporting the professional judgment that regressions in functional impairment would occur without continuing treatment.

For Child/Adolescent Referrals Only: Check all that apply.

☐ Self-Care: Impairment is manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes, and meeting nutritional needs.
☐ Community: Impairment is manifested by a consistent lack of age appropriate behavioral controls, decision-making, judgment, and value systems which results in potential involvement or involvement of the juvenile justice system.
☐ Social Relationships: Impairment is manifested by the consistent inability to develop and maintain satisfactory relationships with peers or adults.
☐ Family: Impairment is manifested by a pattern of (1) disregard for safety and welfare of self or others (e.g., fire setting, serious & chronic destructiveness), (2) significantly disruptive behavior exemplified by repeated and/or unprovoked violence to siblings and/or parents, or (3) inability to conform to reasonable limitations and expectations. The degree of impairment requires intensive (i.e., beyond age appropriate) supervision by parent/caregiver and may result in removal from the family or its equivalent.
☐ School: Impairment is manifested by the inability to pursue educational goals in a normal time frame (e.g., consistent failing grades, repeated truancy, expulsion, property damage, or violence toward others -- that cannot be remediated by a classroom setting (whether traditional or specialized).

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SECTION P: ASSESSMENT SUMMARY

4 Digit Location Code: **Address:** ZIP:

Current Client Status/Activity Description:

Clinical Intervention:

Client Response/Progress:

Plan: ☐ ECI Scheduled Check-in _____ ☐ Client encouraged to contact ECI/PATH PRN

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SECTION Q: EVENT DATA (AGENCY DATA COLLECTION PURPOSES ONLY)

Were either of the following involved in the intervention? : Legal: ☐ Yes ☐ No
EMS: ☐ Yes ☐ No

Did we request legal help: ☐ Yes ☐ No

➢ **Place a check mark next to any of the following that apply to the client:**
- ☐ Individual is a current CHS client and a suicide attempt led to a hospitalization
- ☐ Individual attempted suicide via overdose on medications prescribed by CHS physician
- ☐ An individual who attempted suicide had contact with CHS staff within the 24 hours preceding the attempt
- ☐ None of the above options apply

SECTION R: DISPOSITION

☐ **Inpatient Psychiatric Hospital** *Admission Status:* ☐Vol ☐Invol *Admitting Physician:* _____

Location: ☐BroMenn ☐Pavillion ☐Methodist ☐St. John ☐Provena ☐St.Mary (Dec) ☐McFarland ☐Linc Prairie ☐Memorial ☐Blessing
☐St. Elizabeth ☐Trinity ☐ Riverside ☐Cottage ☐ Riveredge ☐St.Mary (Kank) ☐ Proctor ☐Other: _____

☐1 ☐2 **MH Outpatient Services**
☐*CHS* ☐*Avert* ☐*CYFS* ☐*YWCA* ☐*Private Practice*
☐*Chestnut* ☐*Other:* _____

☐1 ☐2 **Addictions Services**
☐*Chestnut* ☐ *CDU*
☐*Hour House* ☐*White Oak*
☐*Other:* _____

☐ **Pending Placement/Further Assessment by Others:** ☐*Emergency Department* ☐*Medical Unit*
Staff Responsible: ☐ St. Joe ☐ Bromenn CAC ☐*Unknown (explain):* _____

☐ **Mobile ECI** ☐ **PATH** ☐ **SASS** ☐ **Law Enforcement** ☐ **MCDF** ☐ **Crisis Stab Unit:** _____

☐ **Client Refused Further Services Referrals** ☐ **Other:** _____
☐ **Needs Further ECI Action**

SECTION S: SAFETY PLANNING AND PATH REPORTING (AGENCY DATA COLLECTION PURPOSES ONLY)

Was safety plan completed: Yes No - Hospitalized No - Phone Call No - CL Refused

➢ If Yes, was plan sent to PATH: Yes No -Child/Adolescent No - CL Refused PATH Involvment

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Clinician Signature: X _____

Supervising QMHP Signature: X _____