The Role of Public Health in Chicago's Mental Health System

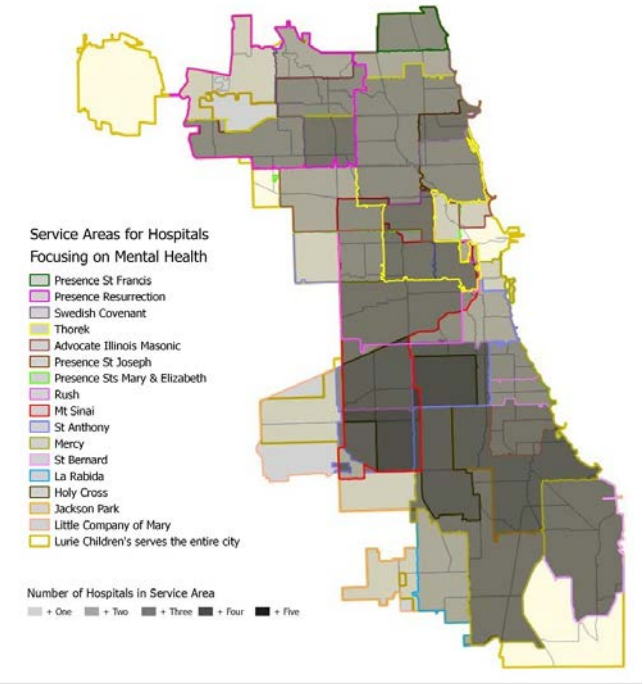
The City's claim that the closing of six mental health clinics in 2012 would improve efficiencies and quality of care has not been borne out. Health & Disability Advocates examined changes in services since that time. This analysis details recommendations to improve services, achieve savings, and increase investments in Chicago's mental health system.

A. BACKGROUND AND INTRODUCTION

Mental Health: A Priority for Chicago Hospitals

In 2015, Health & Disability Advocates (HDA) conducted a review of the Community Health Needs Assessments (CHNAs) completed by Chicago hospitals as required by the Patient Protection and Affordable Care Act. (ACA).[i] The review found that two-thirds of the hospitals prioritized mental health, equal only to the number which prioritized issues related to access to care.

When HDA mapped the shared priorities by hospital service areas, the results were striking - revealing significant overlap and thus a very real potential for collaboration.



With these opportunities in mind, a collaborative of 26 Chicago hospitals was formed and is now working together to share information and data, and to address three key public health challenges: mental health, access to care, and obesity.

To engage hospitals in efforts to improve mental health in Chicago, it is important that they be provided with a clear overview of the current system. As HDA staff began gathering information towards this end, it quickly became clear that more information was needed.

A Focus on the City of Chicago's Mental Health Services

As providers and advocates alike continue to voice concern over the state of Chicago's mental health system, two specific issues are most frequently mentioned: continued threats to State mental health funding and the 2012 closure of six City mental health centers.

State funding cuts have been well documented; however, the impact of the City's mental health changes is less clear. While the Chicago Department of Public Health's periodic status reports have outlined the successes of the consolidation, advocates have maintained the move has been unsuccessful. With this in mind and in efforts to support the work of Chicago hospitals and other providers, HDA explored the impact of the consolidation of City clinics and considered how the role of the City's public health department might be leveraged to improve the overall local mental health system.

For this analysis, HDA reviewed several documents obtained through a Freedom of Information Act request submitted to CDPH in July 2015. Public reports issued by both CDPH and other public health authorities were also reviewed, and interviews were conducted with a small number of community mental health service providers and the Illinois Department of Human Services.

B. THE CONSOLIDATION OF THE CITY'S MENTAL HEALTH CLINICS

In 2012, CDPH announced it would be consolidating its 12 community mental health centers into six as part of a larger effort to improve efficiency at its own centers and to improve the quality of the broader mental health system in Chicago.

The Rationale for Clinic Consolidation

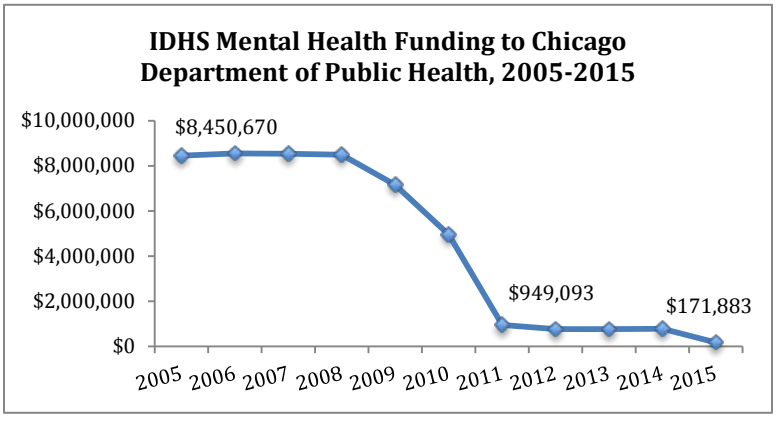
CDPH has noted that key drivers of the consolidation included a desire to improve its quality of care and increase its focus on serving the uninsured, continued decreases in State funding, and staff shortages. This section considers these factors from both a broader contextual perspective and how CDPH operations have been affected.

Serving the Uninsured: The 2010 Affordable Care Act held the promise of significantly increasing the number of Americans covered by health insurance. In Illinois, it was estimated that just over 277,000 persons with serious mental illness or serious psychological distress would become newly eligible for coverage under ACA – 120,000 through the expanded Medicaid program and the remainder through the Illinois Health Insurance Marketplace.[ii]

While coverage information specific to persons with mental health problems is not available, in Chicago, 289,124 residents have gained coverage since the Marketplace and Medicaid expansion began in January 2014.[iii, iv] Nearly 75% of these newly-enrolled individuals, 213,678, became insured under the expanded Medicaid program. CDPH's decision to focus its services on the uninsured came from the recognition that this population has fewer options than individuals with private or public coverage.

Decreases in State Funding: Illinois' spending on mental health declined by $187 million between 2009 and 2012, the fourth-largest percentage decrease among all states during those years.[v] Of current concern is the Governor's proposed FY 2016 budget, which calls for an additional $82 million in mental health funding cuts. If these cuts are realized, an estimated 16,533 persons living with serious mental illness will lose psychiatry, care coordination, evidence-based mental health services and housing supports.[vi]

Figure 1



CDPH has faced significant cuts in State funding for mental health services. (Figure 1) In the seven years preceding the clinic consolidations, IDHS funding to CDPH decreased by 89% from more than $8 million in 2005 to less than $1 million in 2011. Since then funding has continued to

decline, reaching less than $200,000 in 2015, representing a total reduction of 98% over the past decade.

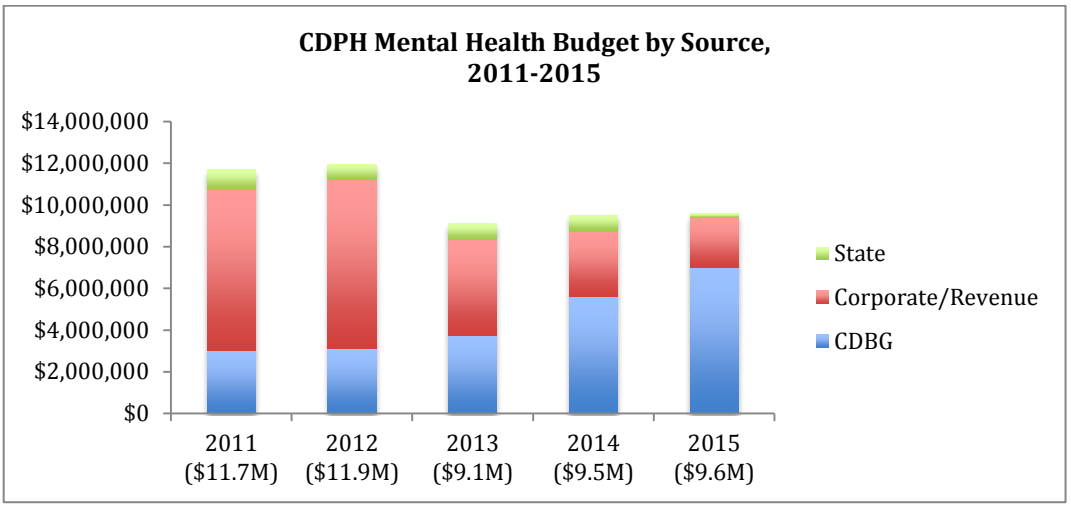
One of the challenges faced by CDPH is that the through its fee-for-service agreement, the State sets a cap on reimbursement for services to the uninsured. Once that cap is reached, any further requests for reimbursement are denied. Because CDPH will not terminate services in these instances, the City must cover the costs of continued care for these patients. In FY 2015 alone, claims approaching $47,000 were denied because CDPH exceeded the service cap.

Some of the City's grants reductions are likely due to overall declines in the State's investment in mental health, and a much smaller part may be attributed to the nature of the fee-for-service nature of the agreement. However, the funding cuts can also be traced, in part, to a failure by CDPH to adequately implement its new patient information and billing system. [vii] In 2008, as CDPH transitioned to a new computerized billing system, IDHS expressed concern that the new software must be programmed to work with the State's billing system in order for claims and services reporting to be accepted. This effort was not initially successful, and because the patient information had already been moved to the new system, CDPH could not submit information either manually or through the State billing system. CDPH did not submit patient bills for six months in 2008 and consequently lost more than $1 million in State funding. Funding has continued to decline every year since.

Total Budget: Historically, CDPH has supported its mental health centers through a combination of Illinois Department of Human Services (IDHS) funding, the City's Corporate and Community Development Block Grant (CDBG) dollars, and in very small part, from private and public insurance. As State funding declined, the City increased mental health funding in an effort to maintain operations.

The City's total mental health budget is reflected in Figure 2. The decrease between 2012 and 2013 total funding can be largely attributed to the 2012 consolidation of clinics and continued State cuts. Between 2011 and 2015, CDBG funding for mental health services more than doubled. Notably, the City's contribution in 2015, when grant funds all but disappeared, increased to the point where the total budget was greater than it was in 2013.

Figure 2

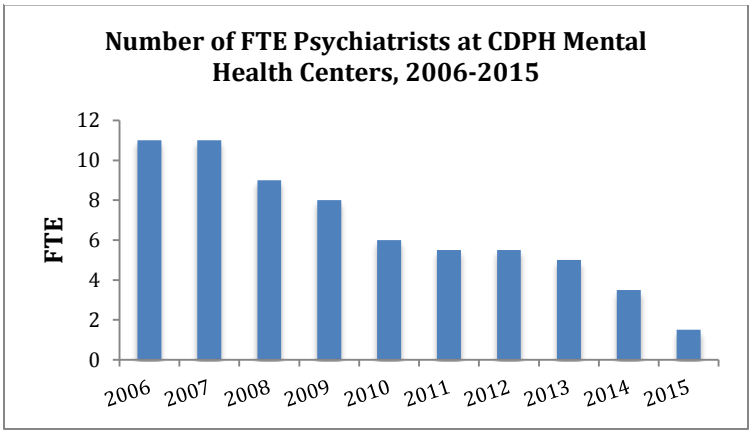


It should be noted that in the past few years when many local mental health providers were partnering with managed care organizations and health plans to maximize revenues, CDPH failed to align its services with any of a growing number of health plans despite be invited to do so. This decision on their part further limited funding that could have been generated to support the delivery of mental health services at City clinics.

Staff Shortages: In Illinois there are 123 federally designated mental health professional shortage areas, meaning that in these areas there are fewer than one psychiatrist per 30,000 population. An estimated 69% of the state's overall mental health professional needs are being met and a minimum of 71 additional psychiatrists are needed.[viii] Cook County accounts for 44 of these mental health professional shortage areas, with nearly 30 such designations in Chicago.[ix] Adding to these workforce challenges is the inclusion of $27 million in proposed State mental health cuts that will eliminate the Psychiatric Leadership Capacity Grant program, which assists community mental health agencies in hiring psychiatrists who cannot afford the low Medicaid reimbursement rates.[x]

The shortage of psychiatrists at the City's mental health clinics and the related concerns of mental health advocates have been well documented.[xi,xii] CDPH has reported that despite repeatedly posting psychiatry positions and conducting community outreach, they have been unable to fill vacancies.[xiii] This challenge began well before clinic closures were being considered. Between 2006 and 2012 the number of full-time equivalent psychiatrists employed by CDPH decreased by half, from 11 to 5.5 FTEs (Figure 3). Since the clinic consolidations in 2012, the numbers have continued to decline and as of January 2015 there were just 1.5 FTE psychiatrists serving patients at six mental health centers.

Figure 3

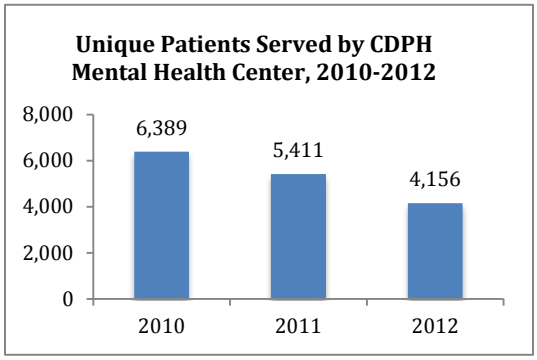


In an effort to better attract and retain psychiatrists, in 2015 CDPH increased the salary for psychiatrist positions by approximately $15,000 to $174,000. This increase did not, however, increase their ability to recruit and hire psychiatrists. Notably, the average salary of psychiatrists in states in the Great Lakes region, which includes Illinois, was $217,000 in 2014.[xiv] The City has publicly stated that is cannot afford to meet market averages.

The Closure of City Mental Health Centers

With continued cuts in funding and ongoing hiring challenges, the number of patients seen at CDPH has declined in recent years (Figure 4) and by 2012, CDPH mental health centers were operating at an average capacity of just 61% for therapy.[xv] It is against this backdrop that, in mid-2012, CDPH closed six of its 12 mental health centers: Auburn Gresham, Back of the Yards, Beverly Morgan, Northtown/Rogers Park, Northwest, and Woodlawn. At the time, CDPH noted it

Figure 4



would retain the capacity to serve more than 3,000 uninsured clients and 1,000 Medicaid/Medicare clients per year.[xvi] CDPH reports that while half of their sites closed, the majority of clinical staff and all psychiatrists were retained.[xvii]

At the time, each of the just under 2,800 active clients from the closing sites was offered services from another provider or at one of the six remaining CDPH mental health centers. During the transition, 429 insured patients (18% of clients) transferred to non-profit community based providers. They were told that if they were uncomfortable with their new provider they could return to one of the remaining CDPH mental health centers; 63 patients chose to return.[xviii] With the capacity created by the consolidation, by the end of 2012, CDPH was serving 752 *new* patients, all of whom were either uninsured or on Medicaid.[xix]

Figure 5

Unique Patients 2012 Before and After Consolidation		
Center	**Before Transition (January-April)**	**After Transition (May-December)**
Englewood	320	743
Greater Grand	328	536
Greater Lawn	253	514
Lawndale	245	298
North River	376	500
Roseland	364	473
Auburn Gresham	282	0
Back of the Yard	243	0
Beverly Morgan Park	215	0
Northtown Rogers	155	0
Northwest	121	0
Woodlawn	218	0
Totals	3,120	3,064

Despite the capacity that CDPH retained as a result of the clinic closings, two points are worth noting. First, the number of clients served at the remaining six CDPH mental health centers has continued to decline each year since 2012. The number of clients served in 2014 (2,545) was 16% lower than the 3,036 served in 2013. Second, the Despite well-intentionedDespite well-intentioned clients who are uninsured did not increase. It has in fact declined – from 71% in February 2014 to 23% in July 2015. These two shifts may be related. As enrollment under the ACA began in January 2014, an increasing number of Chicagoans have gained health insurance. It is likely that some of these newly insured were CDPH clients who have since exited care at the City and transitioned to a provider within their new health plan.

Finally, as CDPH was closing its six mental health centers, they simultaneously worked to identify additional partners. By the end of 2012, Human Resources Development Institute (HRDI) had begun delivering mental health services at the former Auburn Gresham Mental Health Center, reporting just under 4,000 visits for 2014. In June 2014, a second provider, Thresholds, began operating out of the former Woodlawn center offering mental health outreach services to area residents. By the end of 2014 they had provided 12,470 visits. These two partners operated with significantly greater efficiency, providing 6,500 more visits annually from the two former sites than CDPH had delivered in the last full year of service at those locations prior to the clinic closures.

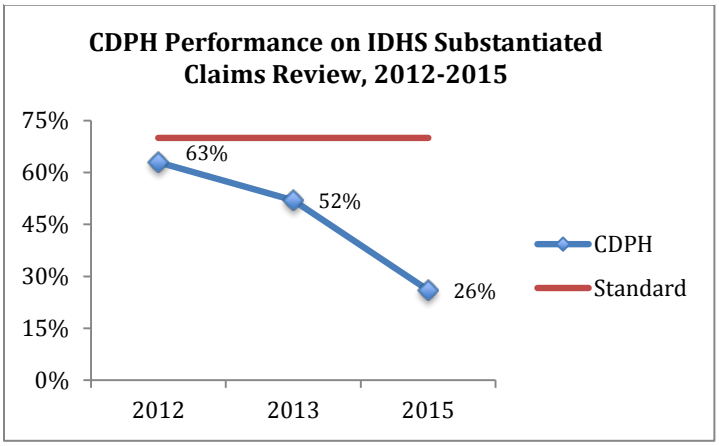
CDPH Performance as a Direct Service Provider

On an annual basis, the Illinois Department of Human Services, through the Illinois Mental Health Collaborative, conducts a post-payment review of its grantee organizations that bill Medicaid. HDA obtained the review summaries for site visits conducted at CDPH in 2012, 2013 and 2015. [xx] For each of these periods, CDPH's performance consistently fell below the thresholds established by the State. The reviews focus both on contract and rule compliance, and on substantiated payment claims.

Under the compliance review, IDHS conducts chart reviews and assesses performance on 11 factors. On two of these items – the location of a valid Mental Health Assessment (MHA) and location of a valid Individual Treatment Plans (ITP) – CDPH failed each year to meet the established standard of 90%. One reviewer noted that there were several charts where the MHAs were missing and in some files, there was no history of an MHA for over 2, 3 and 4 years of service.

Despite recent improvements with the rules and contracts part of the State review, the City's performance on the payment claims part has not improved, and in fact has gotten significantly worse (Figure 6). In 2012, 63% of 114 claims submitted by CDPH and reviewed by IDHS were substantiated. This percentage is used by IDHS as the overall review score where the threshold or standard score is 70%. When the overall score decreased to 52% the following year, an overall Plan for Improvement was required, in addition to the plans already required to address deficiencies found in the review of MHAs and ITPs. The most recent review, covering a one-year period from May 2014 to May 2015, resulted in an overall score of just 26%. While IDHS is not able to discuss specific grantee organizations, they did tell HDA that when a provider's score falls below 50% there is a suspension of Medicaid.[xxi] It is therefore presumed that as a result of their performance, CDPH's Medicaid billing was suspended following their last review. For providers to get Medicaid reimbursement reinstated, a Plan of Correction is required and must be supported by either another on-site review or desk audit that demonstrates improvements are occurring.

Figure 6



As previously noted, in its 2012 Mental Health Services report, CDPH clearly stated that its mental health clinics were operating at just 61% capacity.[xxii] This fact makes it difficult to understand how providers, therefore, did not have the time to do the expected charting that would have prevented some of the deficiencies identified repeatedly during its State reviews.

Summary

When closing six mental health clinics in 2012, CDPH claimed the move with improve efficiencies, result in high quality care, and make available needed services for the uninsured. Over two years later, these do not appear to be the outcomes achieved. The City is seeing at least 16% fewer clients

than it did in 2013 and is now down from 5 (in 2013) to just 1.5 FTE psychiatrists. As the number of uninsured has dropped, the expectation of an increasingly uninsured patient population has not been realized, although it still exceeds the number for which the State is willing to reimburse. Further, the City's decision not to join Medicaid or other health plans means that CDPH mental health clients are not receiving integrated care (the standard), and the staff are not held to the same quality standards as providers that have chosen to join with health plans.

C. SHIFT TOWARDS COMMUNITY PARTNERSHIPS

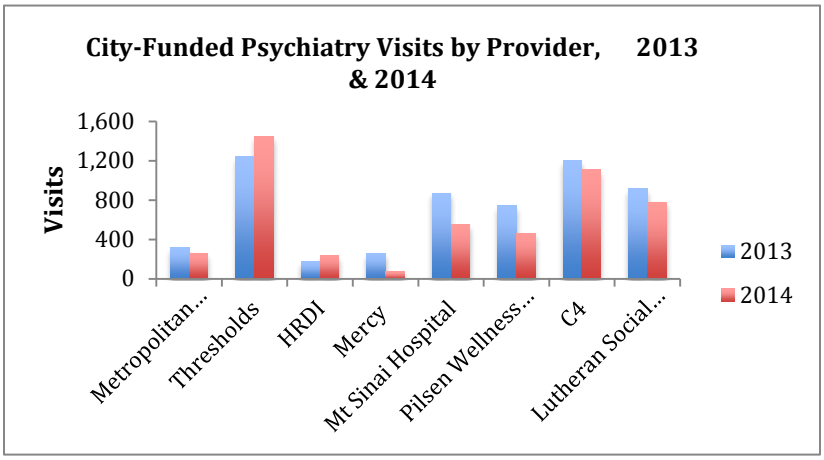
The consolidation of CDPH mental health centers was accompanied by an expanded focus on community partners. Over the past several years, CDPH has engaged in a variety of partnerships to increase service availability, integrate services, and address the most vulnerable populations in need.

Community-Based Psychiatry Services for the Uninsured

When the City closed the six mental health centers in mid-2012, it simultaneously awarded $500,000 in funding to seven agency partners to increase community capacity for psychiatry services for uninsured persons. The funded agencies were Community Counseling Centers of Chicago (C4); Human Resources Development Institute (HRDI); Lutheran Social Services of Illinois (LSSI); Metropolitan Family Services; Mt. Sinai Hospital; Pilsen Wellness Center; and Thresholds.[xxiii] An eighth partner, Mercy Hospital and Medical Center, was also funded when an additional $500,000 was awarded in 2013, and again in 2014.

In 2013, the eight funded community partners collectively provided 5,727 psychiatry visits to uninsured residents (Figure 7). That number decreased to 4,927 in 2014, when six of the funded providers saw combined reductions in visits of 25%, and just under $200,000 or 40% of the funds awarded by CDPH went unspent. One explanation for this drop is that there were fewer uninsured residents, as 2014 was the first year of enrollment under the ACA. During that initial open enrollment period, approximately 405,000 Illinois residents gained coverage under the expanded Medicaid program, while another 217,000 enrolled in a plan through the Illinois Health Insurance Marketplace.[xxiv]

Figure 7



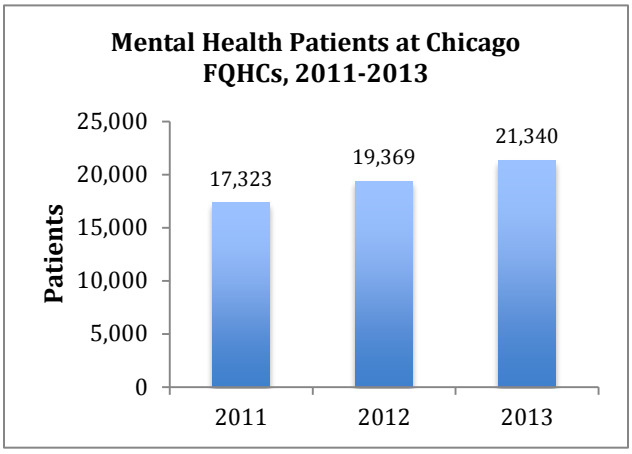
FQHC Partnerships

While planning for the closure of the six mental health centers, CDPH partnered with more than 40 community-based providers to ensure that patients affected by the closures had a new mental health service home.[xxv] Among these providers were federally qualified health centers (FQHCs),

which receive federal funding to serve an underserved area or population, and qualify for enhanced reimbursement from Medicaid and Medicare, among other benefits.

In anticipation of the ACA's insurance mandate taking effect in 2014 and the expected increase in demand, the federal Health Resources and Services Administration (HRSA) began in 2010 to award significant funding to increase the service capacity of FQHCs. Since 2010, 89 ACA grants totaling over $148 million have been awarded to Chicago-based FQHCs to support service delivery.[xxvi] These investments have contributed not only to enhanced primary care capacity, but also to a 23% increase in the number of FQHC patients receiving mental health services (Figure 8). According to the most recent HRSA data available, over 58,000 mental health patients were served by Chicago FQHCs between 2011 and 2013.[xxvii]

Figure 8



In July 2012, the City entered into partnerships with seven FQHCs to assume operations of CDPH's neighborhood health centers. Six of these partners are among the 17 Chicago FQHCs that provide mental health services.

Focus on Justice-Involved Populations

In 2011, CDPH began working with criminal justice partners to address the challenge of mental illness health among Chicagoans who spend time in Cook County Jail or who otherwise interact with the police, including the homeless.

Cook County Jail Collaboration: In 2015, CDPH provided $250,000 in funding to support the expansion of Threshold's Justice Program to include a four-person Discharge Linkage Team which engages detainees in Cook County Jail who could benefit from intensive community support post-discharge. The Discharge Linkage Team screens 2-3 individuals with serious mental illness per day for service needs, discharge planning, and linkage to care services. The Team then works with participants to create an individualized treatment plan. Upon release, the Team provides support for linkage to housing, psychiatry, medication management, substance abuse treatment, and vocational services. The work also includes aggressive outreach for participants who are lost to care.

Crisis Intervention Pilot Program: Using Chicago Police Department data, this pilot program links residents in mental health crisis in three police district with mental health services. When a resident in crisis interfaces with the police, a community-based partner is engaged to provide mental health triage services in a hospital setting in an effort to link the individual to appropriate mental health services. To support this effort, CDPH provides funding ($100,000) to HRDI to have crisis staff at St. Bernard Hospital that can help stabilize residents brought into the hospital (and others in the project area) by the police and link them to ongoing community-based services upon release from the hospital.

Crisis Response and Recovery Program: This two-year, $2 million Justice Department funded effort supports family members of homicide victims. CDPH is partnering with Chicago Survivors and Thresholds to implement this pilot program in two police districts. The pilot, which began in

2015, immediately connects survivors of violence to mental health and other support services, to minimize trauma and reduce further acts of violence. The effort is being monitored by a committee of four City agencies with the goal of expanding the program to additional districts and, ultimately, citywide.

Services for Children

In the past few years, CDPH has engaged in a number of partnerships to promote positive mental health by strengthening the resiliency of children as well as to serve children who are suffering from trauma or other mental health problems.

Restorative Justice: In 2015, CDPH partnered with six community partner organizations to engage expand restorative justice practices in elementary school. The goal of the program is to prevent youth violence and victimization, and support the recovery of violence-impacted students through the use of restorative practices in the academic environment and the increased availability of effective recovery services and supports. CDPH supports this work through grants totaling $371,000.

Childhood Sexual Assault Services: In 2015 CDPH awarded $250,000 to the Chicago Children's Advocacy Center to expand its services. The Center is the city's only not-for-profit organization that coordinates the efforts of child protection staff, law enforcement professionals, family advocates, medical experts and mental health clinicians under one roof, with the goal of reducing further trauma for the child and affected family. The grant supports ongoing mental health treatment and supportive services to childhood victims of sexual and/or physical assault, as well as their families.

Increased Community-Based Care: In 2013, CDPH began working with the Illinois Children's Healthcare Foundation (ILCHF) to increase access to mental health services for children. According to the Department, this partnership resulted in grants totaling $4 million to providers – Erie Family Health Center and Metropolitan Family Service to work with partners to create integrated systems of primary and mental health care services on the city's south and west sides.

Other Partnerships

Engagement of Hard-to-Reach Populations: CDPH has developed two initiatives to support the engagement of harder to reach populations and link them to care. CDPH has awarded $125,000 to Thresholds to address the needs of homeless persons with mental illness. Under this agreement, Thresholds conducts street outreach in the Uptown and Englewood neighborhoods to engage these adults and link them to appropriate mental health and other supportive services, including housing.

A second initiative focused on residents who are ineligible for insurance through the ACA, with a specific focus on undocumented residents. With $125,000 in funding, the Puerto Rican Cultural Center and Pilsen Little Village Wellness center are conducting community outreach to mentally ill adults and linking them to ongoing mental health services.

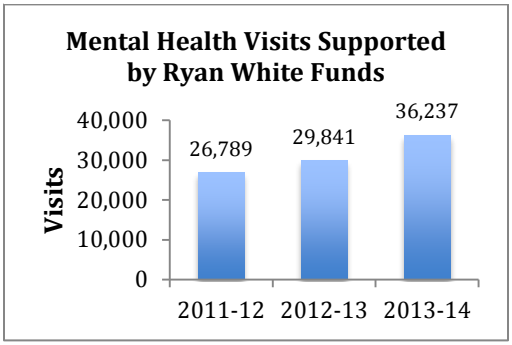
Federal Grant Programs: Prior to 2012, community partnerships for mental health services fell under two federal grants awarded to CDPH. Ryan White Part A funds have supported a continuum of services, including mental health, to persons with HIV/AIDS since 1990. Over the past few grant

periods, as depicted in Figure 10, the mental health visits supported by the grant have increased by 35%.

More recently, CDPH was awarded funds from the federal Substance Abuse and Mental Health Services Administration to provide integrated mental health, substance abuse and HIV screening services.

Funded community partners provided just over 3,700 visits in each of the past two years.

Figure 9



D. AN APPROPRIATE ROLE FOR PUBLIC HEALTH AGENCIES

While CDPH has historically served as a mental health "provider of last resort," the Department is somewhat unique among local health departments. The National Association of County and City Health Officials' 2013 Profile of Local Health Departments documents the extent to which the nation's approximately 2,800 local public health agencies provide a range of services.

The profile survey found that while more than 90% of local health departments provide such services as immunizations and disease surveillance, just 10% report they provide (either directly or through contract) behavioral/mental health services.[xxviii] The profile also includes the median number of full-time public health professionals in specific positions. For local health departments serving jurisdictions over 1,000,000, the median number of 'behavioral health professionals' is zero.

The question of what is an appropriate role for public health agencies in mental health services has been explored by experts several times over the past two decades. A 2001, supplemental report to the U.S. Surgeon General's seminal report on Mental Health, notes that an appropriate role for public health agencies in addressing mental health is one that identifies problems and develops solutions for entire population groups. [xxix]

In a 2005 report on The Role of Public Health in Mental Health Promotion, the U.S. Centers for Disease Control and Prevention noted that the challenges for public health are to identify risk factors, increase awareness about mental disorders and the effectiveness of treatment, remove the stigma associated with receiving treatment, eliminate health disparities, and improve access to mental health services.[xxx]

The National Prevention Strategy recommends roles for different sectors, including (a) Individuals and Families; (b) Community, Nonprofit, and Faith-Based Organizations; (c) Health Care Systems, Insurers, and Clinicians; (d) Early Learning Centers, Schools, Colleges, and Universities; and Businesses and Employers; and (e) State, Tribal, Local, and Territorial Governments. The NPS recommends a variety of roles, but suggests community organizations work to expand access to mental health services and identifies screening and integrated mental health care programs as a role to be filled by health care system and clinicians.

Figure 10

The recommendations in the above-referenced reports are strongly

aligned with the 10 Essential Public Health Services (Figures 10 and 11).[xxxi] These widely adopted services describe the public health activities that all communities should undertake, and they serve as the framework for public health system assessment instruments and public health department accreditation requirements. None of the reports recommend that governmental public health agencies directly provide mental health services.

Figure 11

U.S. Surgeon General's Report, 2001	U.S. Centers for Disease Control & Prevention, 2005	National Prevention Strategy, 2011
Define the problem using surveillance processes designed to gather data that establish the nature of the problem and the trends in its incidence and prevalence.	Conduct surveillance and research to improve the evidence base.	Enhance data collection systems to better identify and address mental and emotional health needs.
Identify potential causes through epidemiological analyses that identify risk and protective factors associated with the problem.	Incorporate mental health promotion into chronic disease and prevention efforts.	Ensure that those in need, especially potentially vulnerable groups, are identified and referred to mental health services.
Design, develop & evaluate the effectiveness and generalizability of interventions.	Collaborate with partners to develop comprehensive mental health plans to enhance coordination of care.	Pilot & evaluate models of integrated mental and physical health in primary care, with particular attention to underserved populations and areas.
Disseminate successful models as part of a coordinated effort to educate and reach out to the public.		Include safe shared spaces for people to interact in community development plans, which can foster healthy relationships and positive mental health among community residents.

E. RECOMMENDATIONS FOR MOVING FORWARD

The picture painted in this report of CDPH's current role in mental health is mixed. While work in some areas, such as direct service delivery, has proven to be problematic, many of the new community-focused initiatives hold greater promise. This is not surprising as the work of governmental public health agencies is most effective when done in partnership with other key stakeholders. This final section offers a set of strategic recommendations about the direction that HDA believes CDPH should take in the mental health arena.

1. **CDPH should increase its epidemiological capacity to conduct behavioral health surveillance.**

For many of its core programs, CDPH uses data to better understand public health problems and highest risk populations, and to target evidence-based interventions. Mental health should be no exception. CDPH should create a behavioral health epidemiologist position to work with public agencies and community partners to advance its mental health work.

2. **CDPH should use its bully pulpit to unite the City, County and State to develop consensus on mental health priorities, programs, and policies.**

Providers report there is a lack of consensus across jurisdictions regarding priorities, programs, and policies for addressing mental illness. As a public health agency, CDPH is well positioned to publicly call for and participate in the development of strategies to coordinate activities and resolve area where inconsistencies exist.

3. **CDPH should convene a Mental Health Committee of its *Healthy Chicago Interagency Council* to identify needs and mission-aligned opportunities for intervention by City agencies.**

The *Healthy Chicago Interagency Council* consists of senior staff from approximately 15 City of Chicago departments including the Family and Support Services, Buildings, Aviation, Public Libraries, Park District, Housing Authority. Each of these departments, and the others on the Council, may serve populations that are affected by mental illness, or encounter them in the course of carrying out their daily business. A Mental Health Committee could work to identify the needs from an agency-specific perspective and leverage existing resources to develop strategies for prevention and intervention.

3.1 CDPH should develop and implement an inter-departmental strategy for addressing mental illness and homelessness.

The National Coalition for Homelessness has estimated that between 20% to 25% of the homeless population in the U.S. suffers from some form of severe mental illness.[xxxii] Estimates of the number of homeless in Chicago range from just under 6,000 (from the City's 2014 Point in Time Study) to 138,575, estimated by the Chicago Coalition for the Homeless. The Department of Family & Support Services funds Chicago's network of homeless shelters, and the police routinely interact with homeless persons. CDPH should work with these agencies and key community providers to develop an integrated strategy for serving this population.

4. **CDPH should enhance its focus on justice-involved populations.**

The U.S. Justice Department has estimated that 60% of incarcerated persons have mental illness. Approximately 100,000 detainees are admitted to Cook County jail annually[xxxiii], suggesting that as many as 60,000 detainees are living with mental illness.

CDPH should reconvene the 2011 criminal justice/mental health task force to draw on the expertise of its partners from the Chicago Police Department, the Cook County Sheriff's Office, the Cook County Jail, and experienced providers to determine which interventions are proving most effective for serving this population. CDPH should then allocate grant funding to increase promising and best-practice activities.

5. CDPH should expand efforts to promote the mental health of children.

With continued education budget challenges, it is likely that the Chicago Public Schools (CPS) will be forced to reduce funding for non-educational programs, such as those that promote resiliency in young students, such as social emotional learning. CDPH should identify best practices in this area and then work with CPS to develop, fund, and implement a strategy.

6. CDPH should identify qualified community providers to assume operations of the six remaining mental health centers.

Despite well-intentioned efforts to focus its direct service delivery efforts on the uninsured, including offering a higher pay rate, CDPH has been unable to fill critical vacancies. It continues to struggle both with service delivery and administratively, as reflected in IDHS's most recent review. CDPH should not close its mental health centers but rather maintain the mental health service delivery footprint by entering in partnerships with qualified providers who can assume responsibility for center operations. CDPH should award grants to these providers to cover high quality, uncompensated care and more comprehensive and coordinated services for the under-insured at the remaining six mental health centers. This approach will ensure that services continue without interruption, at the same location, and that patients are not lost to care.

Savings achieved through this shift should be substantial. These dollars should be re-directed to support community-based providers participating in interventions, recommended above, for justice-involved populations, children, and the homeless.

7. The City of Chicago should dedicate 2% of annual gross income from any future Chicago casino to support mental health services.

Studies have shown that problem gamblers are at increased risk for several psychiatric diagnoses, including depression, anxiety disorders, antisocial personality disorder, and alcoholism; and they are also at increased risk of suicide.[xxxiv],[xxxv] It follows then that the presence of a casino should be accompanied by an increased commitment to mental health services. In 2014, Illinois' 10 casinos had gross receipts of over $1.4 billion. The highest gross revenues – $425 million – were achieved at the only casino in Cook County, the DesPlaines River Casino. If a Chicago casino generated half that amount, a 2% annual commitment to mental health would add $4.2 million to the system each year. These new mental health dollars should be allocated as grants to community-based mental health providers.

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