An Investment in Our Future

Accomplishments and Lessons Learned from the *Children's Mental Health Initiative, Building Systems of Care Community by Community*

Illinois Children's
Healthcare Foundation

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About Illinois Children's Healthcare Foundation

The vision of Illinois Children's Healthcare Foundation (ILCHF) is that every child in Illinois grows up healthy. ILCHF cultivates, supports, and promotes initiatives that improve the health and wellness of children in Illinois, primarily in the high-need areas of children's oral and mental health.

ILCHF's philosophy is that health care must address the whole child and that the healthcare system in Illinois must be responsive to the needs of all children. Working through grantee partners across Illinois, ILCHF focuses its grant-making on identifying and funding solutions to the barriers that prevent children from accessing the ongoing health care they need. Since its inception in 2002, ILCHF has invested more than $63 million in organizations throughout the state that work tirelessly to improve the health of children in their communities.

Children's Mental Health Initiative Timeline

2009

SEPTEMBER
Planning Grant RFP released by the Illinois Children's Healthcare Foundation

2010

MAY
CMHI Planning Grants awarded to five communities for the period
of June 1, 2010–August 31, 2011

2011

AUGUST
4 CMHI Communities—Adams County, CLOW (Carol, Lee, Ogle, and Whiteside
Counties), Livingston County, and the City of Springfield were awarded five year
grants encompassing three years of Implementation and two years of Monitoring

SEPTEMBER
Year One of Implementation for the 4 CMHI Communities begins

2013

JANUARY
Year Two of Implementation for the 4 CMHI Communities begins

2014

JANUARY
Year Three of Implementation for the 4 CMHI Communities begins

FEBRUARY
Understanding the changing contexts of the communities and the difficult and
unpredictable nature of systems change, the ILCHF Board of Directors invests an
additional year of Implementation Funds into the four CMHI Communities

2015

JANUARY
Year Four of Implementation for the four CMHI Communities begins

2016

JANUARY
Year One of Monitoring for the four CMHI Communities begins

2017

JANUARY
Year Two (the final year) of Monitoring for the four CMHI Communities begins

Executive Summary

In the United States, 48% of the population will develop a mental disorder at some point in their lifetimes, with 75% having the onset before the end of adolescence (age 24) and 50% starting before the end of childhood (age 14).[1] This public health crisis is aggravated by the fact that many communities have neither the resources nor a strategy to address this pervasive threat to children's healthy development. The Children's Mental Health Initiative (CMHI) was designed to address these challenges and has, in just three years, significantly changed the way that the partner communities approach children's mental health.

With support from ILCHF, four CMHI teams have dramatically shifted community culture and practices surrounding children's mental health with the goal of identifying and serving all children in need of mental health care. The CMHI empowers communities through investments in their unique visions and capabilities, enabling providers to align their organizational focus and serve children through a community wide lens.

The most significant accomplishments of the CMHI communities at the mid-point of this initiative include:

1. **Increases in the number of children screened and accessing mental health services.** Communities are screening more children and thereby identifying more children with or at risk of developing mental illness. In 2014, more than 35,000 of a possible 86,000 children were screened across the four communities. As a result, more children are connected to appropriate services and there are early indications that this effort is improving children's mental health in the CMHI communities.

2. **Improvements in children's mental health care.** The implementation of innovative strategies that better standardize the integration of mental health services across practices and settings has improved care, as evidenced by:

   a. Improved cross-sector collaboration. Child-serving agencies and providers have expanded and improved their service coordination and collaboration, resulting in more children being served more effectively.

   b. Increased sense of ownership over the mental health of children. As key stakeholders have gained a better understanding of their respective roles in supporting the mental health and wellness of children in their communities, there has been an increased commitment to the CMHI projects. Collaborative, cross-sector leadership structures have developed to provide strong governance and oversight, fostering a shared sense of purpose and ownership.

   c. Improved ability to address children's mental health. Investments in workforce development and training opportunities for providers and community members have better prepared the CMHI communities to provide appropriate mental health services for children in natural settings, such as schools and medical offices.

3. Community-wide commitment to long-term, sustainable change. CMHI project teams have employed multiple strategies to increase their likelihood of sustaining the systems of care in their communities, including:

a. Continuously expanding the number of participants engaged in the CMHI. With an expanding contingent of providers and sectors engaged in the systems of care, improved practices are increasingly systematized and embedded across the communities.

b. Using local evaluation data to support the case for continued community investment. Data generated at the local level is a catalyst for ongoing community investment in the system of care.

c. Engaging in long-term planning from the outset. Because sustainability planning has been a requisite element of the CMHI since the initial planning period, the projects have been thoughtful about how their systems of care can be permanently embedded in the community. There are indications that some aspects of the systems will be sustained for years to come.

The four communities have encountered and are learning from the following common challenges:

1. Variability in provider buy-in and screening practices. Due to the independent nature of the child-serving organizations involved in the CMHI, their capacity to engage, as well as the extent of their participation in the CMHI, is highly variable. In order to increase engagement, participation, and standardization of processes, communities implemented multi-level organizational and peer support systems.

2. Recruitment and retention of skilled mental health professionals. Despite using various strategies to recruit and retain qualified mental health professionals, there continues to be a shortage in the CMHI communities. Additional supports are needed to expand the number and variety of these skilled clinicians, especially in rural areas.

3. System model replication. Although the creation of one or more fully replicable systems of care models was an initial goal of CMHI, full system replication does not seem possible because the systems are dependent upon each community's unique set of resources. Replication of selected elements of each of the systems is more likely.

4. Long-term financial sustainability of multiple system of care elements. From the inception of the CMHI, communities have been planning for and committed to the long-term sustainability of their programs. Nonetheless, the lack of public financial support will likely jeopardize some elements of the new systems of care at the end of the CMHI grant term.

5. Comprehensive evaluation of systems-change efforts. Though evaluation is critical to understanding the impact of systems-change efforts on children's mental health, it is difficult to evaluate the full range of CMHI's work and immediately apply the findings in practice.

Although these challenges are complex and at times overwhelming, they have made the CMHI communities more resilient, nimble, and committed to their communities' children's mental health. The communities continue to grow their systems of care and improve the delivery of mental health care to children. Their accomplishments and stories serve as inspiration to child-serving organizations, funders, practitioners, and policy-makers committed to improving the healthy development of children.

ILCHF Children's Mental Health Initiative

Introduction

In 2009, ILCHF launched the Children's Mental Health Initiative, *Building Systems of Care, Community by Community* (CMHI). The goal of the CMHI is to enhance and integrate available resources to build community-wide systems of care that prevent, identify, and treat children's mental and behavioral health problems.

By sharing what has been learned during the planning and initial implementation phases of the CMHI, we seek to highlight the work of the CMHI communities, as well as draw further attention to and ultimately improve children's mental health. Implementation began in 2011, following an 18 month planning process. This report reflects CMHI activity through 2014, the end of the third year of the initiative's implementation phase.

CONTEXT

The failure to provide children with comprehensive mental health care is a significant public health crisis in the United States. Behavioral, emotional, and other mental health disorders in children can be reliably identified and treated, but are all too often not.[2] Approximately 13% of children ages 8 to 15 had a diagnosable mental disorder in the past year, with that prevalence rising to over 21% among youth 13 to 18 years of age.[3] Equally troubling is the early age at which mental disorders develop. The median age of onset for anxiety disorders is 6 years old, followed by 11 years old for behavioral disorders, 13 years old for mood disorders, and 15 years old for substance use disorders.[4]

Despite the high prevalence and early onset of mental illness, the necessary systems and supports are sorely lacking to appropriately prevent, identify, and treat children with or at risk of mental illness. National estimates suggest that fewer than 1 in 8 children with identified mental health problems receive treatment, and only 50% of children with behavioral problems are actually identified.[5] Children and youth at high risk for developing mental illness are often unable to receive needed support and treatment, despite significant evidence that early intervention improves their academic, economic, health, and mental health outcomes.[6]

This reality must change. Effective, efficient, and evidence-based interventions exist to address the mental health needs of children; yet, the majority of current systems do not effectively implement these interventions. In addition to improving child and family health, comprehensive systems of care can decrease the need for more expensive interventions found through in-patient hospitalization, special education, and the juvenile justice system.[7] The CMHI is the Illinois Children's Healthcare Foundation's response to this public health crisis in the state of Illinois.

CMHI SYSTEMS OF CARE

Seeking to improve access to children's mental health care, ILCHF issued the CMHI Planning Request for Proposals (RFP). The RFP sought applicants from communities across the state to create comprehensive, coordinated, and integrated community-based systems of care to prevent, identify, treat, and promote children's mental health.

In 2010, five communities received 13-month planning grants of approximately $300,000 each. In 2011, each community submitted an implementation application supported by data from a comprehensive needs assessment conducted during the planning period and a sustainable financial model.

The Foundation awarded implementation grants to four community teams. Their creative and innovative plans emphasized the importance of community-based collaboration and built upon their existing services to ensure tha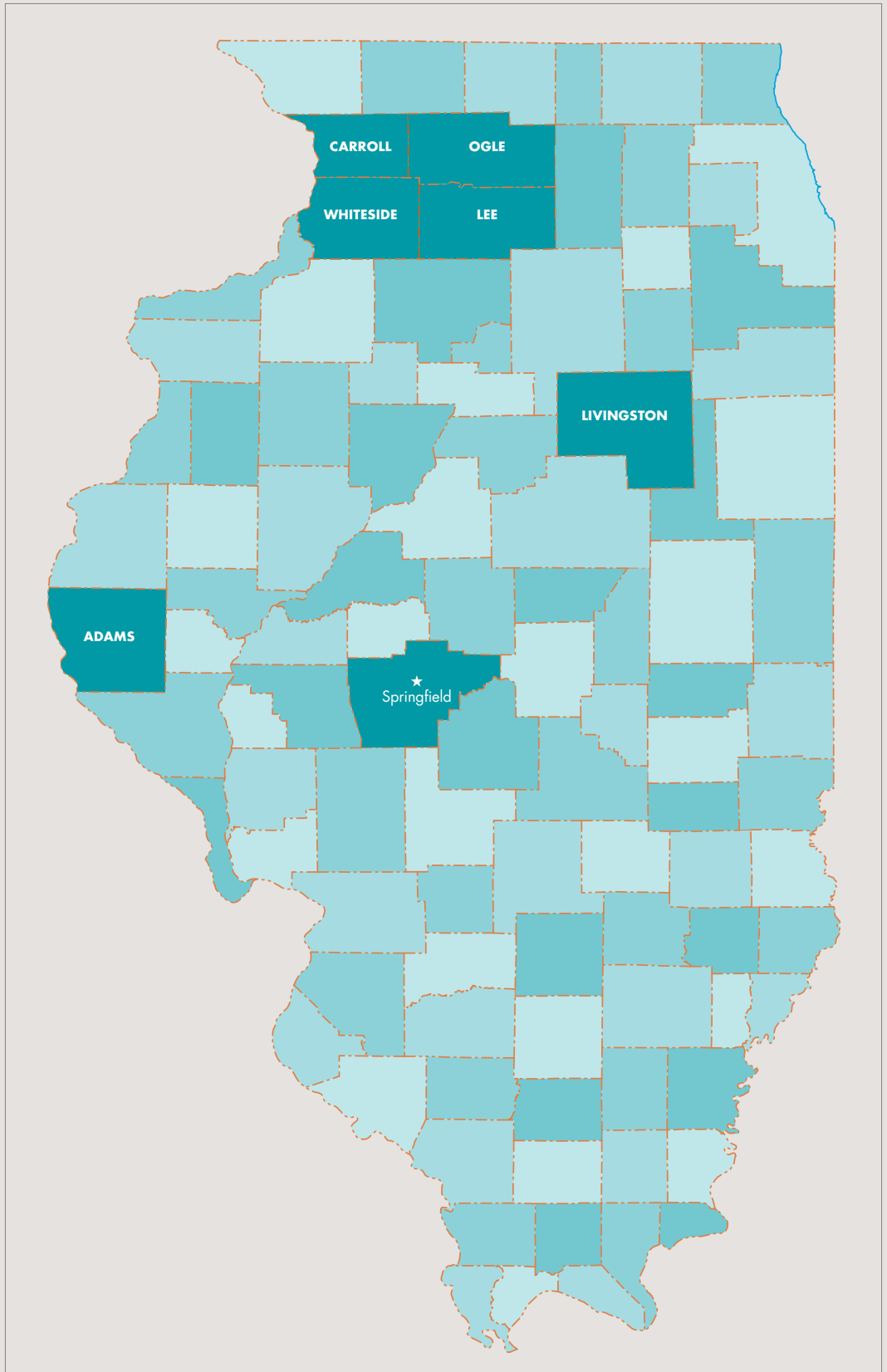t children would receive integrated, comprehensive mental health care. Each community received an initial grant of $2 million over five years to implement, monitor, and evaluate its system of care. As the second year of the implementation phase was drawing to a close in 2013, it became clear that while progress was being made in each community, more time was needed to fully implement the proposed systems of care. As a result, the ILCHF Board of Directors chose to invest an additional year and $300,000 in each CMHI site in 2014. The implementation phase runs through 2015 and will be followed by two years of monitoring and evaluation ending in 2017.

The four CMHI projects and the communities they serve are:

- *Adams County Children's Mental Health Partnership (ACCMHP),* serving Adams County
- *Community That Cares (CTC),* serving Carroll, Lee, Ogle, and Whiteside Counties
- *Livingston County Children's Network (LCCN),* serving Livingston County
- *The Children's MOSAIC Project (MOSAIC),* serving the City of Springfield

Now in the fourth and final year of the implementation phase, the CMHI communities continue to refine their systems of care to ensure that they are effective, integrated, and supporting children's mental health. Detailed information about each project can be found in Appendix A.

Children's Mental Health Initiative Communities Served

Map of Illinois counties. Highlighted counties labeled: CARROLL, OGLE, WHITESIDE, LEE, LIVINGSTON, ADAMS. Springfield is marked with a star.
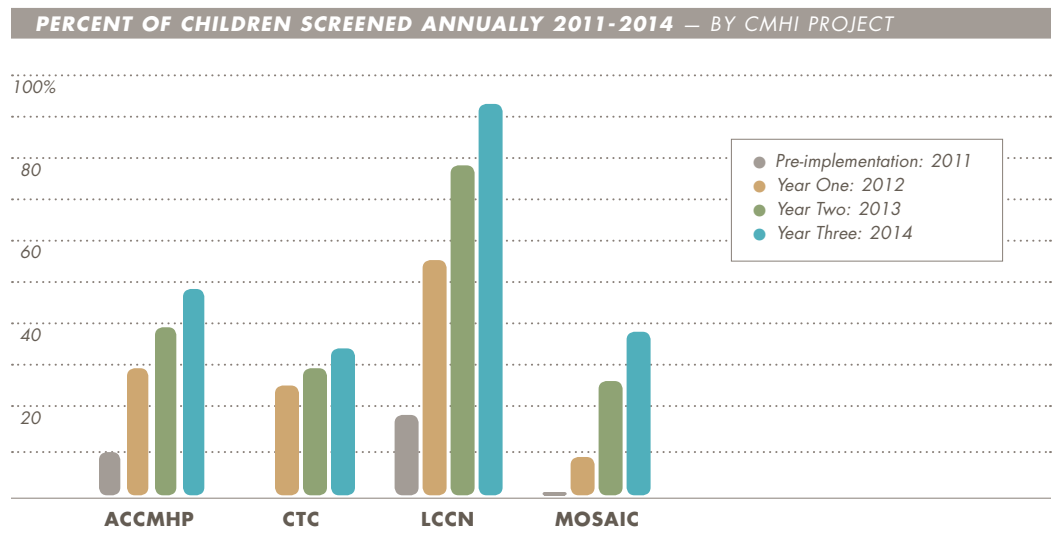
Accomplishments

Children's mental health care has improved in all CMHI communities. This section highlights the projects' accomplishments and the profound ways in which they have impacted how children's mental health is now addressed.

More children are screened and accessing mental health services. A primary goal of the CMHI is annual universal screening in order to identify children at risk of or living with mental illness. Since implementing the CMHI, all communities now use validated screening tools[8] and have dramatically increased both the number and percentage of children receiving mental health screenings every year.

NUMBER OF CHILDREN SCREENED — BY YEAR[1]				
CMHI Project	Total children in community	Baseline 2011	Year One 2012	Year Two 2013	Year Three 2014
ACCMHP	15,139	1,537 10%	4,450 29%	5,956 39%	7,282 48%
CTC[2]	35,467	0 0%	8,824 25%	10,277 29%	11,920 34%
LCCN	9,500	1,713 18%	5,256 55%	7,385 78%	8,852 93%
MOSAIC[2]	26,000	317 1%	2,366 9%	6,700 26%	10,004 38%

1 Data is not cumulative across the years.

2 Given the large number of children in their communities, CTC and MOSAIC initially targeted specific clinical and school sites and have increased the number of targeted sites and children each year.

PERCENT OF CHILDREN SCREENED ANNUALLY 2011-2014 — BY CMHI PROJECT

This feat was accomplished through the standardization of mental health screenings in a variety of settings, including primary care offices, schools, day care centers, and juvenile court and probation systems. This alone is a significant accomplishment because simply preparing a setting to implement screening is an enormous endeavor; settings must evaluate their current practices, identify staff members to champion the initiative, incorporate screenings into existing workflows, train staff, and pilot the screening initiative before expanding it throughout the program or agency.[9] Additionally, settings must identify mental health resources internally or in the community, track referrals to mental health service providers, and continually monitor children with positive screens.[10] Such transformation requires a shift in organizational practice that results in improved care for children and families.

An additional benefit of mental health screening is that it shifts organizational and community culture by raising awareness and increasing knowledge. This helps medical professionals, school staff, and other service providers feel comfortable collaborating with their mental health colleagues and talking about mental health with children and families. Survey data from the MOSAIC Project indicate that physicians believe screening is beneficial. Of 39 physicians surveyed:

- *84% report that screening instruments provide useful information not otherwise available*
- *72% report that responding to/discussing the data gathered from screening is a good use of their time*
- *75% report that they are identifying more children at-risk for mental health issues than before the MOSAIC project*

The CMHI communities are, however, doing more than screening to improve children's behavioral health; they also are increasingly connecting children who need help with appropriate services in a timely manner. These services may include school-based group counseling for children requiring relatively low levels of intervention, short-term solution-oriented therapy with a behavioral health specialist located in a primary care office, or multi-agency family-oriented treatment for a child with significant behavioral health needs.

Although more time is needed to gauge the full impact of the CMHI, there are early indications that the projects are benefiting children in every community. The MOSAIC project's local evaluation team compared the experiences of children who received school-based mental health care through the project with those who received care in a traditional, non-MOSAIC outpatient setting. They found that children who received school-based MOSAIC services engaged in therapy for more sessions, had lower rates of no-show appointments, had fewer crisis events, and missed less instructional time.

CTC also has early indications that its interventions are successful. Morrison Community Unit School District #6 in Whiteside County implemented universal screening and a social-emotional curriculum for children in PreK-8th grade. The mental health screening scores have steadily improved, and it appears that the longer the students receive the curriculum, the better their scores. Additionally, the number of students identified as at-risk due to their screening scores has decreased by 35% over the three years since the implementation of the social-emotional curriculum. Similarly, the number of students with co-morbid disorders has decreased by 20% during that time period. These preliminary data from the CMHI communities suggest that children are accessing services and that the interventions are effective.

spotlight

Implementing a Tiered Mental Health Model

The Livingston County Children's Network (LCCN) connects children to appropriate services via a tiered approach.

TIER I. All children receive Positive Action, a classroom-based social-emotional curriculum.

TIER II. Children with additional needs may require low levels of intervention, such as group counseling in a school setting.

TIER III. Children and families receive individual therapy with parent consultation.

TIER IV. The highest need children receive coordinated, multi-agency family treatment.

The tiered system ensures that all children are receiving the appropriate level of service and that the social-emotional health of every child in the community — not just those with presenting problems — is addressed. Livingston County is now screening 93% of children county-wide. Approximately 80% of children and youth considered to be at-risk for mental illness receive individual or group services at school.

Children's mental health care has improved as a result of innovative strategies to better integrate mental health services in standard practices and settings. While each community is unique, there is commonality among the types of people and organizations building the systems of care. Common participants include community mental health providers, school personnel, primary care physicians and pediatricians, and community leaders. Some projects have also worked with their mental health board, faith-based organizations, juvenile justice system, and early childhood providers. The CMHI enables communities to work across these sectors to develop systems of care with the following outcomes:

a. Increased and improved care coordination has resulted in more children being served more effectively. Stakeholders from all four communities report that a primary success of the CMHI is improved information-sharing across organizations that had traditionally operated in silos. Some participants noted that children now access services more quickly because increased communication between sectors has led to a decrease in response times.

Sharing information across sectors alone is not sufficient to create effective services for children; it is also necessary for communities to bring mental health services to new settings where mental health traditionally has not been addressed, such as medical offices and schools. Access to children's mental health services generally occurs along a spectrum ranging from a referral to co-location to integration of services (see Definitions below). When children's mental health services are provided on-site, via either co-location or integration, there is oftentimes a shift in organizational culture. On-site mental health providers foster organizational competence around children's mental health and increase the likelihood that a child's issues are addressed in a timely manner.

b. Structures to improve communication among local providers has increased community-wide ownership of the systems of care. All four CMHI teams invested significant time and effort into building and maintaining relationships with key community stakeholders in order to secure their long-term engagement. These stakeholders were included in the planning and implementation of each system of care, and their feedback was continuously solicited and incorporated to create community alignment in addressing children's mental health.

Strong leadership structures in the CMHI projects also promote a shared sense of ownership by ensuring that all sectors are actively communicating, establishing and maintaining trust, and collaborating over the years. Steering and/or advisory committees—which consist of representatives from key stakeholder groups and sectors in the community—provide oversight and guidance on the implementation of the systems of care. They meet and communicate regularly to problem-solve issues that arise, as well as to maintain the momentum of each project. Annual surveys that assess each team's perceived commitment to the CMHI project indicate increasing support and commitment from community leaders over the years.

DEFINITIONS: *ACCESSING MENTAL HEALTH*

There are three primary access points to mental health services—a referral, a co-located provider, or an integrated provider.

- *Referral: when a physician, school teacher, or other professional sends a client, patient, or student to a behavioral health professional (typically off-site) who can address an identified need.*

- *Co-location: when a behavioral health professional is located on-site at a primary care office or school. This model allows for easy, on-site mental health referrals and combats the stigma associated with seeking mental health care by providing services at a neutral location.*

- *Integration: takes co-location one step further by fully integrating an on-site behavioral health professional into the healthcare or educational team. Shared planning, communication, space, and records are indicators of integration.*

Anecdotal feedback suggests that the CMHI projects have significantly shifted community cultures, making all community institutions and stakeholders more receptive to effectively addressing the mental health needs of children. There are often tangible outcomes when community agencies take action together to better address children's mental health, as exemplified by the opening of Florissa, a full-service pediatric assessment and treatment center in the Carroll, Lee, Ogle, and Whiteside county service area.

"Out of those relationships [formed through the CMHI] emerged the pediatric resource center [Florissa]. It's an amazing process to see that collaboration." — CTC PARTICIPANT

c. Investments in professional training have better prepared the CMHI communities to address children's mental health. All CMHI communities have invested in the professional development of child-serving providers to help them better recognize and address children's mental health needs. With input from local steering committee members and professionals, each project identifies and provides targeted professional development and training opportunities throughout the year.

Resources provided by the CMHI allow communities to offer trainings directly in their communities. Through these trainings, communities increase their capacity to serve children as well as improve the quality of care they provided.

"Providers were able to attend trainings that were offered to them for free; we would not otherwise have been able to train them due to a lack of financial resources." — ACCMHP PARTICIPANT

In addition, some of the CMHI projects have strengthened medical providers' relationships and access to consultation with psychiatrists and psychologists. With these mental health experts readily available to provide assistance, community-based providers gain the professional supports and knowledge they need to respond to a variety of children's mental health problems that they otherwise may feel unprepared to address.

The CMHI projects have increased their likelihood for long-term, sustainable change by using multiple strategies to help embed their systems of care, including:

a. Expanding the number of participants engaged in each system of care. Effective systems of care include a broad array of community-based services and supports for children and youth with or at risk of mental illness working in a meaningful partnership to improve outcomes. In order to attain that broad array, the CMHI communities have continuously increased the number of community partners and sectors working in their systems of care. By sharing stories and information about how children and families, as well as service providers, are benefiting from the enhanced system of care, project staff is able to engage even more partners and stakeholders who help further expand and embed systemic changes in the community.

spotlight

Data from Springfield's MOSAIC project *show that the presence of embedded mental health professionals at two primary care sites—Southern Illinois University and Memorial Physician Services-Koke Mill—helps ensure that both children and physicians take advantage of on-site mental health services.*

A survey of 39 physicians indicated that the presence of mental health professionals improves their practice as follows:

- **97% of physicians report** that having an embedded behavioral health clinician increases the likelihood that patients will participate in mental health treatment.

- **82% of physicians report** good communication with the behavioral health clinician, which keeps them up-to-date on their patient's progress.

Referral data from Springfield further corroborate the value added by having on-site behavioral health clinicians. In the last three quarters of 2014, 453 children from the two sites were connected to on-site mental health services. Of those, 134 children (29%) were connected because of a positive mental health screen, while the vast majority (319 children, 71%) were referred based on physician judgment. These data indicate that not only does screening help identify children in need of services, but also that the presence of on-site mental health professionals encourages physicians to make referrals more frequently.

b. Focusing on evaluation. The CMHI evaluation occurs on two levels. The cross-site evaluation gathers information from each community regarding its number of screenings, the impact of the system on a cohort of children, system integration, and workforce development. Simultaneously, each project has a local evaluation that provides the communities with data they use to improve and support their particular system of care. These data tell the story of the impact of the CMHI on children, families, child-serving providers, and communities. Participants report using local evaluation data to motivate others to become part of the initiative.

"We continue to attend meetings because we feel success over problems we've all struggled with for years…based on the [local] data and anecdotes shared with us." — ACCMHP PARTICIPANT

c. Engaging in long-term sustainability planning from the outset. Sustainability planning is a requisite element of the initiative and was a critical component of the planning grant. The CMHI communities are working to sustain their projects by establishing community buy-in and increasing provider capacity, as well as by embedding policies and practices that support the system of care. Each year, a team of stakeholders from each CMHI project responds to a survey assessing its perceptions regarding the extent, scope, and depth of systems integration that has been achieved. The survey looks specifically at integration across the domains of human resources, funding, impact, and communication. Mean scores from this survey have significantly increased over time across every domain, indicating that providers across systems are integrating their work more fully in order to better serve children.

The communities report that nearly all sites which currently conduct screenings have embedded them into their practices and are likely to continue screening after the conclusion of ILCHF funding. Furthermore, personnel who are critical to ensuring that children receive mental health services, such as care coordinators and mental health clinicians in primary care settings are partially, if not already fully, funded through Medicaid and health insurance billing, contracts, and/or other local revenue streams. Across the board, the communities report that their partners are increasingly committed to sustaining the critical components of their projects.

"Our sustainability is on track to sustain virtually everything we've developed and there's no way that these structures would have been built if all of those people hadn't been at the table trying to figure out the long-term outcomes." — LCCN PARTICIPANT

spotlight

*In its community needs assessment, the **Adams County Children's Mental Health Partnership (ACCMHP)** identified gaps in mental health services for children under five years old and a dearth of service providers with specific clinical specialities. In addition, physicians were hesitant to conduct mental health screenings without the assurance that there would be a qualified workforce to meet identified needs.*

In response, ACCMHP launched a multi-pronged workforce development strategy focused primarily on training and professional development.

Training opportunities during the first three implementation years included:

- Seven Continuing Medical Education trainings on topics chosen by physicians and other medical providers.

- Five 2-day workshops to train mental health providers in evidence-based practices.

- A series of Mental Health First Aid (MHFA) trainings for a variety of stakeholders to increase community awareness and decrease stigma associated with mental health. By the end of 2014, 86 community-based providers and community members had been trained in MHFA, and were thus better prepared to aid young people dealing with a mental illness or crisis.

Local data indicate that these training opportunities were well-received by participants. More importantly, the trainings changed practice. In a 2015 survey asking about the usefulness of trainings, two-thirds of the respondents reported using strategies they had learned in the trainings occasionally, often, or in all applicable cases. This is a remarkable feat, especially in light of the fact that surveyed practitioners were asked about trainings dating back to 2011.

ILCHF Children's Mental Health Initiative

Challenges and Lessons Learned

Remaining resilient in the face of significant challenges and barriers is an integral part of systems change work. Some challenges faced by the CMHI communities were anticipated from the outset while others presented unanticipated opportunities for learning and growth. This section covers some of the most common challenges and highlights both the communities' approaches to these challenges and the resulting valuable lessons learned during the first three years of implementation.

Communities are confronting variability in provider buy-in and screening practices by providing multi-level organizational support. Partnering with and investing in communities provides an incentive for stakeholders to collectively tackle pervasive problems in children's mental health care delivery. However, financial investment alone does not guarantee that the various stakeholders and systems will comply or change their practices and policies. While the lead agencies, as grantees, have agreed to tangible deliverables and reporting requirements, the participation of other community stakeholders is voluntary. As a result, the level of buy-in, participation, and compliance varies widely across and within each community.

All CMHI communities found that establishing a uniform screening protocol and garnering universal provider buy-in are immense challenges, despite the apparent benefits. Even if a school district or medical practice is committed to the system of care, individual teachers and/or physicians may be hesitant to change their standing practices. In addition, some school districts and medical practices are reluctant to join the new system of care out of fear that they will not have adequate resources or knowledge to address children's mental health needs that may be identified in the screening process.

The communities have been able to confront this challenge through strategies related to stakeholder engagement and buy-in. From the beginning, the four project teams have put significant effort into building supportive relationships with various agency leaders. These leaders have approved changes in organizational policies and procedures, and also allowed the CMHI teams to access their professional staff. Nonetheless, it was nearly impossible to make systemic changes with regard to both screening and the care that children receive without multi-level support across the organization. As important as it is to have the commitment of executive management to support changes to work policies and procedures, it is just as critical to garner buy-in among front line practitioners and administrative staff who actually implement these services on a daily basis. Understanding the needs and realities of these key stakeholders is crucial.

"It is important to meet people where they are. Start where they are willing to start. Incorporate their voice into implementation, and go from there." — **LCCN PARTICIPANT**

Several CMHI communities employed a peer support strategy to engage and support front-line practitioners and administrative staff. Strong champions of children's behavioral health were selected to serve as coaches and champions among their peers. They often received a stipend to support and provide resources to their colleagues, as well as to proactively encourage others to get involved. These coaches ensure that front line practitioners have access to the knowledge and support they need to enhance the services they provide to children.

The recruitment and retention of skilled mental health professionals remains a challenge. All CMHI communities have reported that workforce development is a significant challenge, particularly in regard to the recruitment and retention of mental health professionals. These professionals are

spotlight

Using Peer Supports

The Community That Cares (CTC) project *has effectively utilized the peer support model to strengthen its system of care. Peer coaches help key stakeholders increase their knowledge and become more actively involved in children's mental health care.*

- **Engaging families:** CTC employs a Family Care Coordinator (FCC) to facilitate system development and help families in its four counties access necessary social services using a family-driven, strengths-based approach. The FCCs, who are community members with personal experience accessing relevant services, interact with children and families on a regular basis, creating and strengthening relationships to better understand their needs. Through the efforts of the FCCs and the CTC Parent Coordinator, several parent support groups have been developed and sustained by parents themselves.

- **Engaging schools:** A licensed professional counselor from one of the elementary schools serves as a School Coach and liaison between CTC and the schools. In this role, he supports schools that are implementing screening and social-emotional curricula and establishes relationships with schools not yet involved in the system of care. He also addresses the questions and concerns of school staff as they learn to administer screenings and effectively respond to students' needs.

- **Engaging physicians:** A local physician who has been supportive of CTC's efforts since its inception serves as a Community Development Coach to help primary care physicians broaden their responses to children's mental health. She builds relationships and supports other physicians in all four counties to engage them in CTC's screening and early intervention efforts.

needed to grow the capacity of the systems of care and address the needs of children and families. Unfortunately, the CMHI alone cannot solve this systemic problem.

To minimize the impact of this problem on social service systems, the CMHI communities employ a variety of strategies including:

- Creating a supportive professional and community culture
- Providing appealing work environments
- Improving the pipeline of skilled professionals by working with various universities
- Utilizing search firms to fill open positions
- Utilizing the J-1 Visa Program
- Exploring the use of telehealth
- Providing primary care providers with expert consultation and support around psychiatric medication management

Although these strategies do not resolve the personnel challenges faced by the CMHI projects, they provide a starting point for communities to address recruitment and retention. Rural areas will continue to face workforce shortages to meet the demand for mental health services. They will need additional supports in developing and implementing innovative strategies to better address this persistent problem.

System replication is not always possible. One of the Foundation's aspirations was that one or more replicable system of care models would result from the CMHI. But as the Foundation learned more about the individual communities, it quickly concluded that systems replication is not always possible and, perhaps, not desirable. While some elements of the CMHI may be replicable, it is the Foundation's hope that what has collectively been learned from the initiative can help other communities create system changes in children's mental health that is tailored to their unique needs and capacities.

Long-term financial sustainability remains a challenge for multiple elements of the new systems of care. Sustainability is a key component of the CMHI; when ILCHF invested in each community, it sought evidence that the initiative would continue to change the lives of children and families long after its grant funding ended.

Significant components of each project are likely to be sustained because they are either embedded in daily practices (e.g. mental health screenings in certain schools and medical practices) or have revenue streams associated with them. During the first three years of implementation, funds and resources garnered from other sources have increased steadily. For example, by the end of the third year of the implementation phase, LCCN and CTC's budgets indicated that 49% and 40% of their projects, respectively, would be funded by sources other than ILCHF. Medicaid billing and local support from mental health boards, schools, and medical practices constitute the primary sources for this funding. Despite community-wide commitment to sustain these projects, key aspects of the initiative currently lack a sustainable funding source. One component at risk is the position of the project director, whose responsibilities include maintaining project momentum, communicating with stakeholders, and tracking results. These activities are not billable and thus lack an obvious sustainable funding source.

As the CMHI projects work to strengthen their financial stability, common sociopolitical challenges threaten sustainability. These include:

- *The Illinois state budget crisis, which threatens to decrease reimbursement rates that are already too low*
- *Billable service arrays, which do not include all of the CMHI's services*
- *Uncertain school budgets, which could result in the loss of mental health screenings and services in schools*

To increase financial support of their projects, the CMHI teams will continue to use data to make the case for the positive and cost-effective impact of the CMHI on their children and communities to local foundations, school districts, hospitals, mental health boards, and municipalities.

Though evaluation is critical to understanding the impact of systems-change on children's mental health, it is difficult to evaluate the full range of the CMHI's work and immediately apply findings in practice. An initiative as ambitious, far-reaching, and complex as the CMHI requires extensive collaboration and open communication among stakeholders from the planning phase and throughout its implementation. Similarly, the evaluation component requires the same degree of deliberate planning and collaboration. In order to fully appreciate the impact of the CMHI, the project evaluation was designed to occur at two complementary levels—local and cross-site. Each project undertook a customized local evaluation approach to address its specific clinical and local implementation strategies and challenges. These local evaluations are spearheaded by third party evaluators in or near the communities, and are designed to fit each project's unique goals and expected outcomes. In addition, a cross-site evaluation, conducted by NTI Upstream, collects and integrates data from all four communities in order to assess systems issues on a broader scale. These evaluations collectively serve as the basis of our understanding of the CMHI's process, progress, and outcomes.

Despite carefully designing the local and cross-site evaluations, they were each designed to meet specific needs and are thus not fully integrated. Because each project designed a community-specific model and corresponding evaluation to fit its local context, the attempt to evaluate the four different projects using the same measures proved to be more challenging than anticipated.

As a result of this initial foray into complex cross-site project evaluation, the Foundation has gained a greater understanding of the requisite level of discussion, input, and collaboration necessary among evaluators and stakeholders. Only by careful planning and collaboration can one effectively design an evaluation plan that is effective and efficient, while also avoiding being unduly burdensome.

The challenges that the CMHI faced in aligning a two-tiered evaluation across four projects illustrates the importance of fully documenting workflows and seamlessly embedding data collection into daily operations. It also made clear that throughout the course of an evaluation, ongoing communication helps ensure that data are both relevant and applicable. Operationally, evaluation findings should be used regularly to assess progress toward implementation and inform programmatic decisions. This will then provide project staff with the real-time information they need to enhance service delivery and reach more children. Over time, this information can also help the communities sustain their systems of care as mounting evidence of their impact is collected and shared with interested parties and supporters.

Next Steps

As the CMHI communities continue to refine their systems of care while preparing for the end of ILCHF funding, the Foundation continues to support this transition by building upon what has been learned to date.

Cognizant of the complex milieu in which these systems operate, in part due to the state's budget crisis and ongoing transitions related to the advent of managed Medicaid, ILCHF has offered a supplemental funding opportunity to each CMHI project. The additional funding of up to $175,000 per community in 2016 would support key components of each project which are not yet sustainable.

In addition, several CMHI stakeholders have successfully applied for funding through a separate ILCHF initiative, the Innovation & Collaboration Tour, which provides one-year grants of up to $100,000 for innovative and/or collaborative programs. Stakeholders from LCCN and CTC used the knowledge gained from the CMHI to apply for and receive ILCHF funding for three new projects involving workforce development, an expansion of school counseling services, and the expansion of direct services at an assessment and treatment center for children with significant mental and physical health needs.

Finally, ILCHF recently funded a grant to the Sargent Shriver National Center on Poverty Law to work with the CMHI communities (and other children's mental health providers) to develop and implement advocacy plans that address their barriers to financial sustainability, such as billing limitations due to provider qualifications or the nature, location, and timing of services. A purpose of this grant is to build capacity to advocate for relevant policy changes that directly affect the CMHI programs and the services they provide.

Conclusion

As a result of the CMHI, more than 35,000 children have been impacted by the work of hundreds of professionals committed to improving the health and well-being of children and their families. There are early indications that more children's mental health issues are being identified and treated. There is clear evidence of a cultural and organizational shift in the CMHI communities towards a coordinated, collaborative approach to children's mental health. The CMHI has provided the resources, technical assistance, and support for the communities to take time to collaborate and focus on solving complex issues.

Those leading and implementing the CMHI have had a significant impact on their communities. Their accomplishments and perseverance are commendable, especially in the face of the challenges and barriers encountered in comprehensive systems-change.

Writing this report provided an opportunity for the CMHI communities and the Foundation to analyze and reflect upon early learnings. As the communities and the Foundation learn from each other, we hope that others who undertake similar work can benefit from the knowledge gained through the CMHI.

The CMHI has also deepened and reinforced the Foundation's understanding of its role as a funder and the following concepts:

- ***Planning grants are an effective tool in complex initiatives.*** ILCHF provided planning grants to each community because the Foundation understood the importance of providing organizations the opportunity and the time to plan together. Participants have reported that this initial time and investment were vital to the subsequent changes in the communities.

- ***Relationship building takes time.*** ILCHF's initial timeline for this grant included a three year implementation phase followed by a two year monitoring phase. However, we learned that three years was not sufficient to build robust sustainable systems, resulting in an additional investment of approximately $300,000 in each community and a fourth implementation year.

- ***It takes time to see evidence of impact.*** ILCHF originally believed evidence of impact would emerge during the three-year implementation grant. However, the Foundation learned that it takes more time than anticipated to see concrete evidence of impact.

- ***Perseverance and long-term commitment are required.*** Once built, relationships and partnerships must be nurtured through regular and clear communication, active collaboration, and follow-up among and between providers and the communities that they serve.

- ***Flexibility and responsiveness to community needs are critical.*** As an engaged learning partner, ILCHF seeks to be flexible and responsive to the CMHI communities. We have learned that it is sometimes necessary to adjust both our expectations and requirements in order to decrease the burden on grantees but still obtain important project information.

- ***Detailed documentation can ease staff transitions.*** Due to the complexity and length of these projects, staff changes at the Foundation and project level have had a significant impact on project management and operations, including delays associated with new staff becoming familiar with the project. The importance of documentation to support continuity and consistency has proved paramount during staff transitions.

- ***Project design, technical assistance, and evaluation are separate functions requiring well-defined roles and transparent communication.*** When engaging consultants to provide expertise with these complex efforts, it is important to establish and communicate a clear separation of roles between consultants helping design the systems of care, providing technical assistance, and evaluating the impact of the projects.

- ***Communities benefit from a full spectrum of support.*** A financial investment is just one of many tools available to facilitate the work of grantees. ILCHF sought to support the ideas and passions of grantees and then provide resources for technical assistance and continuing education. The Foundation continues to explore ways that it can actively share the work of the CMHI grantees with the public and help build their capacity for long-term sustainability.

Despite our collective efforts, there are still thousands of children and families in Illinois suffering from the effects of untreated mental illness. We know there is still much work to do in the CMHI communities, as well as in communities across the state of Illinois. Attempting to identify the gaps in services and then comprehensively systematize the full spectrum of services necessary to meet the needs of children and their families is incredibly complex and, at times, daunting work. However, for an investment of approximately $2.6 million over seven years, each of the four communities has been able to position its local systems to more effectively respond to the mental health needs of its children. Imagine what is possible if similar investments were made across Illinois.

In the years since the CMHI was launched, there is an increasing national trend to integrate care. While ILCHF is excited about and supports this momentum, our efforts thus far highlight the actual challenges of creating, scaling, and replicating system of care models. By sharing what we've learned, we hope to inspire and encourage others to develop effective, comprehensive care models that meet the behavioral health needs of children. The Foundation invites you to contact ILCHF to learn more about this initiative and to leverage what we and others have learned to date so that more children have the opportunity to grow up healthy.

Appendices

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Adams County Children's Mental Health Partnership (ACCMHP)

PROJECT OVERVIEW

ACCMHP consists of various members and providers from health care, social services, education, mental health, and the general community who have collectively created a county-wide children's mental health system of care. Its vision is that all Adams County children will possess the social and emotional health to lead productive, meaningful lives. Goals include:

- Build a qualified workforce
- Develop a universal screening, triage, and referral process
- Integrate behavioral health services into primary care
- Improve cross-systems processes for high-need children
- Maximize access to natural supports by decreasing stigma and increasing understanding

CHILDREN SERVED

Approximately 48% of the children in Adams County were screened by the end of 2014. Screening occurs in Quincy Public Schools and all three primary care sites.

Schools. Four of the five county public schools engage in screening at one or more grade levels through registration, health classes, and/or back-to-school fairs. All schools benefit from additional services, such as on-site community-based therapists, and improved skills among teaching staff.

Primary care. All three primary care clinics adopted screening practices using the ASQ 3 and ASQ SE.

CHILDREN SCREENED
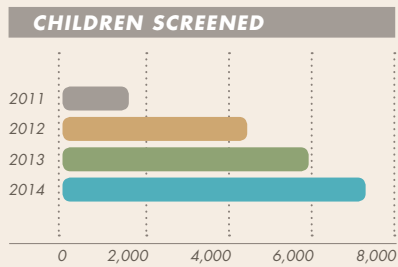
MAJOR ACCOMPLISHMENTS

School-based services. Mental health screening is fully integrated in Quincy Public Schools' multi-tiered system of support. Following screening, school Mental Health Professionals review student needs and present their recommendations to the school's Tier II intervention team. Together, they determine next steps to match a student's identified level of need with the appropriate level of intervention.

Service co-location. Behavioral health therapists are co-located at each primary care site and in the schools. Each clinic has a unique screening and care coordination model.

Comprehensive assessments. A Child Assessment Center at Quincy Medical Group provides comprehensive, team-based assessments.

Workforce development. Targeted trainings have better prepared professionals and community members to meet children's needs.

LESSONS LEARNED

Community awareness. To reduce stigma—a barrier to early intervention—ACCMHP provided Mental Health First Aid training to more than 86 faith providers, school staff, nurses, and community members. ACCMHP also leverages local media to increase community understanding and acceptance.

Parent engagement. Although providers are improving how they partner with parents by increasingly viewing them as an essential part of their child's treatment, improved parent engagement remains a need in the county. ACCMHP identified best practices and strategies for parent engagement, and identified parents to serve on community groups benefitting children.

Services for highest-need children. ACCMHP offers wraparound training for schools and community-based organizations to help them develop a child-centered, family-focused plan of support for youth and families with the most complex and/or severe needs.

[1] United States Census, *State & County Quickfacts,* "Adams County, Illinois." Accessed August 5, 2015. http://quickfacts.census.gov/qfd/states/17/17001.html

Community That Cares (CTC)

PROJECT OVERVIEW

CTC is dedicated to creating an effective and efficient system of care for children and their families to reach their optimal level of development, health, and wellness. CTC values community education, suicide prevention awareness, social/emotional education and wellness, and stigma reduction. Goals include:

- Enhanced screening efforts
- Enhanced outreach and care coordination
- Comprehensive assessment and effective treatment
- Increased promotion of positive mental health and prevention initiatives and programming
- Accountable governance structure with increased community ownership

CHILDREN SERVED

CTC has screened approximately 34% of the children in its service area, primarily through the schools. CTC also offers family support programs.

CHILDREN SCREENED

Year	
2012	
2013	
2014	

0   3,000   6,000   9,000   12,000
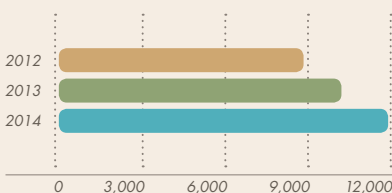
Schools. 42 of the 87 schools in the four counties offer social/emotional screenings. A school work group helps schools screen and complete social/emotional report cards to determine the impact of their efforts.

Primary care. Family Care Coordinators (FCC) connect families to primary care, with many PCPs participating.

Probation departments. Each county's probation department supports CTC within its community. Lee and Ogle county probation participate in the CTC steering committee.

MAJOR ACCOMPLISHMENTS

Family Care coordination. FCCs interact with children and families on a regular basis, creating and strengthening relationships to better understand their needs. More than 500 families have been helped by FCCs.

Parent support. Over 500 families have participated in more than 61 Parent Cafés, which are self-sustained parent support groups. CTC also promotes family-focused events.

Pediatric developmental center. CTC partners collectively secured a $1.5 million federal grant to open a local center where children can receive comprehensive screenings, psychiatric assessments, autism services, infant mental health services, and other needed services.

Infant mental health services. CTC added Early Childhood clinicians who provide direct services for children ages 0-5. More than 165 families have used these services, including home-based, attachment-focused interventions.

LESSONS LEARNED

School engagement. A peer coach helps address schools' concerns regarding the extra time, costs, and workload required to implement screenings. He also provides staff training and support.

Primary care engagement. It has been challenging to fully engage all 62 primary care providers in the CTC service area. A local physician serves as a peer coach to help more physicians conduct and submit screening data.

Organizational and staffing structure. CTC's large geographic reach, increasing volumes of data, and variability in screening tools across providers have made it difficult to track and monitor its efforts throughout the four county region. CTC's staffing and organizational structure were modified to help manage these challenges of size, volume, and diversity.

1 United States Census, *State & County Quickfacts*, "Carroll County, Illinois." Accessed August 5, 2015. http://quickfacts.census.gov/qfd/states/17/17015.html

2 Ibid., "Lee County, Illinois." 17/17103.html

3 Ibid., "Ogle County, Illinois." 17/17141.html

4 Ibid., "Whiteside County, Illinois." 17/17195.html

Livingston County Children's Network (LCCN)

PROJECT OVERVIEW

The Livingston County Children's Network (LCCN) is comprised of entities committed to working together for the good of the county's children. The LCCN's four-tier public health model promotes the health of all citizens, identifies early those at-risk, and provides appropriate intervention to prevent the development of illness. Goals include:

- Increase system of care capacity
- Increase service accessibility
- Increase service coordination
- Decrease risk behavior rates, and frequency and severity of mental disorders

CHILDREN SERVED

Approximately 93% of the children in Livingston County were screened by the end of 2014. Screening occurs in the medical, educational, and juvenile justice sectors.

CHILDREN SCREENED

Year	
2011	
2012	
2013	
2014	

0   2,500   5,000   7,500   10,000
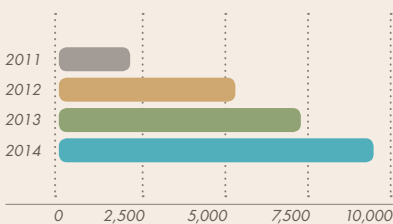
Schools. Screenings and social-emotional curriculum are universally implemented in all 27 elementary attendance centers. Ninth graders in all six high schools receive mental health screen-

ings, with two of these schools also screening higher grade levels. Eighty percent of all children with positive screens receive group or individual treatment in schools.

Primary care. Nearly all children have a medical home. Twelve of the 18 medical practices across the county administer mental health screenings. Eleven OSF Healthcare sites screened 96% of 0-5 year olds and 84% of 6-18 year olds.

Juvenile justice. LCCN provides screening, referral, and case management for high-need, court-involved, and at-risk youth and families. A Family Support Specialist (FSS) ensures mental health screening of children who enter the system, and connects them and their families to needed services.

MAJOR ACCOMPLISHMENTS

Service coordination. All entities in the county recognize a universal release of information form, and have communication protocols across sectors. Providers' knowledge of each other and of the services available across sectors has increased.

Treatment accessibility. The community mental health center has placed therapists in natural settings to overcome treatment barriers. Services are available in rural primary care practices, churches, libraries, and homes.

Supports for justice-involved youth. LCCN has shifted the county's discipline system from a punitive to a restorative justice model. Youth are responding positively to the emphasis on relationships and rehabilitation.

Comprehensive assessments. A team of cross-sector service providers conducts comprehensive, inter-disciplinary assessments for children with the highest needs and recommends appropriate services.

LESSONS LEARNED

Curriculum implementation. It has been challenging to get all schools and teachers to implement an evidence-based social emotional curriculum. A project manager with school-based experience works with the schools and individual champions to expand implementation and increase fidelity.

Parenting support. Implementing a universal, evidence-based parenting program proved too costly to sustain. LCCN instead connects community members to existing parenting resources and provides training to professionals in contact with parents.

Provider support. Sociopolitical changes and related stressors, such as budget cuts and new mandates, have increased the work scope and subsequent burden on direct service providers across all sectors. LCCN's Leadership Team strives to support employees and collectively plan for sustainability.

[1] United States Census, *State & County Quickfacts,* "Livingston County, Illinois." Accessed August 5, 2015. http://quickfacts.census.gov/qfd/states/17/17105.html

[2] A. Meyers, *LCCN Local Evaluation Report.* May 31, 2015.

# Children's MOSAIC Project

PROJECT OVERVIEW

The Children's MOSAIC Project is a collaborative initiative whose mission is to combine resources to cultivate the social and emotional health of children and families in Springfield. MOSAIC targets three specific settings—high-risk neighborhoods, schools, and primary care—as it develops a coordinated, integrated system where children have access to high-quality mental health care, with a focus on prevention. Goals include:

- Implement the Screening, Assessment, Referral, and Treatment (SART) model within public school boundaries
- Build the community's capacity to offer services/supports needed for children to develop to their full potential
- Enhance and expand interagency communication and collaboration

CHILDREN SERVED

Approximately 38% of the children in MOSAIC's service area were screened by the end of 2014. More than 1,600 children received interventions at home, school, or a physician's office.

CHILDREN SCREENED

Year	
2011	
2012	
2013	
2014	

0   3,000   6,000   9,000   12,000
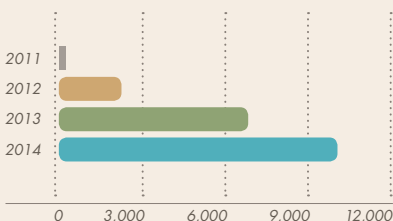
Neighborhood. In partnership with The Springfield Project (TSP), MOSAIC provides mental health and professional development services in the city's Neighborhood of Hope.

Primary care. Three of the city's four large physician groups are part of MOSAIC—SIU School of Medicine's Center for Family Medicine, Memorial Physician Services-Koke Mill, and SIU Department of Pediatrics.

Schools. Five of the 31 District 186 schools participate, as do after school and summer programs of the Boys and Girls Clubs of Central Illinois.

MAJOR ACCOMPLISHMENTS

School-based interventions. Preliminary local evaluation results indicate that the MOSAIC model is effectively engaging vulnerable groups in schools. At one target school, children and families receiving MOSAIC services on-site were more likely to sustain their participation and experienced fewer crises than their peers in traditional outpatient services. Children also missed less instructional time.

Physician buy-in. Physicians engaged in MOSAIC report positive benefits, including an increase in the number of children identified at-risk for mental illness. Of 39 physicians surveyed, nearly all report that an embedded mental health clinician increases the likelihood that patients will participate in treatment. Nearly all physicians also report they would recommend the MOSAIC model to other primary care practices.

Provider training. More than 600 professionals working with children and families have participated in professional development and are better prepared to provide high quality mental health care.

LESSONS LEARNED

Neighborhood outreach. MOSAIC's initial plan to engage families in their homes through neighborhood outreach workers proved unsuccessful. Other strategies for reaching and supporting neighborhood children, such as embedding social/emotional curriculum in after school programs, were more effective and acceptable.

Stakeholder involvement. Staff transitions in key organizations and the changing social and political landscape of Springfield often disrupted stakeholder relationships. MOSAIC counters this by maintaining regular communication with stakeholders and continuously focusing on increasing community awareness and involvement.

[1] United States Census, *State & County Quickfacts,* "Springfield (city), Illinois." Accessed August 5, 2015. http://quickfacts.census.gov/qfd/states/17/1772000.html

[2] D. Racine, *MOSAIC Local Evaluation Report.* 31 May 31, 2015.

ACKNOWLEDGMENTS

The Foundation is grateful to and celebrates the grantees and stakeholders of the CMHI for the work they do on a daily basis to improve children's mental health in Illinois, as well as for the candor of those who shared their experiences and valuable insights which form the basis of this report. We would also like to thank Dr. Ira Chasnoff and Dr. Richard McGourty of NTI Upstream, who have provided evaluation and consultation support since the inception of the initiative. This report was prepared by members of the ILCHF team, including Heather Higgins Alderman, Arianna Cisneros, and Brielle Treece Osting.

METHODS

To develop this report, we reviewed all documents and reports submitted to ILCHF during the first three years of project implementation, including grantee progress and financial reports, evaluation reports, and annual journal entries completed by the project directors. Combined with anecdotal information that was shared during site visits to each of the communities, the information from the document review helped identify and categorize some of the major successes and challenges reported by the communities.

These successes and challenges were discussed more in-depth with CMHI staff, community stakeholders, and local evaluators who convened in July 2014. We then developed questionnaires to further explore and expand on this information and collected additional qualitative data through:

- Two focus groups with CMHI project directors and key staff
- Eight phone interviews with community stakeholders who have been involved with the implementation of their respective systems of care

In addition, this report contains quantitative data gathered through the cross-site and local evaluations, which provide more information on the progress and impact of the CMHI projects.

NOTES

1 Ronald C. Kessler, PhD; Patricia Berglund, MBA; Olga Demler, MA, MS; Robert Jin, MA; Kathleen R. Merikangas, PhD; Ellen E. Walters, MS, "Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication," *Arch Gen Psychiatry.* (2005). 62(6):593-602. Accessed November 24, 2015. http://archpsyc.jamanetwork.com/article.aspx?articleid=208678&resultclick=1

2 Carol Weitzman; Lynn Wegner, "Promoting Optimal Development: Screening for Behavioral and Emotional Problems," American Academy of Pediatrics. *Pediatrics* (February 2015). 135(2).

3 "Any Disorder Among Children," *National Institute of Mental Health.* Accessed July 16, 2015. http://www.nimh.nih.gov/health/statistics/prevalence/any-disorder-among-children.shtml

4 Kathleen Ries Merikangas et al, "Lifetime Prevalence of Mental Disorders in US Adolescents: Results from the National Comorbidity Study–Adolescent Supplement (NCS-A)." *Journal of the American Academy of Child and Adolescent Psychiatry* 49.10 (2010): 980–989. Accessed July 16, 2015. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2946114/

5 Carol Weitzman; Lynn Wegner, op.cit., 135(2).

6 RAND Corporation, *Proven Benefits of Early Childhood Interventions.* (2005). Accessed http://www.rand.org/content/dam/rand/pubs/research_briefs/2005/RAND_RB9145.pdf

7 M. E. Warfield, *Assessing the known and estimated costs and benefits of providing mental health consultation services to preschool-age children in early education and care centers in Massachusetts: An economic evaluation of the Together For Kids (TFK) project.* Worcester, MA: Community Healthlink. (June 2006).

8 Screening tools include but are not limited to the Pediatric Symptoms Checklist, Ages and Stages Questionnaires, Behavioral and Emotional Screening System, Social Skills Improvement System Performance Screening, the Devereaux Student Strengths Assessment, and Developmental Indicators for the Assessment of Learning.

9 Carol Weitzman; Lynn Wegner, op. cit., 135(2).

10 Sheila A. Pires, *Building Systems of Care A Primer for Child Welfare.* National Technical Assistance Center for Children's Mental Health, Washington D.C. (2008). PDF.

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Healthcare Foundation