

Illinois Children's Healthcare Foundation

**FINAL REPORT
DECEMBER 2018**

Accomplishments and Lessons Learned:

*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 healthcare 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 \$75 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	<ul style="list-style-type: none"> ● ILCHF releases Planning Grant RFP
2010	May	<ul style="list-style-type: none"> ● 13-month CMHI Planning Grants awarded to five communities
2011	August	<ul style="list-style-type: none"> ● Five-year grants awarded to four CMHI Communities <ul style="list-style-type: none"> > Adams County > Carroll, Lee, Ogle, and Whiteside Counties > Livingston County > City of Springfield
	September	<ul style="list-style-type: none"> ● Year one implementation begins
2013	January	<ul style="list-style-type: none"> ● Year two implementation begins
2014	January	<ul style="list-style-type: none"> ● Year three implementation begins
	February	<ul style="list-style-type: none"> ● ILCHF invests an additional year of funding of up to \$300,000 for each community, to address unpredictable challenges in systems change, thus adding a sixth implementation year
2015	January	<ul style="list-style-type: none"> ● Year four implementation begins
	August	<ul style="list-style-type: none"> ● CMHI Advocacy Planning Project Grant of \$80,000 awarded to Sargent Shriver National Center on Poverty Law (Shriver Center) ● Advocacy Planning Project Grants of \$5,000 each awarded to the four CMHI communities
	December	<ul style="list-style-type: none"> ● Stabilization Grants of up to \$175,000 each awarded to the four CMHI communities
2016	January	<ul style="list-style-type: none"> ● Year five of implementation begins
	October	<ul style="list-style-type: none"> ● Advocacy Planning Project Grants of \$5,000 each awarded to the four CMHI communities
2017	January	<ul style="list-style-type: none"> ● Year six (final year) of implementation begins
	August	<ul style="list-style-type: none"> ● ILCHF Board authorizes up to \$10.1 million for CMHI 2.0 planning, implementation, and evaluation
	October	<ul style="list-style-type: none"> ● Mentoring Grants of \$75,000 each awarded to the four CHMI communities
2018	January	<ul style="list-style-type: none"> ● Mentoring year begins
	June	<ul style="list-style-type: none"> ● CMHI 2.0 Planning Grants of \$200,000 each awarded to five new communities for planning, implementation, and evaluation
	August	<ul style="list-style-type: none"> ● CMHI Advocacy Planning Project Grant of \$160,000 awarded to Shriver Center
	October	<ul style="list-style-type: none"> ● CMHI 2.0 planning year 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 issue is aggravated by the fact that many communities have insufficient resources or strategies to address this threat to the healthy development of children. The *Children's Mental Health Initiative, Building Systems of Care, Community by Community* (CMHI 1.0) was designed to enable four communities to find local solutions to these critical challenges.

Since 2010, ILCHF has invested \$11.27 million across the four grantee communities, and \$915,000 in a cross-site evaluation. Each of the four grantee communities received approximately \$2.85 million over eight years (one planning year, six implementation years, one mentoring year, and two years of advocacy technical assistance funding).

With this ILCHF grant funding, the four CMHI teams significantly shifted community culture and practices surrounding children's mental health. CMHI has shown that empowering communities through an investment in their unique visions and capabilities enables providers to align their organizational plans and operations in order to more effectively serve children with a community-wide strategy.

The four CMHI 1.0 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

In 2009, ILCHF identified the following five guiding principles for CMHI:

1. Engage community-based professionals and families to collaboratively create a child-centered and family-focused system of care.
2. Leverage existing networks of community-based service providers to supply evidence-based and culturally sensitive services.
3. Ensure the capacity to prevent, identify, and treat children at risk for, or with, existing mental illness.
4. Incorporate the concept of a medical home, with integrated behavioral and pediatric healthcare, as the focus of services.
5. Include comprehensive plans to educate and engage all who play active roles in the lives of children, with a particular emphasis on mental health, healthy development, and stigma.

Every CMHI 1.0 community now incorporates the five guiding principles with varying levels of intensity and success.

ILCHF was committed to learning from and sharing the successes, challenges, and failures of each unique CMHI 1.0 project. To that end, each community wrote a manual describing its efforts, including problems, solutions, and strategies. The manuals are a rich resource of information about the extraordinary work in each community; the manuals are available from ILCHF at www.ilchf.org.

In synthesizing the key findings presented here, the Foundation draws upon extensive reports from the sites, third party evaluators, and ongoing relationships with key personnel at each site. Five primary elements of the projects discussed below are:

1. systems integration
2. sustainability
3. mental health screening
4. evaluation
5. advocacy

Significant accomplishments of and lessons from the CMHI 1.0 communities include:

- 1. CMHI 1.0 was very successful in significantly improving the level of systems integration in all four communities over the first six years of the project.** Survey instruments sent to each service provider in the community provided ratings of all other providers in terms of their level of integration and partnership. Integration of human resources, funding, overall impact, and communication were assessed. The scale rated collaboration elements on a scale from one (informal relations) to five (full integration). All four communities achieved statistically significant improvement in their systems integration.
- 2. CMHI 1.0 systems have been sustained, even as grant funding gradually decreased.** From the onset of CMHI 1.0, ILCHF was concerned with sustaining enhanced mental health services and overall integrated systems of care beyond the grant period. All four communities utilized grant funds to pilot and implement the integration of mental health screening and services into both medical and school settings. These mental health services are now sustained through an array of funding mechanisms and strategies.
- 3. Mental health screening in schools and primary care practices are routine in all four CMHI communities. CMHI communities succeeded in dramatically increasing the rates of children being screened for developmental and mental health concerns.** In 2010, at the start of the project, fewer than six percent of children were screened. By 2016, nearly half of all children in the communities were screened. In 2017, the Quincy Public Schools began screening **all** children during school registration. In 2018, Springfield public schools began screening **all** children in selected grades. For the CMHI communities, mental health screening is now routine for families and is part of the expected experience in medical care and school settings.
- 4. CMHI incorporated a complex evaluation—including a cross-site evaluation and four local evaluations—producing varied but useful results.** Systems integration data gathering produced useful results. The longitudinal cohort study encountered significant challenges in connection with enrolling and retaining children in the study, as well as difficulties in gathering data. These challenges have significantly informed the evaluation plan for CMHI 2.0.

5. Policy and advocacy capacity building was successful. ILCHF funded a collaboration between the CMHI 1.0 communities and the Sargent Shriver National Center on Poverty Law (Shriver Center). Shriver Center provided CMHI communities with technical assistance on policy advocacy, including the skills to navigate the Medicaid reimbursement system. The communities and Shriver Center worked together to devise education, legal advocacy, and problem-solving mechanisms that resulted in a significant strengthening of the children’s mental health system overall. The successes were primarily in the areas of insuring Medicaid reimbursement during the state budget impasse; expanding the available array of mental health services and increasing reimbursement rates; problem-solving around Medicaid coverage lapses for clients; and Medicaid plan changes.

Based on its experience with CMHI 1.0, ILCHF has learned that the most effective means of impacting the lives of children and families is to support the system of care at the community level. CMHI 1.0 produced impressive outcomes related to the successful integration of child-serving systems within the local community. CMHI 1.0 reduced the burden of emotional distress and mental illness. The services

that were developed through the initial grant investment have been largely sustained.

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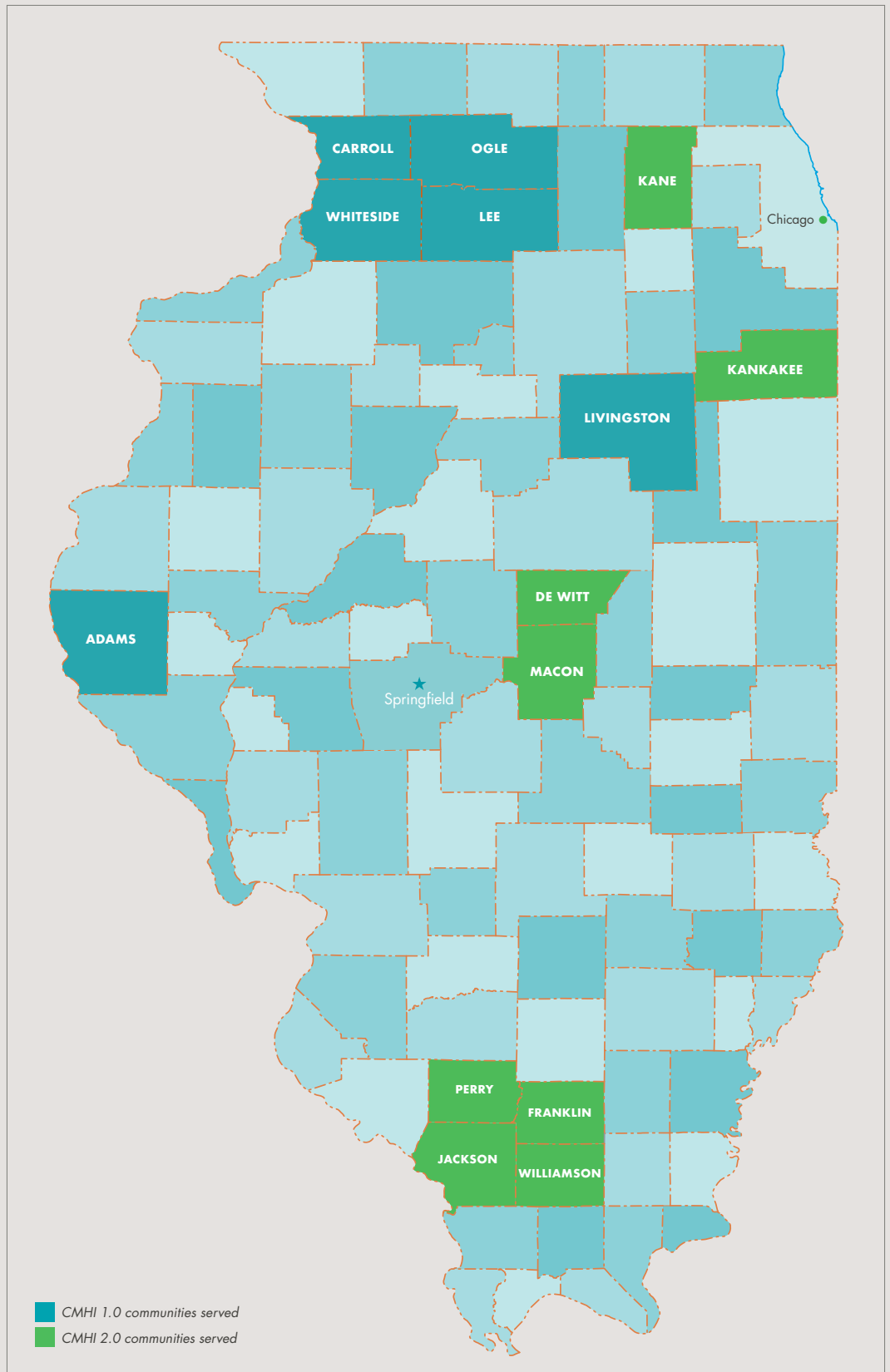
ILCHF is committed to continuing its investment in the Illinois children’s mental health system: Children’s Mental Health Initiative 2.0 (CMHI 2.0) is a \$12.6 million seven-year investment in

a second round of system of care development grants. In July 2018, ILCHF awarded planning grants to five Illinois communities to develop and implement a children’s mental health system of care. The lead grantees and communities to be served are:

- *Centerstone*, serving Perry, Franklin, Jackson, and Williamson counties
- *Community Foundation of Kankakee River Valley*, serving Kankakee County
- *Heritage Behavioral Health*, serving Macon and DeWitt Counties
- *Kane County Health Department*, serving Kane County
- *Primo Center for Women and Children*, serving homeless youth and families in Chicago

We welcome these organizations to the CMHI 2.0. We are excited to see what they can learn and then teach others about improving children’s mental health through the implementation of their systems of care.

Children's Mental Health Initiative Communities Served



Introduction

In 2009, ILCHF launched the *Children’s Mental Health Initiative, Building Systems of Care, Community by Community* (CMHI 1.0). CMHI 1.0 was designed to enhance and integrate available resources to build community-wide systems of care that prevent, identify, and treat children’s mental and behavioral problems. This report offers the summative results and what has been learned from CMHI 1.0, beginning with the planning year (2010) through the completion of the implementation phase (2017), and into the mentoring year (2018). Building on CMHI 1.0, we also delineate ILCHF’s next steps in our commitment to improve the mental health of children in Illinois, including the 2018 CMHI 2.0 planning grants awarded to five new communities.

CONTEXT

The failure to provide children with comprehensive mental health care is a public health crisis in the United States. Behavioral, emotional, and other mental health disorders in children can be reliably identified and treated, but all too often are not.² Approximately 22% of children 13- to 18-years of age experience impairment related to mental illness.³ Equally troubling is the early age at which mental disorders develop. The median age of onset for anxiety disorders is six-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 inadequate to appropriately prevent, identify, and treat children with, or at risk for, mental illness. National estimates suggest that fewer than one in eight children with identified mental disorders actually receive any treatment, and only 50% of children with behavioral problems are 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

Effective, efficient, and evidence-based interventions now exist to address the mental health needs of children; yet, many of our 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 inpatient hospitalization, special education settings, and the juvenile justice system.⁷ CMHI 1.0 was ILCHF’s first significant long-term investment designed to impact children’s mental health systems at the community level.

CMHI SYSTEMS OF CARE

ILCHF recognizes the need to better address children’s mental health in the state of Illinois. In response, ILCHF issued the CMHI Request for Proposals. The Planning Request for Proposal (RFP) sought applicants, from throughout the state, ready to create comprehensive, coordinated, and integrated community-based systems of care to prevent, identify, treat, and promote children’s mental health.

ILCHF retained Ira Chasnoff, MD, and Richard F. McGourty, PhD, through National Training Institute, Inc., (now NTI Upstream) to provide consultation, technical assistance, and the cross-site project evaluation. Drs. Chasnoff and McGourty assisted in the design and implementation of the RFP.

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 community needs assessment and a sustainable financial model.

The Foundation awarded implementation grants to four unique communities whose creative and innovative plans emphasized the importance of community-based collaboration and built upon their existing services to ensure that children receive integrated, comprehensive health care in accessible, community-based settings.

The four CMHI 1.0 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 (CLOW)
- *Livingston County Children’s Network (LCCN)*, serving Livingston County
- *The Children’s MOSAIC Project (MOSAIC)*, serving the city of Springfield

Each community received an initial grant of \$2 million over five years to implement, monitor, and evaluate its system of care. In 2013, as the second year of the implementation phase was ending, it became clear that, while progress was being made in each community, more time was needed to fully implement the proposed system of care. As a result, in 2014, the ILCHF Board of Directors chose to invest an additional year and \$300,000 in each CMHI 1.0 site. In 2015, as the projects moved toward their sustainability goals, the Board awarded grants of an additional \$175,000 to each community.

Beginning in 2015, ILCHF initiated a collaboration with the Sargent Shriver National Center on Poverty Law (Shriver Center) and the CMHI 1.0 communities to engage in advocacy work. Grants of \$5,000 per year, over two years, were provided to the communities, along with \$320,000 in funding over four years to support Shriver Center’s effort to support the CMHI 1.0 communities.

In 2017, the ILCHF Board of Directors decided to fund a second round of CMHI grantees—thus, CMHI 2.0 was born. To enable the CMHI 1.0 grantees to fully share their knowledge and expertise with the next cohort of grantees, mentoring grants were awarded in late 2017. These \$75,000, one-year grants also provided ongoing support for the project leaders in the CMHI 1.0 communities.

To date, ILCHF has invested a total of \$11.3 million in CMHI 1.0 and its communities, along with \$915,000 for NTI cross-site evaluators, and \$320,000 to Shriver Center. As the mentoring year draws to a close, the CMHI 1.0 communities continue to refine their system of care and ensure that each offers effective, integrated, and supportive children’s mental health services.

Detailed information about each of the communities can be found in Exhibit A. Additional information regarding the project is also available at www.ilchf.org in the 2015 CMHI 1.0 mid-project report *“An Investment in Our Future.”*



Accomplishments and Lessons Learned

GUIDING PRINCIPLES

In 2009, ILCHF identified five guiding principles for the CMHI Initiative. Ultimately, all of these principles were realized within the systems; in each community, some principles were realized completely, and others to a more moderate degree.

1. Engage community-based professionals and families to collaboratively create a child-centered and family-focused system of care.

Each of the four communities was successful in attracting and retaining child-serving partners to establish a coordinated system of care around mental health supports. These partners typically included providers in schools, primary healthcare, early childhood services, juvenile justice, and child welfare.

CMHI 1.0 did not focus specifically on including family leadership in the projects. However, all of the communities increased their overall focus on meeting the comprehensive needs of family members.

2. Leverage existing networks of community-based service providers to provide evidence-based and culturally sensitive services.

In each of the communities, mental health professionals were supported to provide evidence-based clinical interventions. Evidence-based trainings were conducted across systems sectors. Several of the communities experienced typical community mental health staff turnover, which slowed the saturation of the evidence-based models. In one community, multiple models were attempted before finding one that was acceptable to the local service system. Ultimately, each community succeeded and the infrastructure for continuing to implement evidence-based interventions remains largely in place.

3. Ensure the capacity to prevent, identify, and treat children at risk of, or with, mental illness.

All four communities increased the ability of their mental health system to provide the full spectrum of mental health care to children. This was particularly true for the early childhood population and for individuals requiring care related to traumatic stress.

Two of the sites increased the number of specialized child mental health providers in their system. Two others struggled to attract child specialists to their rural areas. There was also some difficulty retaining staff in the community mental health system; staff often left for higher paying positions in other child care systems, such as schools and hospitals.

4. Incorporate the concept of a medical home with integrated behavioral and pediatric healthcare.

This principle was fully realized by all four communities. The primary care systems recognized that integrating mental health clinicians into their service system benefitted their overall healthcare practices; they were able to sustain the services beyond the grant funding period.

5. Include a comprehensive plan to educate and engage all who play an active role in the lives of children on mental health, healthy development, and stigma.

This guiding principle was realized to varying degrees in all four communities. There was a great deal of work done to educate the public and non-mental health child systems on healthy child development and on signs and symptoms of emerging-to-crisis-level mental health needs. Youth Mental Health First Aid was used by most communities and served as the model for broadly educating members of the community.

The communities reported a reduction in the stigma related to the issue of mental health. The expectation that caring adults thought about and supported children's mental well-being was increasingly well-accepted and routine.

Learning from and sharing the successes, challenges, and failures of each unique CMHI 1.0 project is one of the goals of the Foundation. To that end, each community has written a manual describing its

Learning from and sharing the successes, challenges, and failures of each unique CMHI 1.0 project is one of the goals of the Foundation.

particular work. The manuals are a rich source of details regarding this work and are available on the Foundation's website at www.ilchf.org.

In summarizing the key findings, the Foundation draws upon extensive reporting from the

sites, third party evaluators, and ongoing relationships with key personnel at each site. The primary elements of the projects discussed below are 1) systems integration; 2) sustainability; 3) mental health screening; 4) evaluation; and 5) advocacy, as well as specific project highlights from each of the communities.

SYSTEMS INTEGRATION

One goal of the CMHI initiative is reflected in the title *"Building Systems of Care, Community by Community."* A system of care has been defined as "a coordinated network of community-based services and supports characterized by a wide array of services, individualized care, and services provided within the least restrictive environment, full participation and partnerships with families and youth, coordination among child-serving agencies and programs, and cultural and linguistic competence."⁸

CMHI 1.0 motivated the child-serving systems to work in a coordinated approach to comprehensively meet the needs of children with mental health symptoms, and their families, within a system of care framework. Many families are involved with multiple service agencies (medical, school, mental health, juvenile justice, child welfare, early childhood, etc.), which often do not communicate or coordinate with one another. Families can experience the frustration of fragmented systems, and often "fall through the cracks." As a result, needs are not met, or there is duplication and/or poor coordination of services. Parents complain frequently about the difficulty they have finding help. Many simply give up.

Among the most important successes of CMHI 1.0, and learning from the cross-site evaluation, is the degree of systems integration that was achieved in all four communities over the first six years of the project.

A survey sent to each service provider in the community rated all the other providers in terms of their level of integration and partnership. Integration of human resources, funding, overall impact, and communication were assessed. The scale rated collaboration elements from one (indicating informal relations) to five (reflecting full integration). All four communities achieved statistically significant improvement in their systems integration. Within the CMHI initiative, the child- and family-serving providers simply began to work together in more effective ways. Children and families benefitted from this coordination of services.

Mean systems integration scores (range 1–5)

<i>Community</i>	<i>Integration type</i>	<i>2010 M (SD)</i>	<i>2015 M (SD)</i>	<i>2016 M (SD)</i>
Adams County	Human resources	1.73 (0.80)	3.67 (0.82)	4.33 (0.58)
	Funding	1.53 (0.74)	3.33 (0.52)	3.33 (0.58)
	Impact	1.80 (0.86)	4.00 (0.63)	4.67 (0.58)
	Communication	1.87 (0.64)	3.50 (0.55)	3.33 (0.58)
Carroll, Lee, Ogle, and Whiteside Counties	Human resources	1.62 (0.92)	3.67 (0.82)	3.12 (1.13)
	Funding	1.50 (0.75)	3.60 (0.51)	2.62 (0.52)
	Impact	2.25 (0.71)	3.87 (0.74)	3.75 (1.28)
	Communication	2.12 (0.64)	4.40 (0.52)	4.12 (2.30)
Livingston County	Human resources	2.29 (0.82)	3.20 (0.63)	3.12 (1.36)
	Funding	2.69 (1.03)	4.30 (0.48)	3.62 (1.19)
	Impact	2.71 (0.82)	4.20 (0.79)	3.38 (0.92)
	Communication	2.57 (0.75)	3.94 (1.18)	2.92 (1.50)
Springfield	Human resources	1.83 (0.83)	3.31 (0.94)	2.77 (1.48)
	Funding	1.83 (0.94)	4.12 (0.62)	3.54 (1.20)
	Impact	2.08 (0.67)	3.40 (0.83)	3.61 (1.19)
	Communication	2.33 (0.89)	3.94 (1.18)	2.92 (1.50)

It is noteworthy that the systems integration scores decreased over the last year of implementation (2015–2016) for some of the communities. 2015 was the last year in which the project director roles were fully funded by ILCHF, and, perhaps, some regression occurred in the absence of that level of system stewardship. In addition, 2015–2016 was a particularly difficult time in Illinois from the perspective of the state budget; some of the regression may have been due to providers feeling increasingly stretched for resources, and, consequently, less able to participate in system-building activities.

Systems integration was also reflected in satisfaction ratings from providers and parents. Over time, the hard work of the communities paid off in terms of both providers of healthcare services and consumer parents reporting high levels of satisfaction with coordination of the systems and the services they received.

-
- **96% of physicians surveyed reported** that the mental health system was very supportive of the work they were doing with families related to their physical health.
 - **97% of parents surveyed reported** that they were well informed about the need for and purpose of the mental health care their children were receiving.
 - **83% of parents surveyed reported** that their children were well established in a 'medical home,' thus, supporting the overall success of integrating behavioral and primary healthcare in these communities.

SUSTAINABILITY

From the onset of CMHI 1.0, ILCHF was concerned with ensuring that the enhanced mental health services and the integrated system overall would be sustained beyond the grant period. Toward this end, the communities were required to produce annual sustainability plans that involved input from all systems partners and to report on their efforts to move toward sustainability. The Foundation consistently assessed the viability of these plans and activities over time, providing feedback to the CMHI 1.0 communities. Originally implementation funding was due to end in December 2014. In late 2013, it was clear to the Foundation that the systems were not yet mature enough to sustain themselves. As a result, increased funds and time were provided. Grant support was extended again on two subsequent occasions.

Grant funds were utilized by all four communities to pilot and implement the integration of mental health screening and services into both medical and school settings. Ultimately, nearly all these mental health services have been sustained by the systems through an array of funding mechanisms and strategies. This is a major area of success for CMHI 1.0.

Mental health services have been financially supported through Medicaid billing by the local community mental health centers; this allows the flexibility to deliver services in diverse community-based settings, including schools and clinics. Services have also been supported in some medical practices as part of billing as a Federally Qualified Health Center, and in other medical settings (both for-profit and non-profit.) Some groups have decided to maintain the mental health services as part of their operating costs. Mental health services have been supported by public school districts as part of their operating costs, as well. Importantly, these medical and school systems were willing to support the expense of mental health screening and services, **only after** the value to the systems had been demonstrated through positive experience supported by ILCHF grant funding.

The project directors in each CMHI 1.0 community were the stewards of the system responsible for bringing the partners together and maintaining the focus of the community on system building. Though the mental health services have been sustained, communities have not been able to financially sustain the full-time project director roles. Thus, the project leadership at each of the CMHI communities has become somewhat diluted as those team members become involved in other projects. The small reduction in the positive systems integration scores for the final year of CMHI funding may be a result of this dilution, or of other external environmental factors. It will be interesting to analyze the 2018 systems integration data, which will be provided as part of the reporting on the 2018 mentoring grants. These data may provide a better understanding of the importance of the consistent project leadership in maintaining efficient, effective integrated systems.

spotlight

Systems Integration Impact—Carroll, Lee, Ogle, and Whiteside Counties

I AM SUBMITTING THIS LETTER AS A TESTIMONIAL to the positive outcomes from the Community That Cares initiative. This is a daunting task as I am not sure I can do justice to all the positives that I believe are a direct result from the work of the CTC.

First and foremost, I would like to mention the relationships that were formed out of the work of the CTC. Partnerships that were once abandoned were renewed. Partnerships with agencies with completely different focuses were begun. Partnerships with competing agencies were forged.

This project brought an opportunity to the parents of over 16,000 (I believe this number is correct) children that had never been available before. Parents were given a choice for mental health screening in a manner that was not and would not have been available except through the CTC. Some parents chose not to participate, but they were given that choice.

The project provided research-based social and emotional learning curriculum to thousands of students. Due to the funding constraints of public education, this curriculum was not and, in all likelihood, would not be provided had it not been for the CTC. The benefits of these curriculums have been widely researched and the effects of this act will be felt for decades to come.

The project spurred additional projects that grew directly from the foundation built by the CTC. One-hundred-eighty days a year, children of school age are located in schools throughout the community. Service providers, in my belief, constrain themselves by forcing customers or clients or patients or consumers to come to them. If we simply bring the service to where the students are, many of these concerns are eliminated.

Additionally, we can serve more students by simply increasing access to service. Over 80% of the students receiving services in the school setting would not have accessed those services had the service not been provided in the school setting. Crisis response was far quicker, missed appointments were eliminated, school absenteeism was reduced, and I believe we will see a reduction in psychiatric hospitalizations in the future due to this program.

I know I have only touched the surface of the impact of the CTC and, by direct extension, the ILCHF. I truly believe the greatest impact has yet to be realized and we have only glimpsed at the long-term effects of the investment in our community.

Selected comments from Steve Braasch, MSED, LCPC, a school partner

MENTAL HEALTH SCREENING

All four CMHI communities implemented mental health screening in their schools and primary care practices. One of the notable outcomes of CMHI is that these screening processes have now become routine for many families and are part of the expected experience in medical care and school settings. Communities have reported that it is rare that parents opt out of participation in the mental health screening of their children, and providers report that the conversations with youth and parents regarding social emotional health are richer as a result.

The communities each selected different mental health screening instruments; the consensus was that the process of asking the questions about children’s mental health was ultimately more important than using a particular measurement instrument. There was also consensus that the instruments needed to be brief, inexpensive, and easy to score.

The communities succeeded in dramatically increasing the rates of children being screened for developmental and mental health concerns. In 2010, at the start of the project, on average, fewer than six percent of children were screened. By 2016, nearly half of all the children in the communities were receiving screening. The initial screening target rates established for the communities by ILCHF proved to be overly ambitious and unattainable in these time frames. However, the trend to increase screenings has continued beyond the CMHI projects. In 2017 the Quincy Public schools began screening **all** children during school registration, and in 2018, Springfield public schools began screening **all** children in selected grades.

Screening rates across the communities over time

	Baseline	2012	2013	2014	2015	2016
Target						
0–5 years old	—	20.0%	50.0%	90.0%	90.0%	90.0%
≥6–18 years old		20.0%	50.0%	90.0%	90.0%	90.0%
Adams County						
0–5 years old	0.0%	27.2%	41.2%	69.9%	68.8%	71.6%
≥6–18 years old		34.9%	28.9%	35.0%	34.4%	13.8%
Carroll, Lee, Ogle, and Whiteside Counties						
0–5 years old	5.6%	24.8%	31.7%	27.1%	21.4%	21.0%
≥6–18 years old		16.4%	15.1%	18.1%	21.1%	18.1%
Livingston County*						
0–5 years old	18.0%	66.6%	82.0%	118.3%	155.1%	140.0%
≥6–18 years old		76.1%	71.9%	81.6%	79.0%	81.9%
Springfield						
0–5 years old	0.0%	8.90%	36.2%	42.6%	43.0%	45.5%
≥6–18 years old		2.90%	13.5%	20.6%	45.4%	50.5%

* Livingston County’s screening data included instances in which children in both age categories were screened more than once. For this reason, the Livingston data is not included in the estimate that in 2016 nearly half of all children in the communities received a mental health screen.



The purpose of mental health screening of individual children is to identify problems earlier than might occur otherwise. This is particularly the case with children experiencing anxiety, depression, or suicidal ideation, which more often go unnoticed when compared to more overt behavior problems. The impact of universal mental health screening on whole community population health has not yet been studied but may tell an important story about community health and well-being.

There is evidence from the CMHI sites that positive screening rates decreased over time as communities implemented their systems. CMHI 1.0 sites had a mean of 22.8% positive (meaning a problem was found) screen rates in 2012, and by 2015 that positive rate had decreased

to 14.2%. This reduction is compelling; however, the cause cannot yet be determined. While it is possible that children are receiving earlier mental health interventions as a result of screening and, therefore, problems are being remediated in the population overall, there may be other explanations for this finding. For example, it may be that as the percentage of children in the community being screened increases, the overall population included in screening is a healthier one than those youth who were targeted for screening early in the process. These are questions for additional study, as well as the question raised by the increase in positive screens in 2016, following a several year trend of decreasing rates.

Rates of positive screens by year*

Year	0-5 years old	>6 years old	Total
2012	17.9%	25.1%	22.8%
2013	13.2%	26.0%	20.6%
2014	12.9%	17.7%	15.8%
2015	11.0%	16.3%	14.2%
2016	14.5%	19.7%	17.4%

* Due to IRB difficulties, Springfield was not able to collect results for the children screened through the CMHI. Thus, Springfield data are not included in this analysis of rates of positive screens.

spotlight

Mental Health Screening Success Story—City of Springfield

TRINA,* A HIGH SCHOOL SENIOR, took part in MOSAIC counseling services after she scored in the highly elevated range on a social-emotional screen. On the outside, she was composed and smiling. Trina was an active student. She volunteered at a local youth organization, was well liked by her teachers, and was enrolled to begin college in the fall. On the inside, she was suffering from Major Depressive Disorder with suicidal ideations.

After receiving a variety of services, including counseling from MOSAIC, she began advocating for other teens who need help. Trina said, “It took me a long time to get better and really deal with my issues. You asked me questions that really made me look at myself, at things I didn’t want to deal with. You really helped me recover.”

Memorial Behavioral Health’s Children’s Mosaic Project is a collaboration of community resources that form a complete network of behavioral healthcare for youth in central Illinois. MOSAIC, or Meaningful Opportunities for Success and Achievement Through Service Integration for Children, brings together healthcare services, schools, and neighborhood outreach programs to create an integrated mosaic of services.

Now a happy and healthy teenager, Trina wanted to share her story to let others know they are not alone. Although she had never had any counseling services before, she said she often felt depressed.

“I think there is a stigma about mental illness among African Americans.” Trina said. “I thought this was normal and I should just deal with it on my own. I think more needs to be done in my community as far as advocacy. I want to become a leader, mentor other kids, and show them they can be successful, too.”

**name changed to protect privacy*

EVALUATION

The evaluation plan for CMHI 1.0 was intended to capture the project’s impact from both an individual community perspective, as well as a total cross-site perspective. Toward that end, ILCHF engaged NTI as the cross-site evaluation team and each community selected a “local” evaluator who was typically affiliated with a nearby university. Thus, there were five evaluation teams involved, representing an investment by ILCHF of \$915,000 in the cross-site evaluation and approximately \$500,000 of each community’s project funds in the local evaluations

Cross-site cohort

NTI worked with each site to collect data about systems integration. They also assessed sustainability across the sites to determine the extent to which sustainable systems to serve children’s mental health needs were being created. The sustainability of the projects has been addressed in the Systems Integration and Sustainability sections of the report.

NTI also worked with the sites to establish a longitudinal cohort of children receiving services from each of the four sites. These children were then followed over time to examine their experience in each system of care and the extent to which they improved over time. In tracking children over time, sites struggled to collect evaluation data from their partners in schools and primary care, due to complexities with IT systems and informed consent rules. There was also a lack of clarity regarding the expectations for the evaluation at the start of the project. Despite efforts towards enrolling children and families in the cross-site evaluation, retaining them once enrolled, and integrating data across four sites in meaningful ways, fewer children were enrolled in the cross-site evaluation than intended. This limited the conclusions that could be drawn about how children in these systems improved over time.

Below are some rates of improvement for children in the cross-site cohort, receiving services through one of the four sites. There were no statistically significant changes in the measures between baseline and six months for this cohort.

Agnes and stages questionnaire (children 0-3; n=76)

<i>Dimension</i>	<i>Number who scored “at-risk” or “borderline” at baseline</i>	<i>Percent who improved at six months</i>
Communication	15	40.0%
Problem solving	14	71.0%
Personal	17	41.0%

Pre-school child behavioral checklist (children 4-5; n=49)

<i>Dimension</i>	<i>Number who scored “at-risk” or “borderline” at baseline</i>	<i>Percent who improved at six months</i>
Emotionally reactive (n=20)	9	67.0%
Withdrawn	7	43.0%
Attention	7	43.0%
Aggression	13	54.0%

Child behavioral checklist (children 6-18; n=99)

<i>Dimension</i>	<i>Number who scored "at-risk" or "borderline" at baseline</i>	<i>Percent who improved at six months</i>
Anxious/depressed	29	52.0%
Withdrawn/depressed	26	50.0%
Thought problems	36	64.0%
Attention problems	47	49.0%
Rule breaking	37	49.0%
Aggression	45	38.0%

A cohort of 58 families followed over one year did show a statistically significant improvement in overall family functioning. The Parent Relationship Questionnaire (PRQ) was used to assess parents' perspectives on family functioning, including attachment, communication, parenting confidence, satisfaction with school, and relational frustration. The emphasis that the CMHI 1.0 communities placed on holistic support of families may be reflected in the results from the PRQ.

The cross-site team worked to evaluate CMHI goals and processes overall. The four local evaluators worked with the individual communities to identify questions they wanted to answer specifically about their projects. The complexity of this multilevel design led to difficulties in collecting data on the progress of individual children and families as intended. Additionally, the sites experienced the data collection process as being a significant burden because it was not easily assimilated into the workflows within any of the child-serving system partners.

The CMHI 1.0 evaluation provided both ILCHF and the CMHI 1.0 communities with important insight into the design and implementation of an effective and efficient evaluation process. The evaluation plan for CMHI 2.0, benefitted from these experiences in the following ways:

- One team was selected to conduct both a cross-site evaluation and a modest local evaluation with each site.
- Data collection staff are required as part of the project within each site.
- The general goals for the evaluation were spelled out in the planning grant RFP for the projects.
- The new sites are involved in selecting measures for the evaluation, including utilization of data already being collected at their sites, whenever possible.
- There will be regular sharing of data from the evaluation team back to the sites.
- Significant attention is being paid to ensuring that the data collected are meaningful and useful to the sites themselves, while also trying to reduce respondent burden for the sites and service consumers.



Specific local evaluation findings

Each project collected data to answer questions about the impact of their project that were unique to their community. The information below represents some of the unique outcomes from the final local evaluations.

ADAMS COUNTY CHILDREN'S MENTAL HEALTH PARTNERSHIP (ACCMHP)

ACCMHP was interested in understanding the relationship between children's mental health screening scores, referrals for services, and what occurred on subsequent screenings. ACCMHP utilized the Pediatric Symptom Checklist (PSC) for youth. Findings indicate that youth who received a referral to developmental parenting education from a healthcare provider, based on a positive screen, showed significant improvement in their social/emotional functioning at the time of follow-up screening. Also, this proved true for those who were referred to a mental health partnership clinician, to "other" support services, and those who were already receiving services at the time of initial screening. It is important to note that there was no data collected regarding whether youth received the services for which they were referred.

THE COMMUNITY THAT CARES (CTC)

The CTC project is in a geographically large, four-county area in northwestern Illinois. There were complexities in implementing the CMHI 1.0 project in an area this large; despite this, there were significant successes and much knowledge was gained. Though the number of the 83 schools in the region that do screening fluctuates over time, schools are increasingly receptive to using behavioral health consultants in the schools and receiving trainings for early social/emotional learning. Preliminary data suggests that 70-80% of children seen by school-based behavioral health counselors would not be able to access services in a traditional office-based setting. In 2017, 29 schools offered universal social and emotional screening; 42 schools provided a social/emotional curriculum.

LIVINGSTON COUNTY CHILDREN'S NETWORK (LCCN)

LCCN focused on increasing the amount and accessibility of children's mental health services being offered by its community mental health provider. LCCN has approximately 9,500 youth below the age of 18; it is estimated that approximately 1,000 of these youth needed a mental health intervention at any one time. When the project began in 2011, only 464 youth were receiving services, less than half of what would be anticipated by demographic estimate. By 2015, that number had nearly tripled, so that 1,266 youth were served by its enhanced mental health system. The number has decreased over the last few years of the project but is holding steady in serving approximately 13% of school-aged youth. This suggests that youth who need mental health services in Livingston County are accessing them.

THE CHILDREN'S MOSAIC PROJECT (MOSAIC)

MOSAIC, located in the city of Springfield, was interested in understanding the relationship between the intensity of mental health services being received by youth and the number of mental health crisis interventions that were subsequently provided. The findings indicate that youth who participated in more mental health therapy and psychiatry services did not access as many crisis services. This suggests that MOSAIC is meeting the mental health needs of some of their youth in a way that reduces their need for crisis services.

POLICY AND ADVOCACY CAPACITY BUILDING

The CMHI 1.0 sites evolved over time into an informal learning laboratory with lessons to learn and share with one another, ILCHF, and the children’s health system in Illinois. **ILCHF became increasingly concerned the CMHI 1.0 grantees were having difficulties due to the Illinois state budget becoming more fragile and the reimbursement system more difficult to navigate.** Though there was additional funding provided to the CMHI communities through their ILCHF grants, at their core, the mental health providers were operating under the same environmental conditions that faced all the other children’s mental health providers in Illinois. In 2015, ILCHF began working with Sargent Shriver National Center on Poverty Law (Shriver Center) to consider ways that



Shriver Center might assist the communities in stabilizing their system of care. Shriver Center has legal experts within the areas of children’s healthcare policy and Medicaid. ILCHF has invested \$320,000 and awarded four years of grant funding to Shriver Center to work with the CMHI 1.0 communities and three other larger child mental health grantees.

Shriver Center staff continue to meet regularly with the communities and listen deeply to the struggles they are having in the context of providing mental health services to children and families. Shriver Center provided the CMHI communities with technical assistance on policy advocacy and skills to assist in navigating the Medicaid reimbursement system. During the final year of CMHI 1.0, Illinois moved increas-

ingly to a “managed” Medicaid reimbursement system, which introduced new complexities to the children’s mental health system overall. **The communities and Shriver Center worked together to devise education, legal advocacy, and problem-solving mechanisms that resulted in a significant strengthening of the children’s mental health system overall.**

The successes were primarily in the areas of insuring Medicaid reimbursement during the state budget impasse; expanding the array of mental health services and increasing reimbursement rates; problem solving around Medicaid coverage lapses for clients and Medicaid plan changes; and teaching the communities advocacy skills that they used in communication with their local officials.

PROJECT SPECIFIC SIGNIFICANT ACCOMPLISHMENTS

Each of the CMHI 1.0 communities is unique and each excelled in various aspects of their work. Below we share specific significant accomplishments from each community.

ADAMS COUNTY CHILDREN'S MENTAL HEALTH PARTNERSHIP (ACCMHP)

The Adams County system of care was very effective in incorporating universal mental health screening into their system in the Quincy Public School District (QPS). ACCMHP's thorough process involved getting buy-in for screening from stakeholders at the level of 1) parents and youth; 2) teachers and support staff; 3) school building leadership; 4) district leadership; and 5) the community-at-large. Their process involved attention to the unique needs and concerns about mental health screening at each level and planning in detail for protocols that addressed these concerns. The screening success was made possible after the community developed confidence that the children's mental health system of care was sufficiently robust to meet the needs of students who screened positive. In 2018, QPS successfully offered mental health screening to parents of every child at the time of school registration, via their electronic registration system. Mental health screening in schools is now a

routine experience for families in the QPS district. QPS and their screening process serves as a model in Illinois and nationally. It will be the focus of an ILCHF-funded learning collaborative for school districts in 2019. Additionally, the Adams County system of care implemented and is sustaining mental health screening and follow-up mental health care in four unique medical systems: a Federal Rural Health Center, a Federally Qualified Health Center, a University Medical System, and a for-profit health system.



spotlight

Integrated Mental Health Services in Action—Adams County

JAYDEN* IS AN EIGHT-YEAR-OLD BOY living with his single mother, Dana. Dana has been working as a server at a local restaurant during the day, raising Jayden and going to school at night to finish her college degree. Jayden has a pediatrician, Dr. Brown, at Blessing Physician Services in Quincy, who has been Jayden’s pediatrician since he was born. Dana trusts Dr. Brown and the nursing staff at Blessing. When Jayden was six, the Blessing medical clinic implemented mental health screening as part of the CMHI 1.0 initiative and integrated mental health services within the clinic.

Dana completed the mental health screen (the Pediatric Symptom Checklist) at the clinic at Jayden’s six-year-old well-child visit. Jayden’s score was high, indicating that there were some early problems with his behavior. Dr. Brown went over the screening results with Dana during Jayden’s well-child visit. Dana acknowledged that Jayden was a “handful” but she did not think he was outside the functioning of a typical six-year-old. Dr. Brown offered to connect Dana to the social worker at the clinic, but Dana declined. Jayden had some behavior problems at school when he was seven, largely “sassing back” with the teacher when she gave him directions. The teacher contacted Dana about her concerns, and Dana scolded Jayden for his behavior at school, but she did not know what else to do about it.

Dana completed the mental health screen at Jayden’s eight-year-old well-child visit. This time, Jayden scored even higher. By this time, Dana had become increasingly frustrated with Jayden; she was ready to accept the referral that Dr. Brown gave her to a social worker at the clinic. Dr. Brown walked Dana and Jayden down the hall to meet Ms. Clark, a social worker who specialized in working with families of younger children. Ms. Clark met with Dana and Jayden that day, and they agreed to focus on both Dana’s parenting practices in managing Jayden’s behavior, and a plan to work with his teacher to apply consistent behavior management both at home and in the classroom.

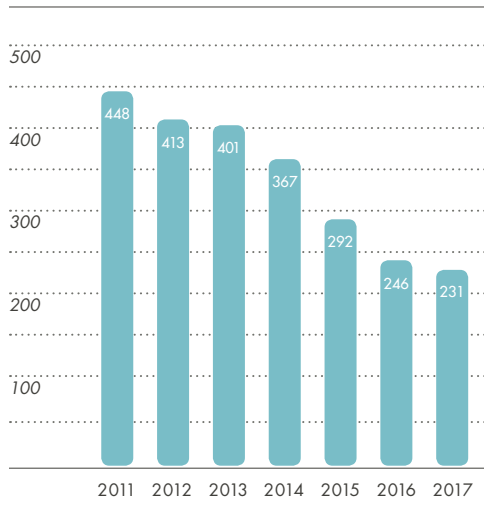
Six months later, Jayden’s behavior turned around and he is doing well both at home and in school. Dana noted that she wishes she had accepted the referral from Dr. Brown the first time she offered it, but is glad that she got help before things got any worse. Though they are finished with counseling, Dana says she is happy to know that Ms. Clark is right down the hall in Dr. Brown’s office if they should need help again.

**Jaden’s story is a composite of multiple patient experiences at Adams County.*

LIVINGSTON COUNTY CHILDREN'S NETWORK (LCCN)

LCCN did notable work in two areas. First, their project focused on implementing mental health supports in their system of care that would influence every child in the county at a level of intervention intensity that was appropriate for that child and family. These interventions ranged from classroom education regarding social emotional health to more intensive interventions, such as family-based case management. The juvenile justice system was a significant partner in the work. As the system of care in Livingston County matured, there was a remarkable reduction in both the number of juvenile police reports, as well as in the caseload of youth on probation; both decreased by approximately half over the course of the CMHI project.

Number of juvenile police reports



Average Livingston monthly caseload: probation



The second unique accomplishment in LCCN was the development and launching of a consent form to release information that was shared among all of the child-serving systems. This document, when signed by a youth and parent, allowed all of the involved professionals across the systems to communicate with each other so that a youth's care could be well coordinated and the typical fragmentation between the systems, that causes confusion and frustration for families, would be eliminated. Though replication of this type of system feature may be highly dependent on the local context, the achievement of this level of information sharing reflects a uniquely successful effort toward systemwide collaboration.

spotlight

Juvenile Justice—Livingston County

JANE* WAS A 14-YEAR-OLD FRESHMAN charged with domestic battery for hitting family members. She was placed on pre-trial supervision and ordered to meet with the Family Support Specialist (FSS).

At an initial meeting, Jane screened positive on the Pediatric Symptom Checklist, a screener for social-emotional concerns. Jane had a history of self-harm and witnessing domestic violence. Her father was incarcerated, and siblings were also in trouble with the juvenile justice system. Jane received several services, including a mental health assessment at IHR, the local community mental health center, and a check-in with her school social worker, as well as a Screening Assessment and Support (SASS) Family Resource Developer referral for her mother.

Two months later, Jane admitted to cannabis use and still had not completed her mental health assessment due to a lack of transportation. Jane's FSS assisted probation in getting a substance abuse assessment scheduled with IHR. The FSS arranged for the mental health assessment to take place at Jane's hometown doctor's office. Following the mental health assessment, Jane was diagnosed with depression and Oppositional Defiant Disorder (ODD) and referred to a nurse practitioner for depression medication. Jane started receiving additional supports after school, including counseling with the social worker. When Jane continued to screen positive for drugs, her FSS provided gas cards so Jane could attend to substance abuse treatment sessions.

Jane's mother started working with the family resource developer on parenting skills. When Jane's mother lost her job and was about to be evicted from her home the FSS was able to find resources to help stabilize her living situation.

Three months later, Jane had her first clean drug screen. Jane's mom found employment but had been suffering from some depression. The FSS helped Jane's mom engage in therapy. Jane was still having defiant behaviors in the home and was participating in more risk-taking behaviors. Probation engaged a mentor to help with issues in the home and provide positive influences to Jane.

Six months later, Jane completed substance abuse treatment, she was regularly seeing her therapist, and she was passing her classes. Jane still struggled with challenging behavior at home, but her mother continued to work with her therapist and other family supports.

Fourteen months after the initial visit, Jane continued to do well, probation saw no need for further reviews, and her case was closed.

**name changed to protect privacy*

THE COMMUNITY THAT CARES (CTC)

The CTC developed unique positions within their project to help shepherd the system of care into their child-serving systems. Because their geographic area covered four counties, there were large numbers of schools, medical systems, family service organizations, and other stakeholders with whom to engage and coordinate. Within each sector, CTC identified system “coaches” who spearheaded the efforts to bring them mental health screening and care coordination. These “coaches” were professionals working within the sectors of school, medicine, and mental health/family services who became ambassadors for the CTC work. Their sector specific knowledge made them uniquely capable of sharing the messages and promise of CTC, as well as reducing barriers to its success in the individual settings.

CTC also developed a position within its mental health service array that was solely focused on supporting the entire family. This position, the Family Care Coordinator, ensures that the needs of the parents, as well as the children, are met. It also recognizes that when parents are struggling with their own concerns it is difficult for them to be as effective in their parenting as they would like to be.

CTC was also remarkably successful at utilizing CMHI funding from ILCHF to leverage additional grants from multiple sources to expand their children’s system of care. As a group of system partners, they successfully applied for grants and received nearly twice the amount of funding received from the initial CMHI 1.0 investment by ILCHF.

THE CHILDREN’S MOSAIC PROJECT (MOSAIC)

The Springfield community saw an impressive change within many of its pediatric medical practices over the course of the CMHI 1.0 project. MOSIAC successfully integrated mental health screening into these practices, and embedded child specialty-trained mental health clinicians. The services began primarily with ILCHF grant supported resources. Over time, the medical practices saw the

benefit to themselves and their young patients in having mental health services on site. These practices are now sustaining the mental health resources through a number of innovative billing and business relationships. More impressively, the mental health integration has occurred within three different settings—rural health centers, a federally qualified health center, and urban primary care practices.

Additionally, MOSIAC was instrumental in helping implement social/emotional screening for all children in the Springfield School District in the 2017–2018 school year.



spotlight

CTC Family Care Coordinator—Carroll, Lee, Ogle, and Whiteside Counties

THE CTC FAMILY CARE COORDINATOR (FCC), JENNIFER, FIRST MET JOHNNY* after receiving a referral from his school at the beginning of the school year. The school social worker was very concerned about Johnny's behaviors in his first-grade classroom and the lack of involvement they were experiencing from Johnny's parents.

Johnny entered school without any preschool or kindergarten experience. He was demonstrating aggressive and disruptive behaviors that were escalating. His mother, according to the school's social worker, was angry, unrealistic, and refused to return phone calls. The school social worker, who was a part of the CTC school workgroup, asked Jennifer, the FCC, to reach out to Johnny's mother in the hopes of improving communication and better understanding what was affecting his behaviors at school.

When the FCC began working with Johnny's family, his mother had a part-time job she was in fear of losing. She was missing work because of being frequently called by the school to pick Johnny up early due to his behaviors. Johnny's father had recently abandoned the family, leaving his mom to support Johnny and his younger sister. Johnny's mother was overwhelmed and struggling to manage her depression. Circumstances worsened for the family when his mother lost her job. Her depression became more severe, and many days she struggled to get off the sofa. Johnny's behavior continued to deteriorate. By the holidays, he was not making any progress either socially or academically and was attending school only three hours a day. The school discussed homebound tutoring for Johnny.

Jennifer provided a range of support for the entire family. She advocated for Johnny with the school, and supported Johnny's mother in being more effective in communicating with school staff. Jennifer helped the family locate a new place to live and linked them to local food pantries and other vital resources. She helped the family engage in therapy for Johnny, his mother, and the entire family. By the end of first grade, both Johnny and his mother's functioning improved dramatically. His mother's depression began to lift, and she learned more effective ways of managing Johnny's behaviors and communicating with the school. Johnny was back in school full days and was able to successfully go on his class field trip. This would not have even been a consideration at the beginning of the year.

In May 2018 Johnny's mother completed a nursing program at the local community college. She started a new career as a nurse at a local hospital. She has been an advocate for the FCC program and attributes her family's success to Jennifer and the FCC program stating, "I don't know where our family would be without Jennifer."

The FCC program provides support to the whole family, who frequently needs as much or more than the child. These family supports were simply not available prior to the ILCHF grant and the development of the system of care, the CTC. The role of family care coordination has been sustained through multiple funding sources and has become an important resource for our communities.

**name changed to protect privacy*

Next Steps

CMHI 2.0

The mental health of a child is essential to and not separable from physical health as a determinant of a child's overall well-being. Research clearly demonstrates that children's healthy social and emotional development is a critical foundation for learning, school success, healthy relationships, and general well-being. These foundations are built prior to school entry. Knowledge of effective interventions for children's mental health has strengthened and expanded significantly in the past ten years through innovative approaches to system development, as well as early intervention and treatment. However, many Illinois communities have not yet been able to develop a coordinated service system necessary to implement these new evidence-informed practices for their local children and families. Supporting efforts to bring together a comprehensive, coordinated, and integrated community-based children's mental health system will ensure more children receive the effective support they need, as early as possible.

At CMHI 1.0's inception, ILCHF's Board of Directors indicated the possibility of funding a second cohort of communities, if the first investments resulted in significant changes in the communities. In August 2017, the Board authorized funding of up to \$10.1 million for the planning, implementation, and evaluation of the CMHI 2.0.⁹

ILCHF is committed to providing support for local communities that are dedicated to solving systems challenges that directly impact children's mental health. ILCHF recognizes the importance of both following the guidance of the evidence base and also allowing for the development of a service system that meets the unique needs of individual communities. Through CMHI 1.0, ILCHF has learned that the most effective means of impacting children and family's lives is to support the system of care at the community level. CMHI 1.0 produced impressive outcomes related to success integrating child-serving systems within the local community. CMHI 1.0 reduced the burden of emotional distress and mental illness and has largely sustained the services that were developed through the initial grant investment.

Being committed to sharing the learning from CMHI 1.0, ILCHF is funding a year-long learning collaborative for school districts to develop their mental health screening processes. ILCHF is partnering with the Quincy Public School district (QPS), a central partner in the Adams County CMHI 1.0 project, to lead this learning collaborative. QPS has an especially impressive and thoroughly developed screening process, which will serve as a model that other districts may learn from. QPS issued an application in November 2018 to identify five Illinois school districts to participate in this initiative, with a goal of implementing universal mental health screening in the districts. ILCHF will support both the training/consultation and costs to districts to participate. The learning collaborative will begin in February 2019.

ILCHF is also committed to continuing its investment in the Illinois children's mental health system through the support of CMHI 2.0, a second round of system of care development grants. Each selected community will have one year to develop a formal implementation strategy, coordinated governance, and a sustainable financial model. ILCHF will then award Implementation Grants to the communities that ILCHF determines have successfully developed sustainable plans to enable implementation of their community-based system of care over the course of a subsequent six-year period. ILCHF anticipates that within a period of seven years, these newly selected communities will serve as model communities to mentor other communities preparing to develop and/or enhance their own children's mental health system of care. In February 2018, ILCHF received 29 CMHI 2.0 applications

from communities across the state. ILCHF had planned on funding four new communities in CMHI 2.0. However, when the top five applications were very strong, the Board of Directors decided to increase the available funding to \$11.5 million for planning and implementation and \$1.1 million for evaluation over the seven years of the project.

In July 2018, ILCHF awarded planning grants to five Illinois communities to develop and implement a children's mental health system of care in their locations. The lead grantees and communities to be served are:

- *Centerstone*, serving Perry, Franklin, Jackson, and Williamson counties
- *Community Foundation of Kankakee River Valley*, serving Kankakee County
- *Heritage Behavioral Health*, serving Macon and DeWitt Counties
- *Kane County Health Department*, serving Kane County
- *Primo Center for Women and Children*, serving homeless youth and families in Chicago

We welcome these fine agencies and organizations into the participating partnerships of CMHI 2.0. We are excited to see what they can learn and then teach others about the quality, access, and provision of mental health care to children and their families.

ILCHF also conducted an RFP process for the CMHI 2.0 evaluation team. In August 2018, the Board of Directors awarded a \$1.15 million evaluation contract to the Children and Family Research Center at the University of Illinois, Champaign-Urbana.

MENTORING BY THE CMHI 1.0 GRANTEES

In 2017, the final year of implementation funding for CMHI 1.0, Foundation staff were designing and drafting the CMHI 2.0 Planning Grant RFP. The CMHI 1.0 grantees and their work were a vital source of information and wisdom during that process. Realizing that the CMHI 1.0 could be an invaluable resource to both the CMHI 2.0 applicants and the recipients of the CMHI 2.0 Planning Grants, ILCHF created the CMHI 1.0 Mentoring Grant initiative. Through this process, the four CMHI 1.0 communities applied for and received one year, \$75,000 grants to support both mentoring activities as well as the continued work of the project director. With their implementation funding ending in December 2017, ILCHF recognized the value in providing ongoing support for each community to utilize all the insights gained in their project.

During the CMHI 2.0 application process, Foundation staff connected applicants to the CMHI 1.0 grantees. The CMHI 1.0 grantee then provided consultation, sharing the insights gained in their work to help strengthen the new applications.

Following the announcement of the CMHI 2.0 Planning Grant recipients, the new communities were each paired with a CMHI 1.0 grantee to serve as their mentor. On September 14, 2018 the Foundation hosted the first CMHI 2.0 gathering, which brought together the five new communities, the CMHI 1.0 mentors, and Dr. Tami Fuller and her team from the Children and Family Research Center. The excitement in the room was palpable, as were concerns about the size, nature, and scope of the undertaking. However, following an inspiring day together, which included deep learning from Shannon Robshaw, MSW, of the TA Network, everyone left invigorated by the prospect of what these new communities can do to improve the health of their children and families.

Conclusion

As a result of CMHI 1.0, more than 40,000 children have been impacted by the work of hundreds of professionals committed to improving the health and well-being of children and their families. The work of the grantees has resulted in the increased identification and treatment of mental health problems facing so many children and families. There is clear evidence of a cultural and organizational shift in the CMHI 1.0 communities towards a coordinated, collaborative approach to children's mental health. CMHI 1.0 provided 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 initiative 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.

CMHI 1.0 has also reinforced and/or deepened the Foundation's understanding of several fundamental concepts in its role as a funder, including the following:

- **Planning grants are an effective tool in complex initiatives.** ILCHF provided 13-month planning grants (of approximately \$300,000) to each community because the Foundation understands the importance of allowing organizations to take the time to plan together. Participants have reported that this initial time and investment were vital to the subsequent changes in the communities.
- **Systems change takes time.** Relationship building takes time. The length of the ILCHF funding commitment must be matched to the level of ambition in the project being funded. The CMHI 1.0 projects were striving for large scale change in their children's mental health system of care, and the work took longer than anticipated. The original ILCHF five-year timeline was too short and had to be lengthened.
- **Flexibility and responsiveness to community needs are critical.** ILCHF learned that its original timeline of three years of implementation followed by two years of monitoring was too aggressive and unrealistic. Three years is not enough time to build robust sustainable systems. A deep partnership with the communities, evidenced by the Foundation's willingness to listen and respond to their experiences, resulted in additional grants of approximately \$550,000 to each community and a lengthening of the project implementation by two years.
- **Detailed documentation can soften staff transitions.** Due to the complexity and length of these projects, staff changes at both the Foundation and project level 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 in policies and management is most acute when project knowledge departs with the departing staff.
- **The sustainability of the system leadership position appears to be at risk.** Based upon current operations, it appears that the mental health services provided to the children and families through these projects will be sustained. However, in the absence of a change in the state's reimbursement or payment rules, it is unlikely that the project leader/system coordination role will be sustained once grant funding ceases. ILCHF is encouraging the 2.0 communities to solve this problem early on by including a local funder in the planning phase that is focused on this particular issue.

-
- **Clarity and cohesion are vital aspects of evaluation.** The CMHI 1.0 evaluation design engaged five separate evaluation teams to conduct the cross-site and local evaluations. This design was too complex to obtain all the hoped-for evaluation data. As a result, some questions about the impact of CMHI 1.0 cannot be fully answered by the data that was obtained. In CMHI 2.0, efficiently designed, single cross-site evaluation will be conducted.
 - **Consistent family and youth participation in project leadership helps overcome barriers.** CMHI 1.0 did not require a specific level of consumer family involvement in the leadership of the project, nor did it require the full array of the partnering child-serving systems to be at the table. The absence of some of these key stakeholders may have resulted in missing potentially useful input available to the communities as they went forward in their work. Some implementation barriers may have been avoided if all stakeholders were “at the table” from the beginning of the project.

The CMHI 1.0 communities are shining lights on the landscape of children’s mental health. ILCHF is profoundly grateful to our grantee partners for their commitment and perseverance to work together to continue to do what is best for the children in their communities in the face of numerous barriers and challenges.

The CMHI 1.0 communities are working every day to continue to improve the mental health of their children and families. 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 \$2.8 million over seven years, each of the four communities has been able to position its local system to more effectively respond to the mental health needs of its children.

Despite the efforts of thousands of professionals and families across the state, it is estimated that at least 130,000 Illinois children and their families are suffering from the effects of untreated mental illness.¹⁰ While we are excited to launch CMHI 2.0 and welcome the five new communities to this systems change work, there is still much to be done in order to improve access to and the provision of quality mental health services to our children. Based upon the 29 CMHI 2.0 applications we received, we know that there are at least 24 other communities across the state that brought together all of their key stakeholders to plan, write, and submit a CMHI 2.0 planning grant application. These communities have taken important first steps toward improving the mental health of their children and families. What can be done to help them move forward with their work? Imagine the improvements we might see across the state if each of those that are “shovel-ready” projects were funded?

In the years since CMHI 1.0 was launched, there is an increasing national trend to integrate care. While ILCHF is excited about and supports this momentum, the efforts of our grantees highlight the tangible challenges of creating, scaling, and replicating system of care models. By sharing what we’ve learned, we hope to inspire and encourage others to undertake this very important work to help develop effective, comprehensive care models that meet the behavioral health needs of children.

ILCHF’s vision is that every child in Illinois grows up healthy. We know that many families and professionals across this state share this vision. The Foundation invites you to contact us to learn more about this important, but difficult work, and to engage in leveraging what we, our grantee partners, and others have learned to date, so that we can move one step closer to our shared vision that *every child in Illinois grows up healthy.*



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Adams County Children’s Mental Health Partnership (ACCMHP)

<p>COMMUNITY SERVED¹</p> <p><i>Adams County is a rural county in West Central Illinois, with a population of approximately 66,988 and a geographic area of 855.2 square miles.</i></p> <ul style="list-style-type: none"> • 22.6% (15,139) under age 18 • 92.6% White, 3.7% Black, 1.4% Latino, 0.7% Asian • 14.4% persons below Federal Poverty Line • 78.5 persons/square mile 	<p>SYSTEM ENHANCEMENTS</p> <p>By the end of 2017, 41,542 child screenings were done.</p> <p>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.</p> <p>Primary care. All three primary care clinics adopted screening practices using the PSC, ASQ 3 and ASQ SE.</p>	<p>CHALLENGES</p> <ul style="list-style-type: none"> • Integrating mental health screening into individual primary care practices.
<p>PROJECT OVERVIEW</p> <p>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:</p> <ul style="list-style-type: none"> • 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. 	<p>SUCCESSSES</p> <ul style="list-style-type: none"> • Strengthened the mental health workforce so that it is capable of intervening with youth of all ages, especially the youngest children. • Fully integrated mental health services into primary care settings. • Established new partnerships among service providers, allowing the child-serving system to be more creative about how to solve community-wide problems. • Routinely screened children for mental health problems in both primary care and school settings, leading to earlier identification and intervention. • Encouraged conversations between parents and school and medical personnel about their children’s development and mental health. • Tracked the value and revenue generated by mental health staff in other settings, leading to these positions being sustained in schools and primary care. 	<p>SYSTEM PARTNERS</p> <p><i>Adams County Court Services Adams County Special Education Association Advocacy Network for Children All Our Kids Network Blessing Behavioral Healthcare Blessing Physician Services Chaddock Child & Family Connections Cornerstone Mental Health Authority–Education Committee Quincy Medical Group Quincy Public Schools SIU Family Medicine Transitions of Western Illinois United Way of Adams County</i></p>
<p>¹ United States Census, <i>State & County Quickfacts</i>, “Adams County, Illinois.” Accessed August 5, 2015. http://quickfacts.census.gov/qfd/states/17/17001.html</p>		

Community That Cares (CTC)

COMMUNITY SERVED^{1, 2, 3, 4}

Carroll, Lee, Ogle, and Whiteside Counties are four rural counties in Northern Illinois, with a population of approximately 158,411 and a geographic area of 2,612.5 square miles.

- 22% (35,467) under age 18
- 87.4% White, 2.2% Black, 8.7% Latino, 0.6% Asian
- 11.6% persons below Federal Poverty Line
- 60 persons/square mile

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.

SYSTEM ENHANCEMENTS

By the end of 2017, 58,058 child screenings were done.

Schools. Twenty-eight of the 87 schools in the four counties offer social/emotional screenings. A school work group helps schools establish social/emotional screening protocols. The school work group also assists the schools to 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 staff participate in the CTC steering committee.

SUCCESSES

- Mental health services for children and families are more accessible, being available in primary care clinics and schools, in addition to the mental health agency.
- Schools are more integrated into the larger system of care and more aware of the effect of children's mental health on their learning.
- Child-serving agencies that were once competitors are now partners and advocates for each other.
- Community providers partnered together to apply for and receive large federal grants.

CHALLENGES

- Four counties make for a very large service area and it was difficult for the project director to manage all the components. The solution was to engage 'community coaches' in primary care, schools, and family services who led the efforts in each sector.
- Leadership staff turnover during year three of the project was disruptive, but has since been stable.

SYSTEM PARTNERS

Over 100 individuals, faith-based organizations, primary care providers, businesses, schools, and child-serving agencies participate in CTC, including:

DCFS

County Health Departments

Lee and Ogle County
Probation Departments

Early Steps Right Steps

Florissa/Krieder Services

Rock Falls, Sterling, Oregon,
Ashton/Franklin Center, Morrison,
Eastland, and Dixon School Districts

All Our Kids Network

Lutheran Social Services

Children and Family Connections

Sauk Valley Chamber of Commerce

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)

COMMUNITY SERVED¹

Livingston is a rural county in Central Illinois, with a population of approximately 37,903 and a geographic area of 1,044.3 square miles.

- 25.0% (9,500²) under age 18
- 88.5% White, 5.4% Black, 4.4% Latino, 0.6% Asian
- 10.3% persons below Federal Poverty Line
- 37.3 persons/square mile

PROJECT OVERVIEW

The Livingston County Children’s Network (LCCN) comprises 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.

SYSTEM ENHANCEMENTS

By the end of 2017, 56,384 child screenings were done (72% of positive screens received follow-up services) and 4,956 children received services through community mental health centers.

Schools. Screenings and social-emotional curriculum are implemented in all 27 elementary attendance centers. Ninth graders in all six high schools receive mental health screenings, with two of these schools also screening higher grade levels.

Primary care. Nearly all children have a medical home. Twelve of the 18 medical practices across the county administer mental health screenings.

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.

SUCCESSES

- Earlier identification of at-risk youth developing social/emotional disorders.
- Increased access to mental health services in natural settings, such as schools and primary care clinics. Twice as many young people are receiving mental health care as they did at the start of the project.
- Improved coordination of services across child-serving systems. This culminated with a universal release of information document used by all the systems to make sure providers can communicate with each other so that children don’t “fall through the cracks.”

- Better pooling of community resources so that all the child-serving systems could benefit from them.
- Increased focus on supporting parents in taking care of their children.
- Sharing community level data reports across providers.

CHALLENGES

- Recruiting and retaining staff in the rural community.
- Implementing mental health care in schools and primary care settings due to some conflicting priorities.
- Tracking children’s progress over time.

SYSTEM PARTNERS

Livingston County Special Services Unit
 Livingston County Mental Health Board
 Livingston County Board for the Care & Treatment of Persons with Developmental Disabilities
 Regional Office of Education for DeWitt, Livingston, Logan, and McLean Counties
 A Domestic Violence & Sexual Assault Service
 Livingston County Probation/Court Services
 Livingston County Commission on Children & Youth
 Institute for Human Resources
 OSF Healthcare Systems, Resource Link
 Livingston County Health Department

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

<p>COMMUNITY SERVED¹</p> <p>Springfield is an urban center in Central Illinois, with a population of approximately 116,809 and a geographic area of 59.5 square miles.</p> <ul style="list-style-type: none"> • 22.0% (26,000²) under age 18 • 74.7% White, 18.0% Black, 2.0% Latino, 2.2% Asian • 17.6% persons below FPL • 1,954.4 persons/square mile 	<p>SYSTEM ENHANCEMENTS</p> <p>By the end of 2017, approximately 40,000 child screenings were done and 11,293 children received services.</p> <p>Neighborhood. In partnership with The Springfield Project (TSP), MOSAIC provides mental health and professional development services in the city’s Neighborhood of Hope.</p> <p>Primary care. Two of the city’s four large physician groups are part of MOSAIC—SIU School of Medicine’s Center for Family Medicine and Memorial Physician Services.</p> <p>Schools. Eleven of the 31 District 186 schools participate, as do other youth-serving organizations’ after school and summer programs.</p>	<p>SYSTEM PARTNERS</p> <p>Mental Health Centers of Central Illinois (Memorial Behavioral Health) Springfield Public School District 186 The Springfield Project Southern Illinois University School of Medicine City of Springfield Community Foundation for the Land of Lincoln University of Illinois Springfield United Way of Central Illinois The Greater Springfield Chamber of Commerce Sangamon County Continuum of Learning Springfield Urban League Boys and Girls Clubs of Central Illinois Sangamon County Public Health Department Memorial Physician Services</p>
<p>PROJECT OVERVIEW</p> <p>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:</p> <ul style="list-style-type: none"> • 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. 	<p>SUCCESSSES</p> <ul style="list-style-type: none"> • Closer working relationships among the child-serving providers. • Integrating behavioral health into primary care settings. • Increased access to mental health services. • Earlier identification of children at-risk or with behavioral health concerns. • Decrease in stigma in the community, related to mental health problems. 	<p>¹ United States Census, <i>State & County Quickfacts</i>, “Springfield (city), Illinois.” Accessed August 5, 2015. http://quickfacts.census.gov/qfd/states/17/1772000.html</p> <p>² D. Racine, <i>MOSAIC Local Evaluation Report</i>. 31 May 31, 2015.</p>
	<p>CHALLENGES</p> <ul style="list-style-type: none"> • Collecting and tracking data across schools, primary care, and the mental health system. • Retaining mental health staff. 	



Appendix B

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The Foundation is grateful to and celebrates the grantees and stakeholders of CMHI 1.0 for the work they do every day to improve children’s mental health in Illinois. The extent of the system improvement and overall learning from CMHI 1.0 is a result of their hard work and candor in sharing insights into what went well, as well as what was challenging. We would like to specifically acknowledge the leadership of the following individuals at each CMHI 1.0 community:

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NOTES

1. Ronald C. Kessler, PhD; Patricia Berglund, MBA; Olga Demler, MA, MS; Robert Jin, MA; Kathleen R. Merikangas, PhD; Ellen E. Walters, MS (2005). 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. <http://archpsyc.jamanetwork.com/article.aspx?articleid=208678&resultclick=1>
2. Weitzman et al. (2015). "Promoting Optimal Development: Screening for Behavioral and Emotional Problems." *American Academy of Pediatrics* 135(2).
3. Any Disorder Among Children. (n.d.) Retrieved July 16, 2015, from <http://www.nimh.nih.gov/health/statistics/prevalence/any-disorder-among-children.shtml>
4. Merikangas, Kathleen Ries 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. PMC. Web. Retrieved July 16, 2015 from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2946114/>
5. Weitzman et al. (2015). "Promoting Optimal Development: Screening for Behavioral and Emotional Problems." *American Academy of Pediatrics* 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. Warfield, M. E. (June 2006). *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
8. Stroul & Friedman, 1986; 1996; Stroul, 2002; Stroul, Blau, & Sondheimer, 2008; https://gucchdtcenter.georgetown.edu/resources/Call%20Docs/2010Calls/SOC_Brief2010.pdf
9. The CMHI 2.0 RFP and associated documents are available at www.ilchf.org
10. Illinois Children's Mental Health Partnership 2017 report to the Governor

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