Livingston County Children's Network

System of Care Development and Implementation Manual

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serving Livingston County

Illinois Children's Healthcare Foundation

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Introduction

The Children's Mental Health Initiative, Building Systems of Care, Community by Community (CMHI) projects funded by Illinois Children's Healthcare Foundation (ILCHF) represent diverse communities and therefore reflect diverse care systems. Though the systems are different, each community has attended to a similar set of processes to develop their system to where it is today.

This manual, a requisite project element, highlights the methods this community engaged in to develop their unique care system from the initiation to the conclusion of ILCHF funding. Each of the four community manuals include descriptions of the collaborative activity among the mental health, education, medical, and other community stakeholder systems. Each area represented potential barriers and innovations in the system. These processes reflect varying levels of adherence to the Child and Adolescent Service System Principles (CASSP).

1.0. Planning

Livingston County is the fourth largest county in landmass in Illinois, spanning 1,034 square miles of geography. The population is ~40,000 with slightly over 50% of the population living in rural areas. Pontiac, the county seat, is home to the only hospital, mental health center, and health department.

1.1. Vision

During a Leadership Institute hosted by NTI in August 2010, after a brainstorming session, three members of the Leadership Team were asked to go into a separate room for ten minutes and attempt to integrate the ideas that had been generated into a coherent "vision statement." The authors understood that this statement could be revised over time; however, the community never found the need to do so. There were several ideas that were important: 1) that families, regardless of their zip codes, would access and value services; 2) a comprehensive continuum of services would be available to prevent, identify, intervene, and treat; 3) that the initiative and services would not just be viewed as appropriate for youth with identified mental health disorders, and 4) that efforts would result in stronger protective factors and reduced risk behaviors.

> Families all across Livingston County will utilize and value a comprehensive continuum of services to promote children's social and emotional development, which will, in turn, effectively reduce at-risk behaviors and strengthen relationships.

1.2. Goals

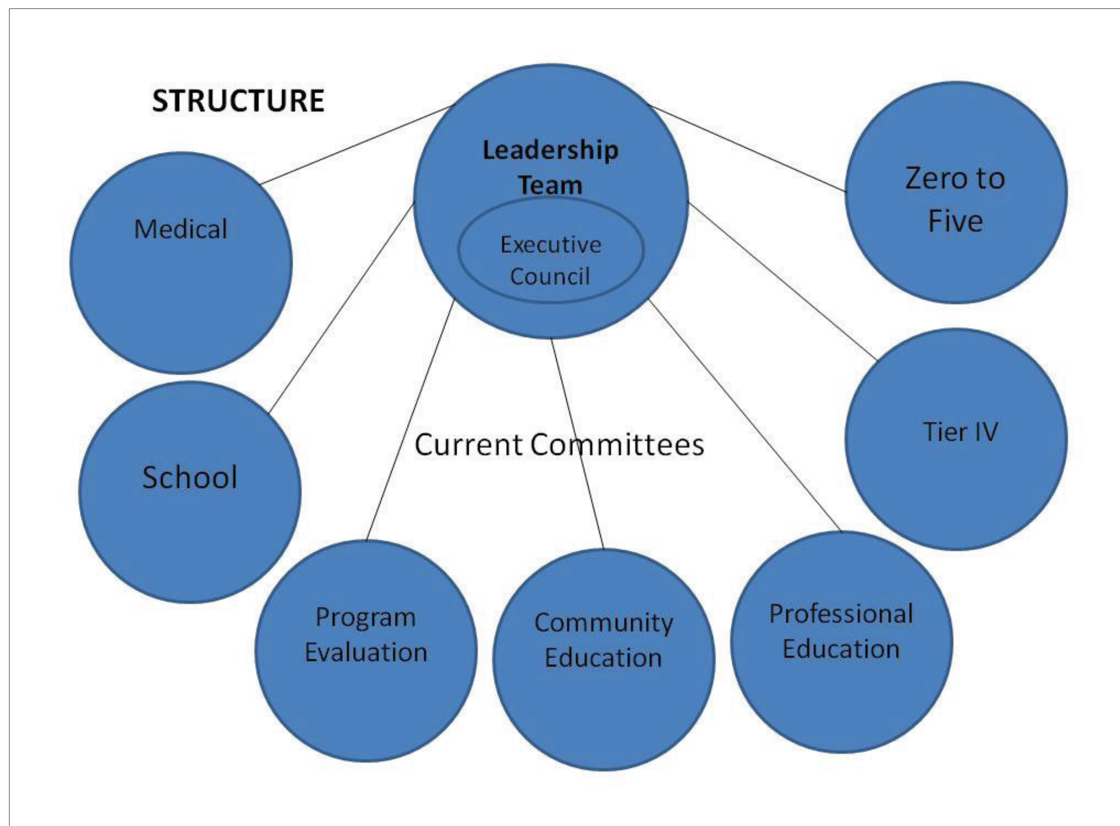
Concerns identified by key informants and stakeholders throughout the planning year were surprisingly uniform and also consistent with those raised by members of the Leadership Team. The following are the four goals developed by the Leadership Team, which were implemented and measured throughout the grant period.

1. **Increase capacity of system of care**
   - A. Increase workforce to meet needs
   - B. Increase skills of current personnel
   - C. Fill identified service gaps
   - D. Identify funding sources
2. **Increase accessibility of services**
   - A. Identify barriers to utilization
   - B. Decrease stigma barrier
   - C. Decrease financial barrier
   - D. Decrease transportation barrier
   - E. Increase awareness of services and how to access them
3. **Increase coordination of services**
   - A. Promote linkages to the medical home
   - B. Increase likelihood of successful transition from one setting/provider to another
   - C. Increase collaboration between providers serving same clients
   - D. Utilize data to evaluate process and outcomes
4. **Decrease rates of risk behaviors and frequency and severity of mental disorders**
   - A. Promote child and adolescent social-emotional skill development
   - B. Nurture protective factors (e.g., adult-child relationships and school engagement)
   - C. Identify and support at-risk children and adolescents

2.0. Governance structure: decision-making and oversight at the system level

At the conclusion of the planning year, in August 2010, the findings of our initial needs assessment were presented to the Leadership Team, NTI and ICHF at The Leadership Institute, which resulted in our developing our vision statement and reviewing in a condensed fashion, the strengths and weaknesses of our continuum of care for each age group of children and youth.

After the Leadership Team reviewed the aggregate action plan and reached an ideological consensus, about what was being proposed, the executive directors of all nine entities who were likely to experience, at an organizational level, human resource and fiscal ramifications, came together to form the Executive Council. The purpose was to have an administrative body that could negotiate these more sensitive matters that would ultimately undergird the success of the systems-level changes. The Executive Council consisted of the designated decision-making authority of each of these organizations, the individuals who had to answer to the respective boards. The Executive Council was partially born to provide a place for these administrators to talk more openly about their doubts and fears, to be skeptical without dampening the enthusiasm and hope of the larger Leadership Team. Even so, the project director also met individually with each of the members to solicit their frankest assessment of the action plan, their perceptions of its impact on themselves, their employees, and their organizations, a process that allowed her to more completely understand the system within its historical context. From that point on, the Executive Council came together regularly to collaboratively and confidentially make decisions based on a common vision for the children's mental initiative. The seven work groups also began to meet regularly to implement those of the action steps that had now been adopted as part of the larger LCCN Implementation Plan.



The success of our initiative rested on the frequent and active engagement of the work groups. The Project Director chaired the bulk of these sessions. In the spring of 2016, the LCCN Executive Council met to discuss the transition of leadership by embedding the workgroups into the existing community infrastructure. The Project Manager, employed by the special education cooperative, began coordinating the combined Professional Education/Community Outreach meeting. She was asked to continue the bi-annual Leadership Team meetings. The Project Director continued to provide clinical consultation to the bi-weekly Comprehensive Inter-disciplinary Assessment staffings, compile the annual local evaluation, and keep community members informed of system developments. She committed to contribute to the agendas of the "work group" meetings and attend, as she was able, until December 31, 2017. The remaining "work group" meetings were as follows:

- Executive Council integrated into Livingston County Youth Commission (Mondays)
- Medical work group integrated into OSF Pediatric Council (Tuesdays)
- Zero-to-Five work group integrated into Local Interagency Council (Tuesdays)
- School work group integrated into LCSSU Articulation Meetings (Fridays)
- Tier IV work group integrated into Comprehensive Interdisciplinary Assessment Team (Fridays)

The most difficult transition involved shifting the administrative and budgetary oversight to a local entity. The Livingston County Commission on Children and Youth (LCCCY), a local 501c3 was selected to serve in this role. The LCCCY is a comprehensive community-based youth services provider in Livingston County. The board is made up of agencies from throughout the county that serve children and youth. In addition, there are student representatives from each high school. Programs operated by the LCCCY include the Youth Initiative Program, which provides crisis intervention for runaway children and youth, as well as follow-up services. Youth who cannot return home are placed with relatives or in licensed foster homes until the crisis can be resolved. "Children First" is an educational program for divorcing couples who have minor children. This program, which is mandatory throughout Illinois, teaches the effects that divorce can have on children. Other programs of the LCCCY include Unified Delinquency Intervention, Family Centered Service, Extended Family Support, Illinois State Board of Education, System of Care, and Local Area Network programs that include mentoring and advocacy for children and youth. The LCCCY also provides funding for all of the Boys and Girls Clubs in Livingston County and the Alternative School. The LCCCY comprises many of the same leaders as those on the LCCN Executive Council. In addition, by virtue of being a non-profit organization, it was able to create a cost-center for the LCCN to receive donations and secure grants. The transition was set to occur at the same time that the Executive Director of the LCCCY, a woman who also served as the Executive Director of the Livingston County Mental Health Board, was set to retire. ILCHF's decision to offer a year of Sustainability Gap Funding was an excellent opportunity to make the transition. The ISU-based Project Director wrote the grant and collaborated with the Executive Director of the LCCCY to administer the grant, including subcontracting with and disseminating funds to the local providers. The Mentoring Year RFP was handled similarly.

RESOLUTION POLICY: ADMINISTRATIVE

LCCN administrators have a long history of working together to reach consensus around serving the children of the county. Members of the Executive Council have demonstrated great respect for one another's contributions and continue to express a common set of values that guide decisions. When conflicts arise, they consider: 1) what will best serve the needs of children, 2) what will best serve the overall system, 3) what will best serve the personnel at their respective institutions, and 4) what will best serve the administrative needs of their respective institutions. Having never encountered a situation where these values have not ultimately led to a consensus, it is difficult to articulate, in the abstract, steps that would be utilized to resolve conflicts.

1. Each party articulates his/her position in writing and shares it with the members of the Executive Council.
2. Members of the Executive Council seek consultation from the literature and their professional organizations regarding accepted practice in similar situations.
3. If, after a discussion of the additional information, a consensus cannot be reached, a simple majority vote will determine the outcome.
4. All parties agree to fully support the decision of the Executive Council.

AGENCY ACCOUNTABILITY

The Executive Council convenes in late November, early April, and late June of each year to review data presented by representatives from each sector. Formative assessments provide feedback on the fidelity with which LCCN protocols are being utilized across settings, and outcome data provide evidence of the effectiveness of the interventions. Modifications are considered as protocols and are fine-tuned over time. When programs are being conducted according to expectations, both administrators and clinicians receive positive feedback in the form of verbal, written, and tangible appreciation. In addition, when data indicates that one or more of the institutions are not fulfilling the obligations outlined in their Memoranda of Understanding, Executive Council members hold one another accountable and generate strategies for remedying the situation prior to the next data review session.

3.0. System management: day-to-day decision-making

Project Director Brenda J. Huber, PhD

During the funded period, the Project Director, an employee of Illinois State University, had primary responsibility for budget management, quarterly reports, and coordination between members of the LCCN. The Director also oversaw all aspects of the grant implementation, including professional development, community/parent involvement, data collection/evaluation, and consultation regarding clinical and legal/ethical concerns. She chaired meetings of the Leadership Team and work groups, which included:

- Developing team meeting agendas
- Arranging the place and time for team meetings
- Seeing to it that minutes were kept and distributed
- Identifying implementation problems and opportunities
- Coordinating the training and technical assistance efforts with the CMHI consultants
- Recruiting people to the various meetings and training events
- Maintaining a relationship with participating community members
- Disseminating process and outcome data for both the local and cross-site evaluation
- Representing the team to the ILCHF Board of Directors, its staff, and its consultants.

Project Manager Kristal H. Shelvin, PhD

The Project Manager, an employee of Livingston County Special Services Unit, provided leadership in all school-based aspects of grant implementation including, but not limited to:

- Laying the groundwork for the three-tiered model for promoting social-emotional learning
- Coordinating professional development to administrators/teachers
- Launching a series of family involvement components
- Providing meta-coaching to school psychologists and social workers who coach teachers regarding implementation of universal curricula and universal screening
- Assisting administrators in generalizing knowledge to the larger school community
- Reviewing multi-informant screening data, communicating with relevant parties, and participating in decisions regarding stepping students up to Tier II

- Participating in school-wide data collection and making presentation of data to the LCCN Leadership Team
- Coordinating implementation of LCCN policies and procedures as they relate to Tier I
- Coaching school psychologists and social workers regarding selection and implementation of evidence-based targeted interventions and progress monitoring protocols
- Periodically reviewing student progress by monitoring data, communicating with relevant parties, and participating in clinical decisions regarding intervention planning
- Participating in data collection and making presentation of data to the LCCN Leadership Team
- Coordinating implementation of LCCN policies and procedures, as they relate to Tier II

4.0. Services

4.1. Service array (types of services allowable, for whom, and under what conditions)

The description that is included here appears on the LCCN website at www.lcchildrensnetwork.org.

ZERO- TO FIVE-YEAR-OLDS

Screening. Children in this age group are screened for developmental and social-emotional delays at the Health Department as part of WIC and Family Case Management Programs (815.844.7174), at OSF Early Intervention Program (815.842.2828), during well-child visits with their doctor, and at the Livingston County Special Services Preschool Screenings (815.844.7115).

Services. Children who screen positive may be served through Head Start, day care and preschool programs, OSF Infant-Toddler Enrichment, and At-risk Pre-K programs. Children who are delayed 30% or more are served through Child and Family Connections and Early Childhood Special Education. In each of these programs, children's progress can be regularly monitored and supports to child and family adjusted, as needed.

Additional services

- Publicly available information on parenting and child development
- Screening in doctors' offices
- Coaching on how to address common parenting problems—doctors' office or Institute for Human Resources (IHR)
- Parent-child services to foster strong, healthy bonds
- Training and resources for day care providers
- Screening and connecting expectant parents and their infants to supports
- Comprehensive assessment and mental health services for young children with psychiatric diagnoses
- In-home coaching for parents of children having emotional and/or behavioral difficulties

SIX- TO 13-YEAR-OLDS

Services. Elementary and junior high students receive counseling in school when referred by a parent or educator; counseling is often provided by a school psychologist or social worker assigned to the child's building from Livingston County Special Services Unit (815.844.7115). In addition, parents often seek therapy services for children at the IHR (815.844.6109).

Additional services

- Training for educators to identify and address students' social-emotional difficulties and improve school climate
- Teacher-delivered classroom curriculum to promote children's social-emotional development
- Coaching on how to address common parenting problems (doctor's office or IHR)

- Training and resources for child care providers, athletic coaches, and clergy
- Screening in schools (teacher report and student report) and doctors' offices (parent report and adolescent report)
- Small group intervention in schools for children identified as at-risk on the screeners
- Comprehensive assessment and evidence-based treatments for children's mental health needs provided in convenient locations (e.g., school, home, community)
- Treatments that involve participation of important adults in the child's life
- In-home coaching for parents of children having emotional and/or behavioral difficulties

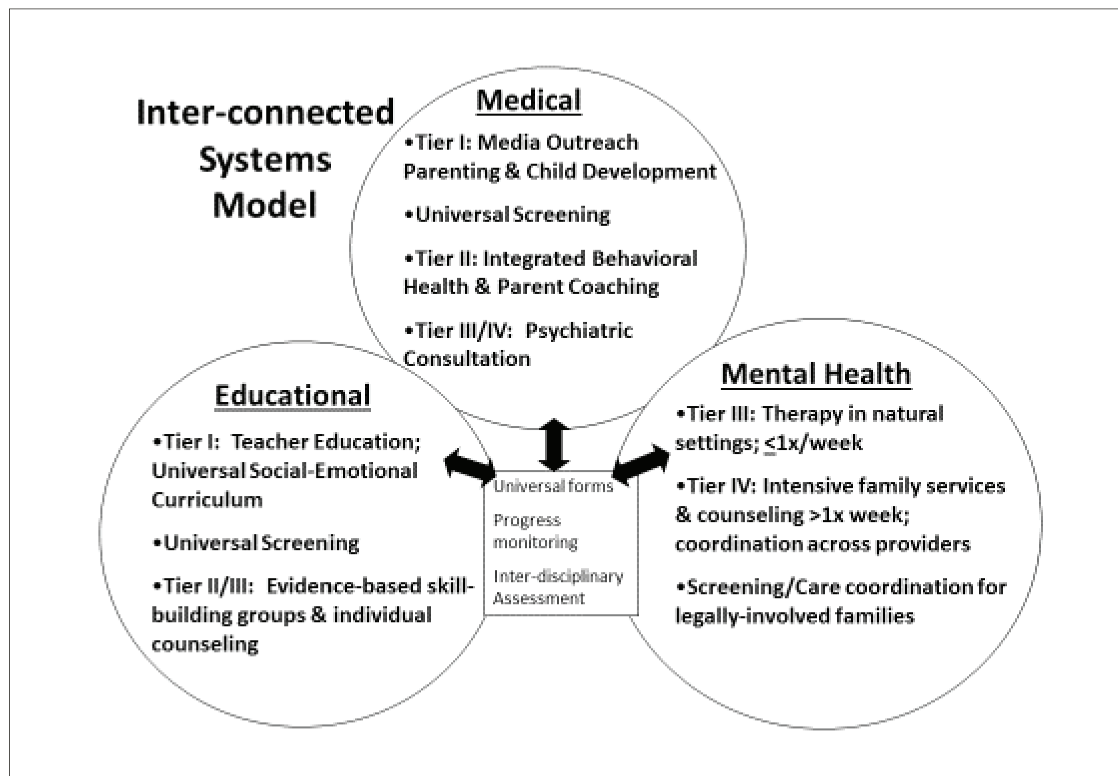
14- TO 18-YEAR-OLDS

Services. High school students receive counseling in school when referred by a parent or educator; counseling is usually provided by a school psychologist or social worker assigned to the child's building from Livingston County Special Services Unit (815.844.7115). In addition, parents often seek therapy services for children at the IHR (815.844.6109).

Additional services

- Training for educators to identify and address students' social-emotional difficulties and improve school climate
- Developing school-based mental health satellites in county high schools to provide: screening for anxiety and depression, small groups to teach coping strategies and decrease symptoms of depression/anxiety, individual therapy for students with identified diagnoses
- Training and resources for child care providers, athletic coaches, and clergy
- Comprehensive assessment and evidence-based treatments for children's mental health needs provided in convenient locations (e.g., school, home, community)
- In-home coaching for parents of children having emotional and/or behavioral difficulties

4.2. Provider network



Most interventions for 3- to18-year-olds are received within the educational sector. Teachers play an important role in children's social-emotional development. In preschool programs, teachers have been trained in Circle of Security concepts and infuse attachment-promoting strategies in the classroom, as well as in their work with parents. Teachers of Pre-K through 8th grade students have been trained in Positive Action, an evidence-based curriculum delivered by the classroom teacher. In high schools, no one curriculum has been adopted; several different curricula are used at the discretion of the school-based mental health team. Among them are Signs of Suicide, Strong Teens, and Mindfulness. In addition, there are several universal intervention programs conducted by non-school providers in schools; these include Second Step/ Steps to Respect, Healthy Relationships and Drug/Alcohol Prevention.

Nearly all students enrolled in public schools are screened each fall; youth in private schools and some grades in some high schools are not regularly screened. Students are also screened in primary care and the juvenile court. Following a positive screen, many students receive evidence-based group or individual therapy in schools (See Evidence-Based Practice 4.4). These services are provided by **school psychologists, school social workers, school counselors, interns or embedded IHR therapists**. Embedded IHR therapists and psychology interns provide integrated behavioral health and therapy in primary care practices (including Obstetrics and Gynecology) and some services are provided in other community settings, such as churches and libraries; often parent consultation or dyadic work occurs. Our **Family Resource Developer** provides in-home parent coaching to our highest need families.

Most interventions for children ages 0-3 occur within the home, with some clinic-based interventions provided by the Health Department, OSF St. James Hospital's **developmental interventionist**, primary care practices, or IHR. Parents who deliver their babies through OSF Healthcare System receive access to The Newborn Channel and a **Nurse Navigator**. Several primary care practices have **mid-level healthcare providers** trained in Positive Parenting Program (Triple P).

A Comprehensive Inter-Disciplinary Assessment (CIA) team was developed to address a gap in the service system for assessment. A core team, comprising the **individuals coordinating care across the four sectors, the Project Director, a clinically licensed school psychologist (Beth Casper, PhD), the Family Resource Developer, and a representative from DCFS, collaborate with the team of professionals serving the identified youth and family, including probation officers, therapists, and school providers** to compile information about the strengths, needs, and services the youth has received and create a coordinated treatment plan. On occasion, additional psychological testing is desired, and Dr. Casper administers, analyzes, and integrates the results of these assessments with existing information.

4.3 Meeting basic needs

This area is one that has not been prioritized within the children's mental health initiative. Families screened within the court system who have unmet basic needs are often referred to existing resources in the community, including the town steward or churches. The Mental Health Board also frequently supports families with service-related costs (e.g., gas cards).

4.4. Evidence-based practices

Evidence based practices (EBPs) were promoted across all tiers of our system of support and infused into the sectors where children spend the most time. As the place where children spend the bulk of their waking hours, a Tier I Intervention was delivered in schools. Following a needs assessment, a cadre of community members, teachers, administrators, and school-based clinicians performed an extensive review of four evidence-based practices. This SEL Parent-Teacher Advisory Committee rated the four EBPs on program design, the availability of implementation supports/tools, the focus on climate development, and empirical evidence. Positive Action's curriculum is scoped by grade level, delivered in a sequence of six units, and spirals such that topics are discussed at increasing developmental levels each year. Additionally, it was

developed to be taught by teachers. The committee determined that a curriculum delivered by teachers would increase school-based clinicians' availability to address service needs at Tier 2 and higher. Following this extensive review, the team adopted the Positive Action curriculum as the Tier 1/universal curriculum to be delivered countywide. This universal curriculum was delivered in grades Pre-kindergarten through 8th. Additionally, Positive Action provides supplemental curricula for special community or school concerns. Thus, there was an opportunity to provide continuity of care in the event that a child required a Tier 2 intervention.

The Positive Action curriculum also allowed for parents and administrators to be involved in the delivery of a social-emotional learning curriculum. While the teachers delivered the curriculum in their classrooms, principals were equipped with a Positive Action Climate Development kit. This kit allowed the language and principles of Positive Action to permeate the building and improve the school climate. Additionally, the included parent letters introduced Positive Action language and principles to parents. We expected that saturating the community with Positive Action language and principles would significantly improve the students' social-emotional functioning.

An evidence-based universal parenting curriculum was initiated with limited success. Community mental health providers and primary care physicians were trained to deliver the Positive Parenting Program (Triple P). Our initial plans included primary care providers (PCP) sharing the Triple P principles during office visits. For example, if the parent of a toddler mentioned difficulty with the child's nighttime routine, the PCP would give the parent a tip sheet that included a list of problem specific evidence-based suggestions. During subsequent appointments with the parent, the PCP would check in with the parent and provide additional suggestions and a referral to meet with a therapist. During the implementation phase of Triple P in our community, there were very few parents who returned for subsequent consultation. It may have been that their needs were met with a single visit; however, no data is available to confirm this. Further, the PCPs found it difficult to add the Triple P discussions into their workflow. After a year, further training and development of the Triple P implementation was discontinued. The counselors and PCPs who were trained initially continue to be equipped to discuss the tips with parents in a less formal manner.

Tier 2 services included delivering social emotional curricula in small groups. These groups often included more in-depth discussion and practice with the universal curriculum, Positive Action, or the addition of a dose of Second Step (a more targeted social-emotional curriculum), WhyTry (a motivational curriculum), or Coping with Stress. Once the child/adolescent has received the course of treatment, his or her needs are re-assessed. If additional support or instruction is needed, he or she would receive a Tier 3 intervention. School-based providers generated a list of the top seven referral concerns in schools; one evidence-based curriculum to address each of those seven needs was purchased that was developmentally appropriate to all grades (See Attachment Three). Clinicians in our schools and community mental health centers delivered the Tier 3 services to children and youth. In addition to using Positive Action, school-based clinicians received professional development in skill specific practices, such as mindfulness.

At Tier 3, mental health services were delivered in the context of individual therapy, including consultation with parents and teachers or dyadic therapy, when possible. At Tier 3, we sought to coordinate evidence-based practices used in school and the community mental health center because many youth were being served in both settings. Accordingly, we began collaborative professional development around common concerns in the area. Our most significant concern was treating children who had experienced trauma. Each year as we completed our local evaluation, we assessed the need to build capacity among our local clinicians. We were well aware of the difficulty of recruiting a significant number of new clinicians. Rather, we focused attention on building capacity in our current clinicians. Through a series of professional development opportunities, we prepared clinicians for delivering interventions to treat depression, anxiety, and the impact of trauma in children and youth. When we determined the need for additional services for our youngest children, we sent our local developmental therapist and one IHR therapist for training in

TheraPlay. Several other IHR therapists were trained on Eye Movement Desensitization and Reprocessing (EMDR).

Grant funds were used to purchase 40 manuals, one for each treatment provider, to guide the development of trauma-informed practices. This manual, *Treating Traumatic Stress in Children and Adolescents* (Blaustein and Kinniburgh, 2010), forms the framework for our treatment of children and adolescents. This was part of our continued effort to coordinate services and develop a system of care for children based on some common understandings of children's' development and response to trauma. In addition to purchasing the books, the LCCN project staff coordinated book discussions to ensure full understanding of the framework shared in the book. The Attachment, Regulation and Competency (ARC) framework has become the lens through which we treat children who have experienced trauma in our county. As trainees provide a substantial amount of therapy in the schools and in integrated behavioral health practice in the medical setting, they receive a copy of the manual. As new licensed clinicians are hired, they receive a copy of the book and are invited to the annual book discussion.

At Tier 4, we move from individualized support to providing services to the family unit. The family unit receives services in a model based on the wraparound framework. All service providers involved with the family are engaged in regular clinical consultation meetings to develop a coordinated plan of care. These plans included evidence-based assessment and treatment recommendations from professionals from the medical, social work, psychology, education, juvenile justice, and child welfare fields. These professionals modify their respective treatment plans based on the coordinated plan developed within the group.

4.5. System access

The community has successfully increased access to services. In schools, 94% of elementary children are in classrooms with a teacher trained in Positive Action and equipped with the evidence-based curriculum. Implementation continues to vary; however, 66% of teachers report being in the Action or Maintenance stage in their readiness to adopt their new role as instructors of social-emotional learning. Students receive an average of 25 lessons per year, which is considered by the publisher to be the bronze level of fidelity.

The community mental health center, the Institute for Human Resources, served nearly three times as many children and adolescents in 2015 than in 2011 (1,266 vs. 464). More parents of 0-5-year-olds and 6-18-year-olds have accessed parent consultation and support with increases of 2.8 and 2.1 times the baseline rate, respectively. Since our DHS office closed, the Livingston County Health Department has helped more families access Medicaid and other health insurance. The number of special education students on Medicaid increased from 470 in 2011 to 651 in 2015 but decreased to 416 in 2016. Increased access to services is due in part to the community's efforts to place providers in natural settings, such as home, church, doctors' office, library, park, and school to overcome stigma, finances, and transportation. For example, there are part-time clinicians in nine primary care practices. Therapists employed by schools, mental health center, courts, and primary care now have tablets to assist clients in accessing on-line resources.

We know that we can have the highest quality services and plenty of providers and still not make a difference for children who are struggling, if adults in their lives are not able, or choose not, to access supports when they are needed. The literature on rural health describes numerous barriers faced by families living in sparsely populated regions. We have drawn ideas from many of these resources, as well as reflecting on lessons learned in the community with previous efforts to support the provision of health services.

Identify barriers to utilization. During intake, families are routinely asked about any anticipated barriers to treatment utilization and these data are gathered by the Project Director quarterly. No one has mentioned stigma directly, but the literature suggests it is often a large barrier in rural areas. People who have accessed medical care and the Resource Link Care Coordinator do not report barriers to services; they may state that they don't want the schools to know their child's problems (i.e. stigma) or report a prior

bad experience with treatment as reasons for not pursuing treatment in the community. It appears that many families with more means go to cities outside the county, where there is more variety of specialty care providers. In the 0-5 population, the most common population to report concerns about accessing services, are families who face language barriers or are not US citizens. Families in the court system, though, typically list many stressors associated with basic survival that have prevented them from accessing Tier I, II, and III level services. Many children reside with individuals who are not their guardians, which makes it challenging to secure parental consent for services. Other barriers include lack of housing, phone, transportation, income, physical safety, and natural supports. With no homeless shelter, it is difficult to stabilize these families and meet basic needs. As we identify and attempt to treat the mental health needs of many of these traditionally underserved families, we are generating additional referrals for other community resources. It has, at times, felt as if we are overwhelming these social services and charitable organizations, as the extent of the needs in the community becomes more apparent.

As part of the longitudinal cross-site study of children ages 2.5-19 years with positive screens, we have assessed parents' perceptions of stigma. Baseline data, from 61 parents, suggest that parents' own perceptions are remarkably positive for personal feelings, thoughts, and behaviors regarding mental illness. In contrast, their perceptions of how others respond to someone with mental illness were significantly different from, and more negative than, their own feelings, thoughts, and behaviors. Also, the more negatively they viewed their own family member with mental health concerns, the more negatively they perceived others to view individuals with mental health concerns. Parents with more agreeable personalities tended to be less negative in their thoughts and behavior and feel closer to their family member with mental health concerns. In contrast, parents who were more emotionally unstable and more likely to experience unpleasant emotions, such as anxiety, sadness, anger, were more likely to have negative thoughts and feelings toward their own family member. These respondents may not be representative of all parents in the community as they are: 1) parents of children with positive screens, and 2) parents who chose to participate in longitudinal data collection. A small sample of parents have completed the measures at multiple points over time. So far, the parents' self-reported stigma and their perceptions of others' stigma regarding mental health has not changed. This lack of change may be due to the small sample size, which does not provide adequate statistical power to detect effects, or due to the relatively brief period of time that the perceptions have been monitored. One would expect that perceptions such as these would likely be slow to change.

We wanted to better understand the role that stigma plays in the lives of Livingston County youth. Stigma by association (SBA) represents the process through which the companions of stigmatized persons are discredited (Pryor, Reeder, and Monroe, 2012). In other words, SBA refers to the extent that students who have a friend or family member with a mental health problem feel disrespected, as well. Previous research has found cognitive, affective, and behavioral components of SBA to be strongly related to perceived public stigma (i.e., perceived societal reactions) and to predict poorer psychological well-being across various stigmatizing conditions (Pryor, Boss, Reeder, Stutterheim, Willems, and McClelland, 2012; van der Sanden, Remko, Bos, Stutterheim, Pryor, and Kok, 2013). In addition, physical and psychological complaints have been reported as symptoms of psychological distress caused by SBA (e.g., irritability, insomnia, fatigue, as well as neck and shoulder pain; Angermeyer, Liebelt, and Matschinger, 2001). Thus, we expected SBA to be associated with more symptoms reported on the Pediatric Symptom Checklist in our high school students who reported knowing someone with a mental health problem.

We were interested in exploring the role of perceptions of public stigma and SBA as predictors of psychological symptoms among our high-school students. We analyzed self-report data from 160 high school students from five schools in Livingston county, with 94 students (59%) who knew someone with a stigmatizing condition (e.g., ADHD, depression, anxiety, or Autism Spectrum Disorder). Correlational analyses revealed that, not only was public stigma positively associated with psychological symptoms, but SBA perceptions among students who knew someone with a mental health problem were also correlated with psychological symptoms.

We were also interested in understanding how students' perceptions of school climate might relate to their experience of stigma and their functioning. Previous research has consistently linked school climate to important student outcomes. The National School Climate Council (NSCC, 2015) defined school climate as the quality and character of school life, including students' perceptions regarding the social, emotional, and academic environment of their school. Positive perceptions of school climate are associated with reduced levels of emotional and behavioral problems and improved psychological well-being (Kasen, Johnson, and Cohen, 1990; Kuperminc, Leadbeater, Emmons, and Blatt, 1997; Kuperminc, Leadbeater, and Blatt, 2001; McEvoy & Welker, 2000). Virtanen and colleagues (2009) found that lack of trust and reduced opportunities for participation were associated with youth-reported depression and physical and psychological symptoms.

Within our sample of 160 high school students, overall school climate, as well as several subscales of school climate (i.e., Safety and Relationships) were negatively associated with psychological distress. In other words, students who reported fewer positive views of their safety and relationships in school reported more psychological distress. And, students who reported more social support reported somewhat less SBA. Students who reported more public stigma felt less safe. The findings highlight the importance of decreasing stigma in schools, particularly feelings of public stigma. The findings also indicate that increasing feelings of safety (i.e., safety from physical harm, verbal abuse, and teasing) and positive relationships (specifically student-to-student relationships) in the school setting is critical to protecting students from the effects of public stigma on psychological functioning.

Another barrier to accessing services is school attendance. Members of the community have been concerned about truancy. In 2014, we analyzed data provided by parents and teachers of 198 children in grades Pre-K through 5th grade. We discovered correlations between children's poor attendance and other concerns. Teachers identified a connection between poor attendance and children's academic functioning (e.g., learning problems, attention problems, study skills) while parent ratings identified an association between poor attendance and externalizing behavior (e.g., hyperactivity and "acting out").These findings highlight the importance of developing school environments that address both the academic and the social-emotional health of children with poor attendance and provide support to parents who may be overwhelmed by their children's externalizing behaviors.

Finally, providers perceived that the burden of securing multiple signed release of information forms unique to each of the sectors often stood in the way of youth receiving treatment. Each entity brought together its version, and a one-page omnibus exchange of information form was made that was approved by each site. A script was written for use by providers who were unfamiliar with securing signed consent to release information. Personnel at all the sites were introduced to the form, and it was fully implemented within the first year.

Decrease barriers. In 2010, community members complained about the wait to get a therapy appointment. By increasing the number of providers and reorganizing therapists' schedules at IHR (our community mental health center), there are four open intake slots daily and time of referral to first appointment is now a matter of days. Appointment times for psychiatric services have been greatly reduced, so that a new appointment can be secured within three months.

Financial barriers, in terms of the cost of treatment, have been greatly reduced or eliminated by providing therapy in natural settings and utilizing local funds from the Livingston County Mental Health Board or Livingston County Special Services Unit. Since February 2013, we have been designated a Health Service Provider Shortage Area (HPSA) in the area of mental health, and, although we do not know the overall outcome of new state and federal policies, we may have additional mechanisms to support the provision of services through the Affordable Care Act and innovative billing options associated with rural health care. Medicaid enrollment in our community is a confusing matter. Although we have a very high Medicaid population-to-provider ratio in comparison to other communities in Illinois, it appears that many of our

residents who would likely be eligible for Medicaid are not enrolled. Our DHS office closed in August 2012, and since that time, families have had to drive to Bloomington to be served. Each quarter, our Health Department provided assistance to families wishing to enroll in Medicaid (see chart below). The numbers of families have increased over 40% from year one to year two. During the fourth quarter of year two, the Health Department began providing in-person assistance for the insurance marketplace and engaged 36 additional individuals through this service. During 2015, only nine families total were enrolled during the first two quarters of the year. The Health Department no longer has the grant to support families throughout the process of getting enrolled. According to the website, acasignups.net, the projected Marketplace enrollment for Livingston County for 2016 is 608 and Medicaid Expansion enrollment is 1,203.

Number of families served	
2012	28
2013	40 (+36 Marketplace)
2014	51
2015	9

The Health Department staff report nearly insurmountable barriers for many families attempting to enroll at a distance, many of which are perceived to be due to the inadequate staffing and resources in the DHS office. However, the special education cooperative saw a steady increase in numbers of special education children on Medicaid up through 2015 with a dramatic decrease in 2016, suggesting that families may be having difficulty maintaining enrollment.

Number of Medicaid special education children	
2011	470
2012	490
2013	580
2014	653
2015	651
2016	416

According to the latest Livingston County Health Department Community Needs Assessment and Community Health Plan (2015-2020), 92.4% of Livingston County residents have health insurance (public/private) compared to 87.1% of Illinois. Livingston County had 34.0% of public health insurance compared to 28.9% for Illinois.

The number one strategy that we have implemented to decrease all barriers (stigma, transportation, funding, child care) is to offer services in community settings. School-based providers employed by LCSSU provide group and individual therapy to students and these services are funded by the cooperative. IHR therapists are embedded in 9 of the 11 OSF practices, as co-located providers, and these sessions are fully funded through a fee-for-service contract with our own mental health board. IHR therapists are now also providing additional part-time therapy services in five of six high schools.

We identified a number of ways to utilize technology to increase consumer access. OSF Healthcare System is implementing the Newborn Channel, which provides web links to clips of information about positive parenting practices and child development. As we explore parenting programs for older children, we are finding many resources available in a similar format, and these have been posted under the “For Parents” tab on our website. Practitioners across sectors have been provided devices to utilize in their offices to connect patients with these resources. In addition, many evidence-based treatments are now being delivered online, with guidance by clinicians, during and between therapy sessions. Lastly, efforts to progress-monitor therapy outcomes have not gained traction. When prompted by DMH, clinicians administer measures to public aid clients. Therapists discuss graphs of client progress with the clinical director in supervision. Therapists across sectors reported that they preferred to administer progress-monitoring tools on a tablet that could score the measure and provide immediate feedback to clients. The data would then be uploaded to their respective entities so that patterns in the aggregate data could be explored. This technology had been made available through the purchase of the Youth Outcome Questionnaire, but it was discontinued in 2018 since a critical mass of providers never adopted use of the tool.

In summary, we have attempted to address barriers such as stigma, finances, and transportation by infusing mental health services in other natural settings. While these strategies appear to be increasing the number and types of assistance that are being utilized, moving forward we plan to explore more fully how technology can connect youth and their parents to needed supports.

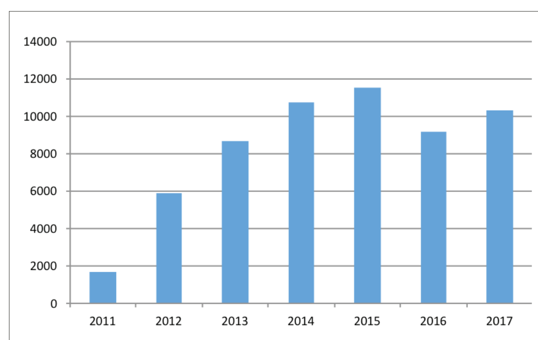
4.6. Screening, assessment and evaluation

Screening. The community agreed that it is important to identify children who need services as early as possible in the progression of a developmental or mental health problem. Before children are born, their mothers are screened during prenatal visits to their doctor or the health department and follow-up services are offered for positive screens for substance use, depression, or domestic violence. We are not specifically tracking data on these positive screens or treatment follow-through; however, the health department consistently serves approximately 50 families through the Healthy Families program and an additional 30, beginning in 2013, through the Better Births program, which casts a wider net for families with slightly lower risk.

In the 0-3 age group, the settings where most screens occur are the health department (Denver or ASQ/ASQ:SE) or the child's medical doctor's office (ASQ/ASQ:SE) and Tier II follow-up occurs in the Infant-Toddler Enrichment program through OSF (partially funded by the 708 board). In the 3-5 age group, most screens occur in the form of Trans-disciplinary Play-based Screenings conducted by LCSSU. Follow-up Tier II is encouraged in the form of structured preschool experiences, At-risk Pre-K, or Head Start. Most youngsters are screened at least annually; however, there is no systematic tracking of from year to year.

The screening process in schools was new for the community. We knew it would be important for the measure to be conducted universally, at least once per year. Once this decision was made, school districts informed parents of the new practice in their handbooks and on websites. Each year in the fall, parents have the opportunity to opt-out of screening, but very few parents have done so. Most parents have expressed support for the practice and appreciation that the school is considering their child's social-emotional needs. Originally, we had intended to use a multi-gated process, whereby the teacher would complete the screening form on the child, and then we would get parental consent for a parent report and a child self-report. As it turned out, it often took one to two months for the follow-up to the screening and to get children connected with Tier II supports. Therefore, the follow-up to the first positive screen is a phone call discussing the results with the parent and getting consent to provide the service, if the parent concurs that support would be beneficial. In many cases, the classroom teachers prefer to be the ones to make this call and have this conversation with parents; however, in other cases, the school psychologists or school social workers make the calls. As one can imagine, connecting by telephone and getting paperwork home and back signed to school can sometimes take time and persistence. Some schools send home letters to all parents to let them know their child's screening results, whether positive or negative.

For grade school students, teachers complete the Behavioral and Emotional Screening System, otherwise known as the BESS (in schools), or parents complete the Pediatric Symptom Checklist, otherwise known as the PSC (in doctors' offices), and positive screens are recommended for Tier II skill-building groups in the schools. In the junior high, students complete a self-report BESS, in addition to the teacher-report BESS. In the six high schools, all ninth-grade students are screened, with two schools also screening older grades using the self-report PSC. Junior high and high school students, also, have the opportunity to complete the PSC in their doctor's office or the juvenile court, in addition to the parent report. On average, we have conducted about 9,400 screens per year on our 9,500 youth. Some students in grades 10-12 in three high schools represent the last known group of unscreened 0-18-year-olds.

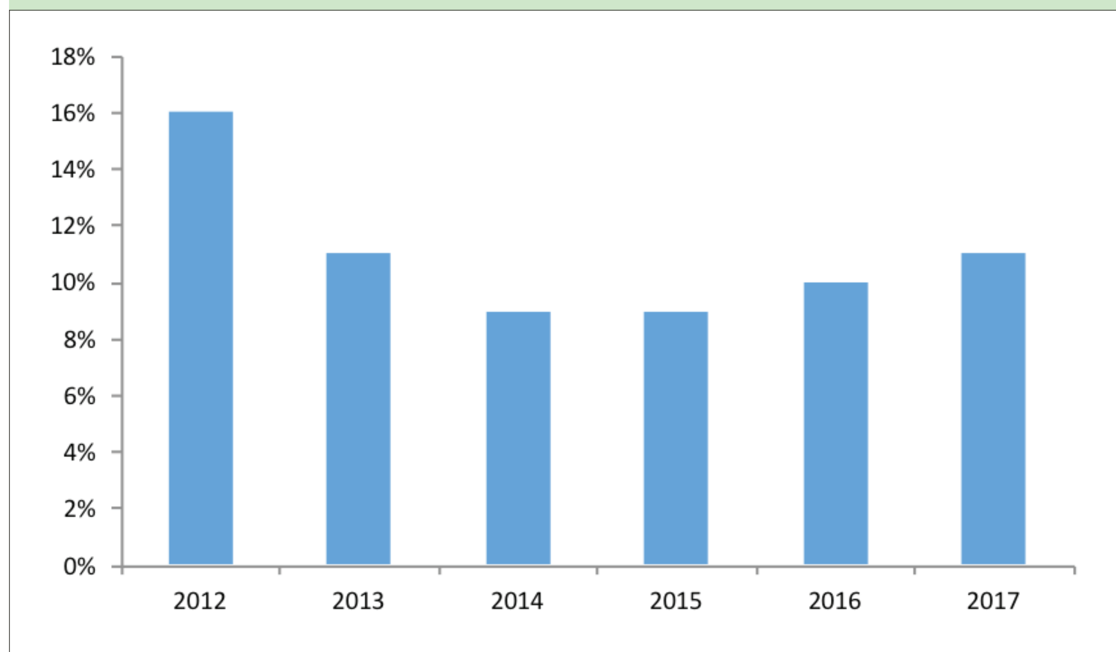


Perhaps even more exciting than expanding our universal screening process is the percentage of positive screens, which ranges from 9-11%. This decrease in positive screens suggests that prevention and early intervention may be successfully decreasing the number of children across the county in need of services.

	Baseline	*2012*	*2013*	*2014*	*2015*	*2016*	*2017*
Total number of screens 0-18	1,713	5,887	8,648	10,783	11,556	9,204	10,306
Estimated number of children	1,713	5,256	7,385	8,852	9,191	8,249	8,657
Estimated % of total population	18%	55%	78%	93%	97%	87%	91%
% of positive screens	UNK.	16%	11%	9%	9%	10%	11%

Provide support for at-risk. An extremely important component of the continuum of services is to provide support for the children who are identified as at-risk for mental health concerns through the screening process. Prior to the grant's initiation, there was a well-developed system for 0-5-year-olds to be screened and funneled into Tier II or Tier III services, as appropriate. As a result, we are monitoring this process, but no new services have been developed.

Percentage of children screening positive (at-risk)



Screening and Tier II services are completely new in the 6 to18 age range. Some of the 6- to18-year-old children who screen positive each year are already receiving services, primarily as a result of teacher or parent referral. When screening data are reviewed by school psychologists, school social workers, and administrators, the team considers whether the current type and level of service needs to be changed to meet the child's needs. Screening is intended to identify children who are at-risk of developing a problem, not just those about whom adults are already concerned. As a result, sometimes elevations are a bit of a surprise and either the parent or the teacher expresses desire to delay or avoid services. There may be actions taken on the part of the parent or the teacher to support the student, but these are not reflected in the Tier II numbers. Also, sometimes a teacher, as a result of a high positive screen rate, will request additional classroom-based, social-emotional support or instruction, and these numbers may also not be reflected in the official Tier II count. The following chart depicts the positive screens in the schools.

	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Positive school-based screens K-12	384	456	838	679	350	444
Number for whom we have follow-up data	210 (55%)	298 (65%)	335 (40%)	430 (63%)	186 (53%)	380 (86%)
Number already receiving services on an IEP	15 (7%)	62 (21%)	16 (5%)	47 (11%)	23 (7%)	29 (8%)
Number received Tier II group intervention	99 (47%)	117 (39%)	115 (34%)	147 (34%)	80 (23%)	130 (34%)
Number received Tier III individual intervention	48 (23%)	61 (21%)	67 (20%)	114 (27%)	28 (8%)	71 (19%)
Number moved out of school following + screen			36 (11%)	1	3 (<1%)	
Number teachers declined to pursue services	24 (11%)	46 (15%)	50 (15%)	53 (12%)	20 (6%)	66 (17%)
Number parent/self declines	24 (11%)	12 (4%)	67 (20%)	68 (16%)	38 (11%)	84* (22%)

**42 of the 84 youth/parents who declined services reported receiving outside services*

Aside from prevention and early intervention service and training needs, community members and mental health providers reported that the most glaring service gaps were for the highest need families. Historically, children with the most complex needs were referred out of the county for psychological assessments, more restrictive educational, day treatment, or residential programming, and treatment for attachment problems and complex trauma, especially that of a sexual nature. We continue to grapple with serving this high-need population, as funding streams continue to be reduced, and we have developed a team approach to assessing and coordinating services for this population.

Comprehensive inter-disciplinary assessments. Prior to the grant, there were four kinds of assessment occurring: 1) global developmental assessments for 0-3-year-olds, 2) trans-disciplinary play-based assessments for 3-5-year-olds, 3) school-based assessments for special educational planning for 6-18-year-olds, 3) intake mental health assessments at the community mental health center, and 4) the CANS in the court system. There was no process in place to thoroughly gather data from all sectors to inform treatment planning for the highest need clients. In October of 2011, we began developing and piloting a process called the Comprehensive Inter-disciplinary Assessment (CIA) team. The team comprises representatives from each of the main sectors (medical, school, mental health, DCFS, and court), as well as specific providers who rotate on depending on the target client.

In July 2013, we conducted a survey of providers who had participated in the CIA. Respondents were extremely positive. In 2015, we repeated the survey and the service continues to be highly valued. In response to feedback, we instituted more structure in the staffing process and identified point people to synthesize data prior to each meeting. We also developed an explanatory sheet for participants initiating a referral and added table tents with names/agencies of team members.

The total number of cases staffed since inception is 59, which is less than 1% of the population. Two of these cases required the collection of additional formal assessment data, resulting in a comprehensive psychological report.

4.7. Decision-making at the service delivery level

RESOLUTION POLICY: CLINICAL

In the past, clinicians have worked in relative isolation. The new system of care requires frequent communication and integration of services across settings and disciplines. It may be that this new model brings to light differences in theoretical orientation, experiences, and training. LCCN clinicians make every effort to convey respect for one another and one another's divergent clinical perspectives. All personnel convey this to one another and to families in our community. If clinicians have marked disagreement regarding the direction of treatment, they come together as a team, without the family members present, and reach a consensus about two to three possible alternatives. These options are subsequently presented to the family with a clear description of the merits of each alternative. Both parties agree to fully support the family's decision about the course of treatment that best fits their situation.

There are four individuals who could be termed "care coordinators." They serve as facilitators of system implementation and care coordination within their own sectors and as liaisons between their sectors and the other three sectors. They are as follows:

- The facilitator/liaison for the education sector is the Project Manager, Kristal Shelvin, PhD.
- The facilitator/liaison for the mental health sector is IHR's Clinical Director, Amy Duffy.
- The facilitator/liaison for the healthcare sector is the Resource Link, Care Coordinator, Kelly Barnes.
- The facilitator/liaison for the juvenile court sector is the Family Support Specialist, Mandy Roberts-Lieb.

4.8. Care management/coordination

Three changes have been made that have helped us meet our objective, to increase transition and collaboration between providers.

- The LCCN has developed a set of universal LCCN forms, as well as flow-charts that have facilitated a more seamless journey across and through the system of care.
- "Case manager" positions in each of the sectors use these forms and monitor the effectiveness of the communication protocols among providers. Additional information about the role of these individuals can be found on p. 49 under Workforce Recruitment.
- For the highest-need families, the CIA meets face-to-face to develop cohesive and coordinated treatment plans for all children in a given household.

At the start of the grant, we suspected that distribution of providers' time might shift as the plan was implemented. In November 2011, we chose to look closely at one sector. We asked LCSSU school psychologists and school social workers to log their time for two weeks to establish a baseline measure of time spent across various duties in their job descriptions. We anticipated that time spent in consultation with school personnel would increase as they provided support to teachers around Tier I and consultation with parents, medical providers, and mental health therapists would increase as the system of care became more seamless. Unfortunately, we never re-administered the time study at the conclusion of the grant. However, even at the outset, we were completely taken by surprise by the number of hours that social workers were spending in communication with medical providers, an average of 2-3 hours each per week, in an effort to remove barriers to learning. Social workers were even, on occasion, authorized by parents to take children to medical appointments. Examples include securing treatment for severe eczema, inhaler for asthma, eye glasses, pain associated with decaying teeth, and side-effects associated with psychotropic medication.

Our model has several different individuals who might fall in the care management/coordination category and we are monitoring the function of these positions. Not mentioned is a slight increase in FTE for home-visiting and case management support for at-risk mothers through a different health department grant. In addition to the individuals described below, the Project Manager, a school psychologist at LCSSU, and the Tier IV Facilitator, the clinical director at IHR, with some LCCN grant funding, serve as point people for the educational and mental health sectors, respectively.

Resource Link Care Coordinator. Just prior to the LCCN grant implementation, OSF created a grant-funded position entitled, "Care Coordinator" to serve in the medical sector. The individual, a social worker who had previously been employed by St. James Hospital, served another county, as well, and was charged with case management for patients referred by any doctor (OSF and Non-OSF) needing therapy. Following referral, she met with the family to understand the child's needs and then facilitated follow-up with IHR or another provider of their choosing. She then continued to follow the case until the family was regularly attending appointments. Her responsibilities also included facilitating the consultations between primary care and child psychiatry. She coordinated the calls and typed and disseminated a summary of the plan. Since we have begun universal screening in doctors' offices, her role has increased. All positive screens from primary care for 6-18-year-olds come to her. She often makes a referral to the school psychologist or school social worker at the child's school for Tier II follow-up. Some positive screens require or prefer referral to a non-school provider. The Care Coordinator is an active member of the CIA team, communicating information, recommendations, and questions to and from medical providers before and after each staffing. OSF has assumed full responsibility for funding this position, which has served incrementally more children each year. In 2014, however, there was a dramatic decrease in the number of families being served by Resource Link in Livingston County. The reason for the decrease is a change in the largest pediatric practice in the county; the new physician in the practice is comfortable with managing mental health concerns in primary care. This practice alone referred 50 fewer patients in 2014, as compared to 2013. The county now has therapists embedded in all the rural OSF practices and the large Reynold Street practice in Pontiac, which may or may not have had an impact on the number of referrals to Resource Link. In addition, the LCCN has utilized the Care Coordinator in other ways that are not reflected in her care coordinator figures: to connect families with a medical home and to serve on the CIA Team.

	2011	*2012*	*2013*	*2014*	*2015*	*2016*	*2017*
Number of families served	78	84	114	72	56	42	60

Whenever children enter special education or start mental health treatment, their parents are asked to identify the child's medical provider. If one is not provided, the provider requests a release of information and makes a referral to the Resource Link Care Coordinator, who helps establish a connection for the family with a medical practice. The Care Coordinator, in turn, connects the child's medical home to other providers in schools, mental health, and psychiatry. Each quarter, she reports the number of referrals.

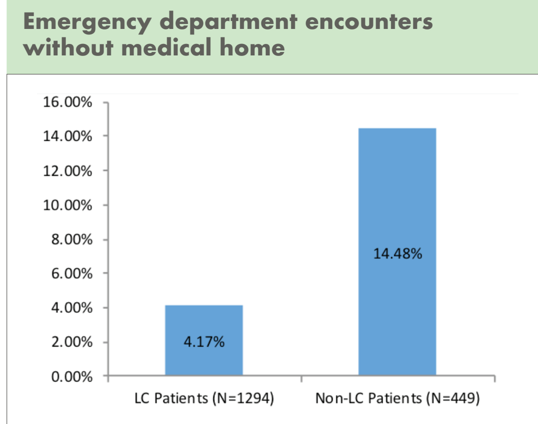
	2012	*2013*	*2014*	*2015*	*2016*	*2017*
Number of families connected to Medical Home	6	9	8	10	6	2
Number of PCP seeking psychiatric tele-consultation	UNK	19	22	22	11	9

We chose also to look closely at the data for pediatric patients who visited the Emergency Department (ED). The generally held assumption is that families without medical homes utilize the ED more frequently than do others.

	2014	*2015*	*2016*	*2017*
Total encounters	72	56	42	60
Unique patterns	72	56	42	60

Because these percentages appeared to be creeping up, we looked a little closer at the data and found that the percentage of visits by patients in 2017 were 3.4% suggesting that the incremental increases observed may be due to families from outside Livingston County, who have been less likely to have benefited from our system of care. In 2017, St. Mary's hospital in a neighboring county closed. The graph below suggests there is support for this hypothesis; it shows that 449 of the 1,743 youth served in the ED were from outside of Livingston County and over 14% of them reported no physician of record.

Emergency department encounters without medical home



Thus, it is likely that the overall percentage of Livingston County pediatric patients in the emergency room without a primary care provider is fairly stable and is probably similar to the percentage in the population, described below, that attends pre-school screenings. Annual percentages have bounced around from 1-6%, with no clear pattern over time but trending downward.

At the trans-disciplinary, play-based screenings, experienced by a vast majority of 3- to 5-year-olds in the county, the facilitator records the names of medical providers and submits them on a quarterly basis to the Project Director. These data have allowed us to get a snapshot of where children get their medical care. These data are particularly important when we think about our universal components, such as screening or parenting resources, reaching all families. We discovered that one-third of our children have a doctor outside of Livingston County and may not receive an annual screening in that setting. Also, for example, if The Newborn Channel is prescribed for families going through the birthing process with an OSF doctor, then it is likely that at least the 11-20% of families who have chosen a non-OSF provider in Livingston County may not access this Tier I parenting intervention.

	2012	*2013*	*2014*	*2015*	*2016*	*2017*
LC OSF	51%	41%	59%	48%	45%	47%
LC non-OSF	16%	17%	14%	11%	19%	20%*
Out-of-country	31%	36%	26%	37%	35%	33%
No medical home	2%	6%	1%	4%	1%	1%

**One Non-OSF doctor in Livingston County participates in LCCN screening and follow-up; that practice accounted for 7% of the population; thus, the percentage in Livingston County without a participating physician is less than 13%.*

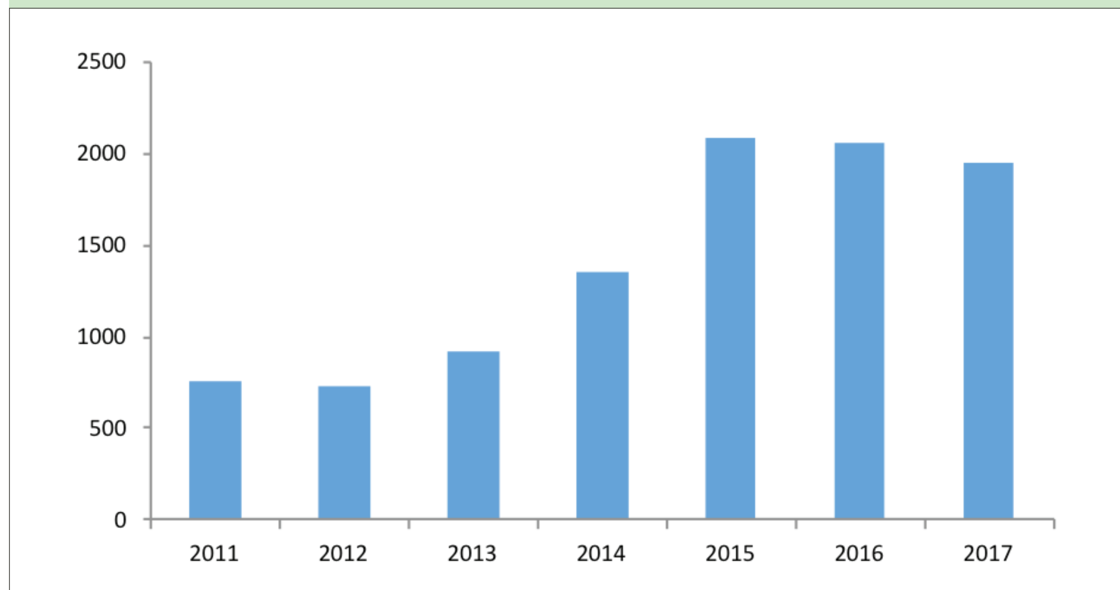
Developmental therapist. One full-time developmental therapist provided the bulk of developmental screening for 0-3 population in the county prior to the grant; the program, which is housed in the Rehabilitation Department at OSF St. James Hospital, is funded in large-part by the Mental Health Board. The program provides children in Livingston County birth through three years of age the following services; identification of children at risk of developmental delays, identification and referral of children with developmental delays, developmental education, developmental stimulation, and environmental enrichment. Children at risk for delays are afforded an opportunity to interact with children with and without developmental delays and to preschool readiness skill instruction. Services are provided in the child's home to foster growth and education in the natural environment, unless the family requests services be rendered at the hospital clinic or another setting. A developmental playgroup is offered in a variety of settings in the county for social development, and a transition group is provided for children two and one half through three years of age in an instructional setting. All positive screens from primary care for 0-5-year-olds come to the developmental therapist for triage and case management. Because screening is now being done by others,

she has been able to devote the time she would have previously spent doing screening to higher levels of care. She typically refers positive screens for 3- to 5-year-olds to the special education cooperative (LCSSU) or District 429 for Tier II or Tier III follow-up. After reviewing the data and speaking with the parents of 0- to 3-year-olds, the developmental therapist frequently moves forward with a global assessment and begins early intervention with no delay. She also conducts a parent-child attachment-building group. The Mental Health Board funds services to children with <30% delay, while children with greater delays are funded through the state early intervention contract. As her caseload has increased, she has taken on some trainees and referred some children with more narrow problems to specific disciplines, such as occupational therapy or speech pathology.

Below are data on her Tier II and assessment services, which have remained stable, while Early Intervention Services have increased by 84%. The enormous increase in the amount of intervention being provided within the OSF Early Intervention program has led to conversations about increasing capacity. The community is exploring possible mechanisms to increase the amount of services available to 0-3-year-olds with social-emotional needs and their parents. There have been other changes in the socio-political landscape that influence service delivery in this age group. A couple of years ago, the Child and Family Connections contract was rebid, and there have been a number of problems within the system of care since the contract landed in Champaign. Children are being referred for assessments to out-of-county providers, and youngsters in the system are not receiving services in the coordinated and seamless manner provided by the Livingston County Children's Network. School providers are consistently reporting missing or delayed reports. Other concerns on the horizon involve proposed changes in criteria for Early Intervention services and funding.

	2012	*2013*	*2014*	*2015*	*2016*	*2017*
Infant-toddler enrichment program	12	10	11	10	10	11
Infant-toddler play group	24	22	18	27	116	19
Referred to early intervention (0-3)	17	22	34	32	33	28
Referred to school district (3-5)	13	22	11	8	9	7
Global developmental evaluations	17	19	18	10	11	9
Early intervention units	736	917	1,354	2,084	2,059	1,946

DEVELOPMENTAL THERAPIST: Units of intervention provided



Family Support Specialist (FSS). Prior to the grant, the individual who is now serving in this role, a bachelor's level social worker, was funded by the Livingston County Youth Commission and the Mental Health Board, through several funding streams. When funding for some of those programs was cut, the community seized the opportunity, with LCCN grant funds, to develop her role and utilize her skills in the juvenile court system (.6 FTE). The presiding judge added language to the pre-trial paperwork that required all families to meet with the FSS for screening and referral. A big part of her job is to facilitate communication across providers, serve on the CIA, and support families in navigating the various systems serving them. In addition to providing case management for families with many risk factors (i.e. homelessness, DCFS involvement, unemployment, substance abuse, domestic violence), she is involved in the initial stages of developing a juvenile mental health court. Her remaining FTE continues to be funded by the Regional Office of Education (ROE) and 708 and 377 boards, and it involves participation in adult mental health court and serving individuals with developmental disabilities. Our sustainability plan included on-going funding for this role. The FSS is providing intensive supports to the highest need youth. In 2014, the scope of her work increased to include screening of youth being served by the ACHIEVE Center (educationally at-risk youth) and those on probation without court involvement.

The community suspected that many youth ending up in the court system were those who had fallen through the cracks. These youth were suspected to have experienced barriers to accessing care, in many cases due to an overwhelming number of family risk factors and/or parental resistance. By adding the FSS to the pre-trial paperwork, the community aimed to more effectively connect both the family and the youth to needed services. To date, this resource appears to be having a remarkably positive influence.

In 2013, we were interested in gathering input from stakeholders that might guide our pursuit of future funding for the position. Providers associated with the courts, probation, DCFS, IHR, SASS, and schools were surveyed regarding their perceptions of the FSS's role and performance. All respondents endorsed items indicating that the FSS increases the quality and effectiveness of the system of care and helps to engage challenged families. The comments provided suggest that the FSS is in a unique position to access and communicate helpful information that, in turn, facilitates work with families across sectors. Seventy percent indicated that her job likely saves them time, but they were unable to quantify this report.

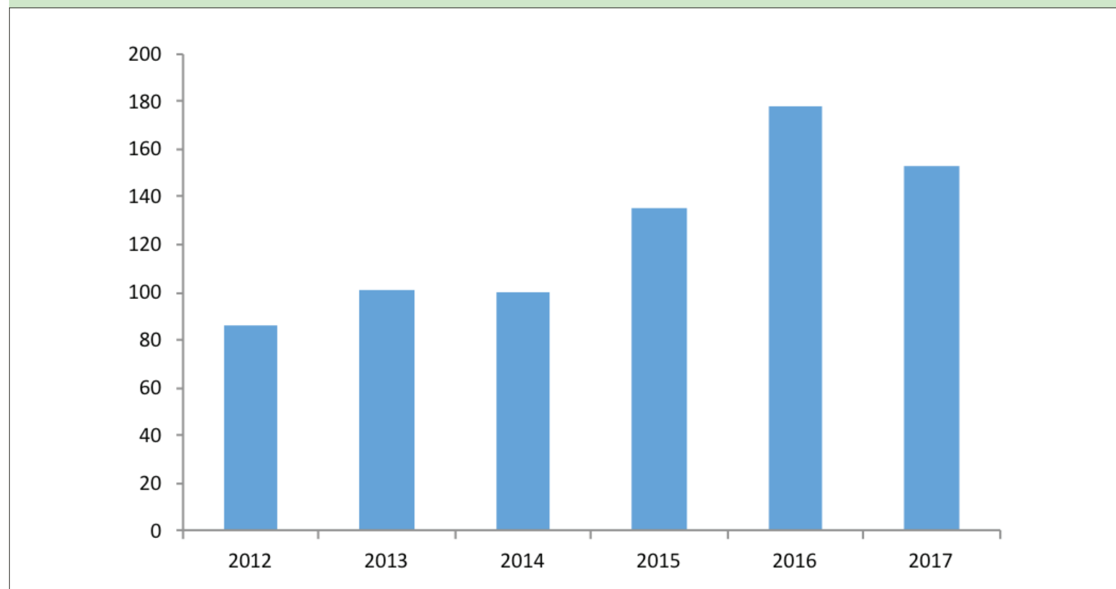
In 2012, 54 youth were screened; their outcomes were followed over the course of the last five years. While probation has been successfully terminated for the majority of youth, it has been surprising to see how many are ultimately placed in DCFS care (19%). An additional 15% were eventually sentenced to the Illinois Department of Juvenile Justice. There was an astounding drop in the number of youth entering the court system (an average of ten per year each of the last four years), with smaller percentages ordered to DCFS guardianship and/or IDJJ in subsequent years. Beginning in 2015, the program evaluation team began conducting an analysis of the juvenile court and probation files to determine factors that lead to successful outcomes for youth.

	2012	*2013*	*2014*	*2015*	*2016*	*2017*
Number of new families served	54	5	20	4	9	15

Family resource developer. We have one individual who provides parenting and in-home supports to parents of children in SASS. As a result of the needs identified in the CIA and in the self-contained programs for children with emotional and behavioral disorders, we increased her time from .6 to .8 FTE in 2014 and finally 1.0 FTE in fall of 2015. The data below reflects the increased time devoted to supporting high needs families during 2016. When not working with families individually, she conducts parent training groups for those mandated by DCFS to attend. She also provides foster parent training and serves as an educational advocate. The position will be maintained by a braiding of funding streams.

	2012	2013	2014	2015	2016	2017
Number of contacts	599	673	701	955	1,584	1,022
Families served	86	101	100	135	178	153

Number of families served



4.9. Crisis management at the service delivery level

In our community, psychiatric crises are managed by the Screening Assessment and Support Service (SASS) and the Crisis and Referral Entry Service (CARES), which is operated by IHR, the local community mental health center. SASS staff assess children and youth to determine the need for psychiatric hospitalization. These services are limited to children whose care will be paid for by one of the state funding systems (DCFS, HFS, DHS). To assist school staff in accessing these services quickly, we developed a guidance document. This document, *Getting Help for Student with Mental Health Concerns*, outlines the path for accessing psychiatric services when a student has private health insurance or is served by Medicaid (Attachment Four).

Our data suggest a small increase in SASS calls since the project began in 2011. We have surmised that the rise in SASS calls is proportional to the increased identification of students with concerning behavior rather than a failure of the system. The increase in calls is viewed as evidence of improved collaboration, confidence in the system, and knowledge surrounding when a SASS call is appropriate. In past years, anecdotal reports suggest that school staff are more likely to call SASS during a crisis today. We have several specialized school programs in the community whose staff have been trained to identify the signs and symptoms that indicate the need to call SASS.

4.10. Crisis management at the system level

When difficulties arose, the Project Director would communicate with individual Executive Council members to assess the situation. On occasion, a situation could be resolved through a series of conversations with other community leaders. On other occasions, if necessary, she would convene an impromptu meeting of the Executive Council and facilitate a problem-solving discussion. The members of the Executive Council, however, had positive working relationships and a long history of successfully and collaboratively resolving community-level crises. Due to the active role of the Project Direct in the CMHI, early on the NTI consultants strongly recommended that the Executive Council to develop an emergency plan, if she were to become unexpectedly unavailable. They identified three members of the Executive Council who would step forward to co-lead if it became necessary.

5.0. Workforce recruitment

When possible, administrators recruit from within for key LCCN positions, reassigning personnel based on their skills and interests. Early in the grant period, several entities had to lay-off staff due to financial shortfalls. At those times, administrators were particularly uncomfortable hiring new staff on the grant; as a result, hiring for some grant-funded positions was delayed. On a rare occasion, a person whose contract had not been renewed could retool and be rehired to perform the desired responsibilities.

LCCN entities participate in pre-service training arrangements with local institutions of higher education and this serves as the primary avenue for securing employees with skills that are a good match for LCCN positions. All LCCN positions, with the exception of the Directorship, are under the administrative umbrella of an LCCN entity; thus, all relevant personnel policies of the employing agency will apply for compensation, remediation, and termination. Administrators are encouraged to solicit feedback forms from all LCCN partnering entities within which the employee is engaged, and the data gathered should be part of the annual evaluation. If staff under-performance compromises the LCCN entity's ability to fulfill responsibilities, the Executive Council will assist the administrator in resolving the matter.

Each year in late fall, Executive Directors of all entities have come together in a group to complete the "sustainability matrix" provided by NTI that monitors the FTE of human resources across a large number of professions, in terms of the expressed need, as well as the personnel in place.

In 2010, when we started implementation, we were down at least one FTE each in medical providers, school-based providers, and community mental health center therapists. In addition to substantial turn-over in providers in these three sectors, we had a number of positions that were lost as a result of Reductions in Force or left vacant without recruiting, due to economic hardships faced by the agencies. This was a tough place to start with implementation because we were asking all existing providers to continue performing their current duties, make changes to the way they do business, and even add tasks! There was also much trepidation about the unknown number of new referrals that could potentially flood the system, once universal screening was fully implemented. Since 2013, all the OSF medical practices and IHR have been fully staffed. The specific disciplines we are monitoring appear below.

Child psychiatrists. One child psychiatrist is contracted by IHR, our community mental health center, to provide services on-site two days per month. On two additional days, he provides services to patients at IHR via tele-health (video/audio). When OSF implemented psychiatry tele-consultation through the Resource Link program, they agreed to contract with the same psychiatrist (even though he is out-of-network) so that there would be continuity of care if the family was subsequently referred to IHR. There is also another OSF child psychiatrist that provides some tele-consultation to medical providers when this psychiatrist is not available. The intent of Resource Link is to assist primary care doctors in managing psychopharmacological interventions for many of their patients. When, through tele-consultation, the doctors agree that a referral to IHR is warranted, the primary care physicians are likely to have better communication with the psychiatrist and be more amenable to resuming responsibility for the child's treatment, once the child is stabilized.
In addition to the increase in time and access to the child psychiatrist, the community now has a full-time psychiatric nurse employed through IHR who can treat adolescents. During the baseline year, the psychiatrist treated 112 children and youth. During 2012 and 2013, he treated 120-130 children and adolescents, and in 2014, that number jumped to 159! In 2016, that number remained steady at 152 youth, with the APN serving 36 over the age of 13, for a total of 188. In addition, we have decreased the wait-time for a first appointment from six to three months.

Therapists. The community mental health center employs 13.5 FTE therapists, which is 2.5 FTE more than in 2010. One full-time therapist was originally completely funded and is now partially-funded on the LCCN grant to provide services to children, adolescents, and their parents in community settings. Four therapists have left the agency since 2010 and all have been replaced; this represents a 30% turnover in staff. This

level of turnover requires thoughtful orientation and routine training on LCCN protocols. Two of the therapists who left the unit served for a time in the role of the full-time community-based child and adolescent therapist, a person who was easily recognized as a face of the LCCN initiative. After losing two individuals in this role, the Executive Director of IHR began to allocate a portion of multiple therapists' time to community settings such as homes, doctors' offices, schools, and churches. The remaining therapists serve all age groups. In 2014-2015, while all community mental health therapist positions remained filled, several providers were out on leave. Some of these same therapists serve on the crisis team for SASS or provide substance abuse treatment. IHR trains two .5 FTE master's level clinical/counseling psychology interns each year. Although we have enough cases to warrant employing more therapists, the ratio of clients with Medicaid to those with insurance is such that we cannot financially sustain more providers. Despite the turnover in personnel, there has been remarkable increase in the number of children and adolescents receiving treatment since the LCCN plan has been implemented. In 2015, IHR therapists served approximately 20% of school-aged youth. Although the numbers for 2016 and 2017 are below that of 2015, they still represent a significant increase over baseline.

	2011	*2012*	*2013*	*2014*	*2015*	*2016*	*2017*
Number of children/adolescents served	464	500	667	776	1,266	981	766

Child psychologists. Since 2010, we have had two dually-credentialed psychologists leave the community. We currently have six people (4.2 FTE) who are doctoral-level school psychologists, and two of them are clinically-licensed, with the remaining two pursuing licensure. The community is committed to keeping several licensed psychologists employed for the following reasons:

- They can supervise doctoral interns who provide inexpensive, but high-quality services; there are currently three people (2.5 FTE) training in the community. Pre-service training has been a tremendous resource for implementation and an excellent recruitment tool, with approximately one out of four trainees choosing to stay in the community.
  - The grant currently funds .5 FTE and the sustainability plan will include generating on-going funding for trainees.
    - On average, post-grant funding, it would cost approximately $6,000 per year (stipend, benefits, and mileage) to have an additional day per week of therapy provided by a doctoral intern in a high school. That intern would provide individual or group therapy to approximately 15-20 students and provide 340 hours of mental health service (therapy 48%; consultation to administrators, teachers, and parents 7%; clinical documentation, coordination, and supervision associated with screening, therapy, and crisis intervention 40%).
    - A doctoral intern providing one day per week of integrated behavioral health in primary care costs approximately $6,000 and serves an average of 200 patients. Two-thirds of patients served are children, adolescents, and parents. Approximately 40% time is devoted to direct service to patients, 40% providing consultation to medical providers, and 20% to clinical documentation, coordination, and supervision.
- They provide leadership in the delivery of clinical services, can function across sectors, and have specialized training in systems-change.
- They can conduct psychological assessments. Prior to the grant, all children requiring psychological assessment were sent out-of-county. One licensed psychologist, employed by the special education cooperative, is contracted by the community mental health center so that assessment services can be billed to third-party payors. The licensed psychologist participates in the CIA team which staffs the most challenging Tier IV cases and takes the lead on assessments when they are warranted.

School psychologists/school social workers. The special education cooperative and the two largest school districts employ a total of 17 FTE school psychologists and social workers, plus the 2.2 FTE doctoral-level psychologists already counted above. Since 2010, there has been a 1.0 FTE increase due to a vacant position being filled. With all the increased responsibilities for Tier I, II, and III services, we would be able to add at least 2.0 FTE ideally in this category; however, the maintenance of several trainee positions to assist with implementation partially meets this need and ensures access to a pool of high quality applicants for any vacancies. Prior to the 2016-2017 school year, LCSSU and one of the largest school districts received resignations from three school psychologists; three part-time school psychologists were contracted to work up to .4 FTE each. At the close of the 2016-2017 school year, two full time school psychologists were hired; however, the remaining full-time position continues to be posted.

We have successfully retained some employees through innovatively braiding funding streams and assignments and by accommodating the providers' need for part-time rather than full-time participation in the workforce. Many of the positions seem to be self-sustaining with the exception of funding our Project Manager and a portion of our trainees. However, our data suggests that training pre-service practitioners is an inexpensive way to increase FTE to meet the demand for services in the schools, as well as a good way to recruit to fill inevitable vacancies. A pipeline of doctoral-level school psychology interns is available, due to an accredited internship consortium nearby that recruits from a national pool of applicants; two to four interns have been trained annually. The community also trains one to two social work interns in the schools and the community mental health center annually. As we prepare for our sustainability plan, we are collecting additional data to share with stakeholders, articulating what funding one trainee actually buys the community in terms of clients served.

Almost all 0-18-year-olds are screened annually. Currently, staffing is adequate, but not sufficient to serve those needing some level of follow-up services, particularly at the high school level. We have employed strategies to increase the effectiveness of services. In addition, we have implemented universal interventions and early interventions that are intended, over time, to reduce the number of children needing treatment for disorders, so that the need for services can be met effectively with current levels of human resources.

6.0. Family involvement at all system levels

Parents, other than those who are involved in the project as a result of their professional capacities, have had little representation at the administrative or policy level. During the planning year, a parent-educator advisory team met weekly for six to eight weeks during evening hours to evaluate and select the best fit for the community from a field of four evidence-based, social-emotional curricula recommended by the evaluators. The team, which received grant-funded stipends for participation, was also asked to provide guidance around consent for universal screening and follow-up. Ultimately, they selected Positive Action to be adopted across all 12 districts and crafted the passive consent process.

Parents are involved in treatment in a number of ways.

- At Tier I, expectant parents are encouraged to view the Newborn Channel and engage with a Navigator who provides psycho-education and support. Preschool parents participate in Parent Education Nights, many of which are informed by Circle of Security principles. Parents of school-aged children are kept informed by receiving Positive Action Newsletters and promotion of their children's involvement in Children's Mental Health Awareness activities. They are welcome to attend the Annual Community Summit to learn and discuss the latest updates and evaluation of children's mental health and the LCCN continuum of care.
- At Tier II, parents and their children 0-3 are included in all interventions of the Health Department, such as Healthy Families and Better Birth Outcomes, as well as Infant-Toddler Enrichment and Play Groups at OSF St. James. Home visitors provide dyadic services through the LCSSU Summer program. In

nine primary care practices, parents can receive parent consultation and dyadic/family services from embedded or integrated behavioral health provider; Triple P, an evidence-based parenting curriculum is available in these practices. Whenever a child screens positive, regardless of the setting, a professional shares the results, provides some anticipatory guidance, offers an appropriate service, makes potential recommendations, or gives a referral.

- At Tier III, parents of young clients are involved in dyadic interventions within the Infant Toddler Enrichment Program at OSF and Early Intervention services. The community gives priority to parent consultation whenever a 0- to 18-year-old receives individual services in schools and dyadic or family interventions when in settings that are more accessible to parents, such as primary care, clinic settings, or the home. Providers have received specialized training in evidence-based dyadic treatments such as Theraplay and the ARC model.
- At Tier IV, the community has one full-time Family Resource Developer (described elsewhere) as part of the SASS program; this person is a parent of an adult child with significant mental illness. She assists families as they navigate the system of care and provide parent training and in-home coaching. Prior to grant funding, this position was part-time and only served children within the SASS program. As a result of the CIA process and ILCHF funding, her role expanded to serve nearly all of the highest need families in the community. It is a critical component of our continuum of care and will be sustained by local funding beyond the life of the grant.

7.0. Youth involvement, support and development

We collaborated with the Livingston County Commission on Children and Youth (Youth Commission). The project coordinator represented the LCCN on the Youth Commission. The commission comprises youth representatives from each high school in the county, school guidance counselors, and a representative from child-serving agencies. In this capacity, the coordinator provided updates on the mental health initiative during the six meetings for the year.

Our county hosts a very large Operation Snowball program each year. This program is targeted at eliminating substance use in children and teens. The project is staffed by teens from the community. The LCCN project coordinator worked with the group of teens hired to include the promotion of healthy activities, along with their efforts to resist illegal substance use. The teens enthusiastically agreed to share a message of social-emotional behavioral health. They wore t-shirts inscribed with Children's Mental Health Awareness Day messages and contact information for the LCCN. These simply messaged shirts were given to teachers, administrators, and students around the county. The high school students wearing the shirts played an important role. We believed that if these older students were observed in the shirts, the younger students would wear them more often. The teens provided the much-needed social acceptance of the shirts. We had hoped the shirts would decrease the stigma surrounding the term mental health. Given that the shirts are still seen in schools around the county three years later, we count this simple marketing tool as a success.

8.0. Clinical staff involvement, support and development

Our implementation plan requires all adults working with children to be prepared to play a role in their healthy development, consistent with the "it takes a village" philosophy. In essence, providers and even the institutions within which they work were challenged to redefine their professional identity to include various aspects of health promotion. Engaging all professionals in this endeavor to create a seamless and cohesive web of supports required people to perform tasks for which they may never have received formal training. Thus, we determined to provide the necessary training and follow-up coaching. The following are all the personnel groups who have participated in training and associated data collection.

Teachers. Children and adolescents in the community were perceived to be growing up with insufficient social-emotional skills. Social and Emotional Learning (SEL) refers to interpersonal functioning and self-regulation skill development of children in grades K-12 (Elias, 2006). Because of growing awareness of the relation between SEL interventions and positive academic outcomes (Durlak et al., 2011), communities at various levels are encouraging delivery of SEL programs within schools (Domitrovich, Durlak, Goren, and Weissberg, 2013).

An evidence-based classroom curriculum to teach these skills was selected from a field of four by a parent-teacher advisory board. Subsequently, PK-5th grade teachers, selected middle school teachers, and many administrators in all Livingston County schools have received training on completing the screener and delivering Positive Action, a social-emotional learning curriculum. The Project Manager and all school psychologists and social workers at LCSSU have also been trained as Positive Action trainers. Each year, new teachers attend a one-day training hosted by LCSSU. Administrators can recommend teachers to attend a booster training, as well.

Teachers voluntarily submit "implementation checklists" upon which they indicate which lessons they have used and which components of those lessons. In Years Two and Three, building-level Social-Emotional Learning Champions distributed and collected checklists from individual teachers to whom they provided coaching; each year a few more teachers submit their data. Teachers, on average, completed just about the same number of lessons per classroom, an average of 25 lessons; however, there remains variability across teachers.

In the Spring of 2013, we conducted a survey of implementers to explore barriers. The survey suggested that 70% of teachers completing the survey felt that the curriculum met students SEL needs well. Sixty-eight percent reported that students seem to enjoy the curriculum, but only 23% found teaching the lessons enjoyable. Some teachers (27%) reported that they preferred a narrower curriculum that had been delivered by social workers in the past; while another 39% indicated they did not have enough time to fit in the lessons. Fifty-one percent reported occasionally seeing students using the skills they have learned in Positive Action. Ultimately, 56% said they would continue with the curriculum after the grant but many of them would only do so if their principals continued to prioritize it.

Three strategies were executed in response. First, the expectation was conveyed by administrators that less enthusiastic teachers would deliver the core 25 lessons of the 140 in the curriculum so that children would receive at least one lesson per week. Second, each building principal was asked to select an SEL champion who would receive a small stipend to coach his/her colleagues, to promote school-wide promotion of Positive Action, and to be a liaison to the Project Manager. And third, the SEL champions and all administrators were invited to a training by the author of the curriculum, which is now being used with five million children in the United States.

Currently, there is a wide range of "buy-in." In the largest district, Positive Action is delivered to nearly every student nearly every day. We have learned that administrator enthusiasm and peer coaching, or on-going support for the use of new skills, is critical to the success of this piece of the plan.

Because the curriculum is provided by classroom teachers, effective implementation depends on teachers' willingness to adopt and embrace the role of SEL instructor. We decided it would be important to better understand how teachers' attitudes about school-based SEL have influenced their behavioral intentions with respect to implementation.

The transtheoretical model proposes that behavior change involves movement through a series of stages, beginning with precontemplation (not thinking about change or that change is necessary); contemplation (recognizing a need for change); preparation (preparing for action); action (taking steps to change behavior); and maintenance (working to maintain a change that has already occurred) (Prochaska,

DiClemente, and Norcross, 1992). When applied to teacher attitudes about SEL learning standards, the transtheoretical model may be helpful in understanding how likely teachers are to implement SEL curricula in their classrooms.

An online survey was used to assess teacher attitudes regarding SEL and their self-assessment of their stages of change. Sixty teachers completed the survey during the 2013-2014 school year. Teachers reported on their attitudes about the following SEL learning standards. Additionally, teachers rated their readiness to change their roles to include implementing an SEL curriculum. For the purposes of this study, the stages of change assessed included Precontemplation, Contemplation/Preparation, Action, and Maintenance.

We found:

- Teacher's ratings for the Precontemplation stage were negatively associated with favorable attitudes towards SEL learning standards.
- In contrast, there was some evidence that teacher ratings for Contemplation/Preparation were associated with positive attitudes about SEL learning standards.
- Finally, strong positive relations were found between teacher ratings of the Action and Maintenance stages of change and attitudes about SEL learning standards.

These results suggest that as teachers move through the stages of change, their attitudes towards SEL learning standards become more positive. Unfavorable attitudes towards SEL are prominent among teachers high in precontemplation; teachers who are thinking about and preparing to change have attitudes towards SEL that are moderately favorable; and teachers high in action and maintenance report favorable attitudes regarding SEL learning standards. Future research should seek to better understand associations between teachers' stages of change and their overt SEL implementation behavior.

In Spring of 2014, 66% of teachers surveyed were in the Action or Maintenance stages and 61% reported using the curriculum at least one time weekly. Data collected in 2015 were similar to 2014, at which point we stopped collecting this data.

Medical providers. Staff from all 11 OSF practices participated in a half-day training by EDOPC on administering and scoring the screening measures and providing anticipatory guidance. A "black belt" from OSF and the nurse educator worked with each practice to develop an individualized process map for integrating screening and the subsequent referral process into the work flow. The top-down administrative support for universal screening has been strong and extremely effective in the roll out. We began with the four practices with the most pediatric patients and the most willingness and slowly added practices until August 2013, so that all 11 practices became engaged.

Each quarter, the following data are pulled from the Electronic Medical Record (EMR): number of patients seen (0-5 and 6-18); number of visits with completed screen, percentage of visits with a completed screen, number of referrals, patient zip code, and number of screens completed during the year (0, 1, 2, or 3). The percentage of 0- to 5-year-olds screened during a visit has consistently been around 96%, while the percentage for 6- to 18-year-olds has been about 91%, with the percentage being higher during the back-to-school physicals and lower during other visits throughout the year. As recommended by the American Academy of Pediatrics and consistent with our plan, 33% of 0- to 5-year-olds received three screens and 15% received two screens. The data reflecting "number of referrals made" is very helpful because this is the only indication we can get from the EMR that the child screened positive. There may be a small percentage of children with a positive screen for whom a referral is not made, but we have cautioned against this during the training process. Data collected from the Developmental Therapist (0-5) and the Resource Link Care Coordinator (6-18), whose roles are described above, should match the EMR. When they have not, we have been able to go back and investigate glitches in the referral process. These checks and balances were helpful in making sure that screening is happening, that it is being done accurately, and that no zip code is being systematically overlooked.

There are seven non-OSF practices in the county. They are either part of large healthcare systems in nearby counties or independently owned and operated offices. In April 2013, all seven practices were invited to an informational dinner (multiple phone calls, postal mailings, and several e-mails). None agreed to attend, and the event was cancelled. A Panopto podcast was developed describing the opportunities for grant-supported activities and disseminated by e-mail to the practices. In addition, a series of phone calls and e-mails were made to the office staff attempting to set up appointments to answer any questions about the video. Several office staff responded favorably to having watched the video. In September 2013, the medical sector (OSF) took the lead in hosting the community Summit and once again invitations went out to each of the practices. Ultimately, several office staff of three physicians attended and expressed interest about learning more; these are the non-OSF providers who have the largest pediatric populations. Since that time, two of those practices were provided with screening materials and training. In 2014, one non-OSF practice began implementing screening and follow-up referral. The second chose to implement policies consistent with a large healthcare system in a neighboring county. Without an overarching administrative structure, it has been difficult to communicate with the general and family practice doctors. We have learned that the medical office staff play a large role in the process of systems change. We have learned that much revenue is lost in order for training to take place and for a new process to go to scale, and this must be taken into consideration. As a result, the portion of patients that are pediatric may have influenced the responsiveness of the providers to implementing the various components proposed, as well as the existing infrastructure for implementing the many new initiatives being required within the changing healthcare environment.

School social workers/school psychologists. School psychologists and social workers (SP/SW) were trained in Positive Action and screening alongside teachers. Then, they received training and on-going support during monthly staff meetings on how to follow-up on positive screens. At the start of the grant period, SP/SW often went into classrooms to deliver social-emotional curricula; the new plan proposed that teachers take over this role and SP/SW provide Tier II supports in the form of small groups. Thus, they needed to have evidence-based resources for this purpose. In addition, much of the individual counseling provided to children with special education IEP's seemed to be long-term supportive counseling of a maintenance nature. They needed evidence-based materials to actively address mental health functioning. The SP/SW assisted in selecting Tier II and Tier III curricula for common referral concerns and familiarized themselves with the manuals individually and in small groups. Some individuals went to external trainings by the publishers and shared what they had learned with their peers. The intention was that they would progress monitor the child's symptom improvement and these data would guide treatment. To date, the only SP/SW actually gathering these data routinely are the trainees who maintain actual mental health files that are signed by their licensed supervisors. It is unclear how consistently SP/SW deliver the curriculum; however, they do tend to regularly draw from these curricula, as evidenced by the high demand placed on them in the LCSSU library. In 2015-2016, all SP/SW were slated to begin using an online progress monitoring instrument for their individual therapy cases; however, with both LCSSU and IHR experiencing staff turnover and shortages, this data collection fell by the wayside.

Approximately half of the SP/SW employed by LCSSU and the two largest districts consistently attend a voluntary group clinical supervision time, during which more challenging cases are presented. This has been highly valued by those who attend as a form of continuing professional development. While Tier II services are primarily skill-building in nature, this group engages in case conceptualization and treatment planning around Tier III cases. On multiple occasions, the group, which tends to think about systems-interventions, as well as those for individual students, has drafted informal policies around ethical or high-risk scenarios. For example, they researched strategies for managing dual relationships, which are common in a small rural community where many of these providers live and work. Another example has to do with evaluating self-injury or suicidal risk and breaking client confidentiality. In 2013-2014, the group enthusiastically responded to the idea of engaging in a "book group" with non-school providers around treatment of children with trauma histories. The online book group participation never really got re-established in the

fall of 2014, although providers anecdotally report using the activities and knowledge from the book with clients. In 2015, we often referred to the book during our Tier IV staffings. Beginning in 2013, interns have been trained in the ARC model through a book study each summer. Additionally, as new SP/SW staff are hired, they are given the book to support their practice within the community.

IHR therapists. A major shift in the service model at IHR involves parent engagement in treatment. In some cases, as is the case in the schools, individual child and adolescent therapy is accompanied by parent consultation. In other cases, however, the target of treatment is the parent-child dyad or the family system. While, in the past, parents would often drop their children off for treatment and head to Walmart for the hour, this practice has stopped. We contracted with NTI to conduct several distance learning sessions with the IHR therapists during their regularly-scheduled clinical staffing time. NTI provided some readings in advance on interventions that were dyadic (i.e. Theraplay, Dyadic Developmental Psychotherapy) and then provided a webinar presentation; the clinicians could see the PowerPoint slides and hear the presenter. Technical difficulties prevented it from being as informative as expected. The training encouraged heightened awareness of interventions and some research. Some practical ideas were given as well as reinforcement of what clinicians were already doing. In the long run, though, if they were going to implement any of the selected treatments, they felt they would need to experience a more in-depth training. Nonetheless, the trainings facilitated the groups' thoughts about parental participation in the treatment process.

Several of the IHR therapists participate in each CIA meeting as they present and discuss their Tier IV cases. As data have been collected on the Tier IV cases that have been staffed, it has become clear that there is a pattern. All of the cases have complicated trauma, attachment, and loss histories. The CIA meetings have been a great opportunity for continuing professional development, and those who participate are eager to be a part of the "book group" over the next few months. The plan has been for everyone to read a portion on their own, dialogue via the internet with providers in other sectors, and talk about the content in the context of current cases, while in their own respective group supervision sessions.

In 2014, several individuals received specialized training in trauma-informed and attachment-informed treatments (3=Eye Movement Desensitization and Reprocessing, 1=Theraplay, 8=Trust-Based Relationship Intervention). In 2015, therapists began using biofeedback technology at IHR and in primary care practices and began progress monitoring therapy cases electronically.

Parent coaching medical providers and IHR therapists. Ineffective parenting has been the single most commonly and consistently reported concern across the community. Although IHR has always offered a group parent training curriculum that some individuals are mandated by the courts to attend, very few individuals ever participated in it, despite free materials, babysitting, food, convenient location, etc. Our implementation plan required a bold and comprehensive strategy to address this identified need.

One program, Triple P or Positive Parenting Program, offered a public health approach that seemed to be a good fit. In particular, the idea of providing Tier II parent support in doctors' offices made sense; children almost always have their parents with them when at the doctor and frequently parents seek their medical provider's advice about social, emotional, or behavioral concerns for their children. We began exploring the model and spoke with medical providers who used Level Three Triple P. They reported that they were definitely pleased that they received the training and were using it in their offices, although they found that they typically could only deliver one to two 20-minute sessions rather than the four suggested by the model. Mental health therapists, given the shift described above to include parents in treatment, were also identified as appropriate for this training. Twenty individuals (half medical and half mental health) participated in a multi-day training in the Spring of 2011. Since that time, 19 of 20 individuals have been accredited by Triple P. Unfortunately, implementation of the curriculum appears to have been relatively unsuccessful.

We surveyed the providers in the Spring of 2013 and received responses from doctors, mid-level providers, nurses, and mental health counselors who had been trained; over half responded. Eighty-three percent said they used Triple P Parent Coaching with 1-24% of their patients, and 90% reported using the Tipsheets with this same percentage. Over 80% of the time, they reported using the curriculum in a single session, with no follow-up visits. In nine percent of cases, providers reported that lack of confidence with the curriculum and too few child patients were barriers to implementation. Most providers listed issues with time and money. Over half of providers (54%) reported that the scheduled visit was too short to incorporate Triple P, and 73% reported that the curriculum had not been effectively integrated into the work flow. In the comment section, providers went on to say that, although they felt the tip sheets and time spent coaching parents was valuable, there were many barriers to implementation. In addition to those listed in the survey, they added inability or lack of knowledge of how to bill for Triple P; the prohibitive cost of training and tipsheets, and lack of administrative support as barriers to implementation.

The IHR therapists continue to use the Triple P DVD and hand out the tip sheets with evidence-based strategies for parents, but they strongly believe that most parents who tend to come to IHR require a more intensive parenting intervention than just a few 15-minute conversations. Medical providers have discovered what the physician champions reported. The curriculum is almost too intensive for them to integrate an unexpected request for parenting help into the busy work flow. Even if they can start a conversation and provide a tipsheet, parents do not return for more parenting help. Basically, we feel like we chose to split the difference between the two groups and ended up with a level of intensity that was not appropriate for either one. As of March 2014, we decided not to pursue the roll out of this curriculum to additional venues.

At the tail end of 2014, we disseminated a technology mini-grant request for proposals. Providers in schools, community mental health, obstetrics, and the courts secured devices to systematically utilize technology to facilitate parents' access to parenting resources. OSF has already launched The Newborn Channel as a Tier I intervention and we are working to stimulate increased utilization of expectant and new parents across entry points.

In summary, we have engaged adults across sectors in the responsibility of nurturing children's mental health. In turn, we have provided training that has led to additional kinds and levels of services being available in natural settings, such as schools and doctors' offices. Lastly, we have shifted some treatments upstream, allowing the therapists and school psychologists/social workers to focus their energies on children and families with the highest needs. This multi-leveled approach within each organization's hierarchy has required a tremendous amount of support at each level. While top-level administrators' buy-in is critical, the buy-in of those actually implementing changes as a part of direct service is every bit as necessary.

9.0. Stakeholder and community orientation, training and communication

When the RFP for the Children's Mental Health Initiative was released, Dr. Huber, who later became the Project Director, approached the Executive Directors of each of the entities later included on the Executive Council. She explored the readiness of each individually and invited them all to a meeting to discuss the ramifications of pursuing funding for a comprehensive systems change. As with any conversation about needs for improvement, individuals can be sensitive to the implication that the current state of affairs is inadequate. In the end, the community collectively expressed concerns over their youth outcomes and committed to self-examination and implementation of a plan to revolutionize the way they do the work of children's mental health. One of the ways we approached this was to ask each leader, "Pretend that it is five years from now and the newspaper headlines report that outcomes of this initiative. What would you want it to say?"

One of the first components of the program evaluation was to get a baseline of youth risk behaviors and psychological functioning. When the data was compiled, we started to work on a fact sheet we titled, "The State of the Children." We expected that this information would compel partners to join together. In consultation with NTI, however, we decided not to disseminate the data. It was demoralizing. What's more, the extensive poverty in the community and long-standing shortage of resources within the community had led to a pervasive sense of deprivation and fore-shortened future. We determined to wait until we could also present the solutions that the community was proposing and, perhaps, even some early successes. This conversation was a precursor to our later development of the Community Scorecard, which shares on-going progress on the community's objectives.

The biggest focus in the early years was on developing awareness among providers in all sectors of what services are available and how to successfully make appropriate referrals. We have made huge strides in this area. Having fully informed "case manager" positions in each sector has also facilitated access, as well as navigation of the system.

Each quarter, members of the Leadership Team report various avenues by which they have raised awareness within the community. These activities include presentations to various constituent groups. We have provided news releases, radio interviews, and newsletters. We have distributed promotional items directing individuals to our website, which is very informative. Finally, in the fall of 2013, we hosted our first annual Community Summit. We informed attendees about our process to date and 16 individuals representing the full continuum of care each spoke about their role. We ended with some stories about lives that have been changed as a result of the community's efforts. Slides and audio of the entire presentation is available through a link on our website. In addition, we hope to engage parents and youth in promoting these priorities in our community. To date, much of what we have accomplished has been TO and FOR youth, and we are interested to learn more about our youth's interests around promoting mental health. For example, recently, the teens at Pontiac Township High School created a YouTube video to promote acceptance of classmates with cognitive impairments. Prairie Central High School students created a mental health awareness video.

In the fall of 2014, 2015, and 2016, we hosted Community Summits during which we presented our "community scorecard" that shares progress on metrics important to the community (Attachment Five). Short promotional videos were shot at each Community Summit and are being used by stakeholders to increase awareness and buy-in. We conducted a walk for children's mental health and other activities in May each year to coincide with National Children's Mental Health Awareness Week. Youth staff of Operation Snowball played a large role in the success of the walk in the elementary schools. We distributed T-shirts that continue to be worn regularly in the schools.

10.0. System level advocacy

Each entity within the community is involved in advocacy around its own sector, with active involvement with their respective professional organizations. The presiding judge, for example, is a passionate advocate for children's well-being and is involved in state and national task forces working to divert youth from the prison system. Several members of the Executive Council have joined together with other CMHI communities and the Sargent Shriver National Center on Poverty Law to develop and promote a legislative platform informed by the lessons learned within the LCCN.

11.0. Financing

11.1. Purchasing/contracting

The grant was administered through Illinois State University with annual subgrantee contracts to the four sectors. Two-party agreements were executed for some individuals. Also, parents in the cross-site and teachers in the local evaluation were compensated for their participation in the program evaluation. The LCCCY followed this same process for distributing the Sustainability Gap Funding.

11.3. Revenue generation and system reinvestment

Several grant-funded positions were piloted to determine whether they might be independently sustained through billing. One such position involved IHR buying out time of a dually credentialed school-based provider. In other words, some school psychologists and social workers who are credentialed to work in schools also hold licenses for independent practice. IHR, with grant funds, purchased a day or two a week of one of these dually-credentialed providers and then billed for those therapy services. From a programmatic stand-point, this was a bit complicated, since providers had to be clear with the schools and families about which employer they were working for on a given day. The intention was to collect funds in a separate cost center to determine if funds collected could off-set the cost of the buy-out. In time, the funds generated could be applied to additional FTE in schools. Similarly, a buy-out of some of a licensed school/ clinical psychologist's time was devoted to performing psychological testing of the highest need youth. The goal was to bill third party payors through the community mental health center's billing infrastructure for this type of testing that would not typically be done as part of a school-based special education evaluation. In both cases, it was initially difficult to determine how much money was actually secured from third party payors, due to delays and denials. Ultimately, it was concluded that neither position could be independently maintained without grant funds.

11.4. Billing and claims processing

The schools and courts are generally not in a position to bill third party payors. Thus, this section will focus on the healthcare system and the community mental health center, IHR. IHR bills, under Rule 132, for services provided to the community's children and youth. Families who are uninsured or under-insured can receive care at a reduced rate; IHR bills the Livingston County Mental Health Board (708 Board) for these sessions. IHR has faced significant difficulties with delays, denials, and lack of payment from the state. Given the community's rural nature and the desire to overcome stigma associated with receiving therapy, IHR chose to place therapists in natural settings. Therapists provided co-located therapy services in all of the outlying OSF primary care practices; all of these cases were officially IHR cases; scheduling and record management were conducted by IHR office staff in Pontiac. All sessions were billed to the 708 Board. In the final year, a full-time therapist was placed in a suite of practices at OSF St. James Hospital; the setting was certified as an IHR Satellite, and these sessions have since been billed under Rule 132.

OSF partnered with ISU to place a doctoral psychology intern in one primary care practice in Pontiac to serve as an integrated behavioral health consultant on the healthcare team that consisted of three doctors and two mid-level providers. OSF covered half the intern's stipend; the intern spent the other half of the week in Livingston County schools, and this portion of the stipend was provided by the education sector. These services were considered "value added," and no billing was attempted.

OSF engages in universal screening of 0- to 18-year-olds. Administration of these screenings are billed to third party payors. Only one Blue Cross Blue Shield plan has denied coverage; some of the few families covered by this plan declined to complete the screener. Resource Link Care Coordination is not billed. Follow-up parent coaching and other mental health services provided within the practices are funded, as described above.

11.5. Utilization of ILCHF grant funds over time

Across the implementation years, the use of ILCHF grant funds fell into three broad categories: System of Care Organizational Structure/Leadership, Execution of the Plan: Direct Service Expenses, and Evaluation and Monitoring of the Project. Consistently, approximately 45% of funds went to each of the first two categories, with approximately 10% devoted to the program evaluation category. The grant was administered through Illinois State University, and 10% of the total was considered indirect cost. None of the local administrators were compensated for their substantial time commitment to the Executive Council, Leadership Team or Work Groups.

The development of each yearly budget followed a similar pattern. After reviewing the data collected and listening to the plans delineated by both the work group members and the leadership team, the Project Director would draft a budget. This draft budget was presented to via e-mail to the members of the Executive Council. Then, during a "closed session" of the Executive Council, the members would openly discuss the line items that were included, as well as the amounts allocated to those line items, until they reached consensus about the use of the funds to support the collective priorities of the group.

In October 2014 and April 2015, the Executive Council requested technical assistance from Dr. McGourty in preparing a sustainability plan. Importantly, the Project Director and Project Manager were not included in this discussion to answer the following five questions: 1) What are we doing differently that needs to be sustained? 2) Has it required additional personnel resources? 3) Is the LCCN Project Manager position still necessary? 4) How will we manage the LCCN project going forward? 5) Which of the current entities are able to commit to remaining an active participant of the LCCN in the future?

All of the entities involved in the development the original implementation plan are still fully aligned with the initiative. The people who are the most aware are also those who are most supportive and engaged. The top-level administrators of each of the LCCN partnering entities have demonstrated strong and consistent commitment to the initiative. The second level, which represents individuals who have one foot in administration and one in direct service, are now fully involved and invested. The direct service level mental health providers are increasingly changing the way they do the business of children's mental health, with few hold-outs. In all four sectors, mental health, medical, juvenile justice, and educational, we continue to make in-roads in terms of further integrating the plan into the institutional practices and identifying funding sources to maintain the plan following the grant period.

Our focus has shifted to maintaining and further embedding initiatives at each tier of our four-tiered public health model and within each of the various sectors, making course adjustments as necessary in response to local evaluation data, and adapting to the changing socio-political climate and its impact on various funding streams.

AT TIER I

- **0-3 years.** The Newborn Channel is providing universal education to new parents regarding the health and well-being of their infants in OSF Obstetric Practices during the pre and post-natal period (~ 250 and 50% of county births). We are continuing to monitor access and utilization as part of our local evaluation and have made efforts to facilitate access through various forms of technology in the OSF OB unit, OSF 0-3 Rehab program, and the Health Department. OSF is responsible for this component and no grant funds are required to maintain it.

- **3-5 years.** In Year Four, we contracted with a provider trained in Circle of Security to provide multiple, sequential, and cumulative trainings to all providers of early childhood services. She is continuing to consult with these providers as they implement Circle of Security principles in their respective settings and providing coaching to parent educators, as they develop parent training. LCSSU is responsible for this component and no grant funds are required to maintain it.

  Of 3- to 5-year-olds participating in screening, approximately 5% have no physician on record. Having a medical home is considered to be a universal intervention; families are connected to Resource Link which, in turn, connects them with a conveniently-located medical provider who will accept their pay source. Resource Link will continue to offer this service to ensure that all 0- to 18-year-olds have a medical home. OSF, in collaboration with the schools, is responsible for this component and no grant funds are required to maintain it.

- **K-8th grade.** Teachers in the county K-5/6 and select middle school teachers have been trained in Positive Action and have a kit available. Many schools have a "social-emotional champion" who, with support from the project manager, is providing on-going coaching to his/her peers on implementation of the curriculum; these champions received their last grant-funded stipend in fall 2015, and most have continued in this role without the added compensation. Utilization is not yet universal in buildings where there has been administrator turn-over or inconsistent leadership with regard to the initiative; however, we are learning that there are teachers who are implementing, but who are not completing the fidelity checklists, suggesting that our data may be an under-estimate. We have continued to monitor teachers' readiness to implement the social-emotional learning curriculum. School districts have absorbed the costs of continuing the curriculum. The Project Manager coordinates the work of the champions and continues to make site visits to keep administrators informed of data being collected within the local evaluation.
- **9-12th grade.** Tier I interventions in the high schools are not universal. The most pervasive concern involves students' ability to regulate their affect. Self-reported risk behavior data suggests that many lack the skills to cope with their stressors. Each building has been equipped with a book of 5-minute "focus activities" to use with all students on a regular basis to teach them mindfulness skills, to quiet their minds, and calm themselves. So far, no building has used these consistently, largely because the Tier III and Tier IV needs appear to require more time and energy than staff can muster. The program manager, school psychologists, and social workers will continue to work with administrators to determine how best to implement this strategy in each building. In several buildings, there have been efforts to integrate a weekly evidence-based skill-building curriculum, Strong Teens, into ninth grade required classes. LCSSU is responsible for this component and no grant funds are required to maintain it. The Project Manager continues to lead problem-solving and planning meetings with school-based providers and leaders to move forward school-wide initiatives that promote health and well-being; feasible implementation strategies tend to be unique to each building.
- **0- to 18-year-olds.** Children, youth, and parents are being encouraged to take advantage of a lengthy list of on-line resources and mobile phone applications available on the LCCN website. Awareness of the website has been increased by community outreach events, such as the Children's Mental Health activities in May 2015 and 2016. Providers in schools, community mental health, juvenile justice, and medical sectors have been equipped with mobile devices to facilitate exposure to the resources. In addition, they have received motivational interviewing "cheat sheets" to use with families to increase the likelihood that they will actually use any of the strategies to which they are introduced. All entities receiving devices are responsible for this service and the maintenance of the equipment, and no new funds are needed to maintain it. The Project Manager will be responsible for maintaining updated resources on the website and promoting community awareness; Sustainability Gap funding has supported her in this role.

AT TIER II

- **0-3 years.** The Health Department and OB practices screen pregnant individuals for domestic violence, substance use, and depression. Approximately 50 families participate in Healthy Families, and an additional 30 families have been engaged through the Better Birth Outcomes grant. The ASQ or ASQ:SE is being administered to 97% of 0- to 5-year-olds during well-child visits with OSF providers. One of seven small non-OSF practices is also screening; most of these have very few pediatric patients. In addition to primary care practices, the Health Department continues to screen using these measures or the Denver in all programs, and OSF's Rehab program continues to provide screening opportunities in community settings.

- Tier II services are almost exclusively provided through the Health Department or through OSF's Infant-Toddler Enrichment Program (funded by Local 377 dollars). OSF offers a parent-child group, which has been attended by as many as ten families, and the group typically runs with few members; we are exploring strategies to increase enrollment. The OSF developmental therapist attended a Theraplay training before the end of Year Four. Head Start secured funding for Early Start and now serves an additional eight children and two pregnant women with in-home services. Several local entities are responsible for these services and collectively commit that they will continue to prioritize local funding for 0-3, despite state budget cuts.

- **3-5 years.** In addition to the screening sources mentioned above, approximately half of all preschool-aged children participate in LCSSU's preschool screenings, conducted by a trans-disciplinary play-based team. The largest school district (#429) screens using the Brigance and was fully integrated into the system of care during Year Four.
  - Tier II services include enrollment in Pontiac Head Start, a structured preschool experience, or At-risk Pre-K program. Beginning Fall 2015, Head Start in Pontiac decreased its services from two classrooms to one. This has had the greatest impact on the Pontiac #429 school system, which is faced with serving approximately 25 additional at-risk preschoolers.

- **K-12th grades.** Our goal is that all school-age children will be screened once in the fall each year. Six- to- 12-year-olds are screened in primary care, using either a parent-report or youth-report Pediatric Symptom Checklist (PSC). Children in all K-5/6 grade classrooms are universally screened by teacher report using the BESS, while junior high students complete the self-report version. The publisher of this measure is releasing a new, updated system, and the community will need to determine in Year Five how it wants to proceed. While the schools have budgeted for the expense of the BESS, it is possible the cost of the new measure will be prohibitive. In high schools, universal screening using the PSC has been successful in some buildings, while in others it has been inconsistent or continues to target one or two grades.
  - School social workers, psychologists, and interns consult with parents and teachers to determine which children are appropriate for which Tier II services. Options include evidence-based groups, such as Strong Kids, WhyTry?, and Adolescents Coping with Stress. Many high school students appear to have a great deal of difficulty managing distress and engage in self-injury or suicidal attempts; as a result, in Year Four, all high schools were equipped with Dialectical Behavior Therapy manuals for use by school psychologists and social workers with groups of students who have these concerns. Eighty percent of students identified as at-risk received individual or group services at school. With the massive increase in the amount of therapeutic services being provided in schools, the sector has begun to rely heavily on additional human resources in the form of trainees. While funds were budgeted to maintain the trainees, the uncertainty of the state budget situation has called this into question.
  - Integrated Behavioral Healthcare is provided by doctoral psychology interns in a primary care practices (.8 FTE); this model seems to be ideal for providing behavioral health consultation and facilitating connections to Tier III services, as appropriate. OSF is responsible for this service, and no new funds are needed to maintain it. With Sustainability Gap funding, an IHR therapist was added (.2 FTE) in a primary care suite within OSF St. James Hospital. This position is in addition to the part-time embedded IHR clinicians in five rural communities.

AT TIER III

- **0-3 years.** Children in this age group and their parents receive services through OSF Rehabilitation or the Health Department. Our Early Childhood Intervention services were re-bid, and we are now being served out of Champaign; there have been some significant disruptions in our otherwise smooth

system of care, due in part to disruptions in state funding. Providers are working diligently to restore continuity of services around Global Developmental Assessments, treatment planning, and therapy. The medical sector is responsible for sustaining this component, and no external grant funds are being sought at this time.

- **3-5 years.** Tier III children in this age group often receive Trans-Disciplinary Play-Based assessments and Early Childhood Special Education services to target developmental needs identified by the team. IHR administrators and therapists have committed time and energy to develop expertise in evidence-based treatments appropriate for younger children, especially those who may have experienced trauma, loss, or attachment difficulties. IHR and LCSSU are responsible for these components and no grant funds are needed to maintain them.

- **K-12th grades.** Children and adolescents receive individual therapy at schools, doctors' offices, at home, or in other community settings. In addition to evidence-based interventions for attachment and trauma, developmentally appropriate curricula are available for the top-five referral concerns encountered in schools. IHR has placed therapists in most high schools for four to eight hours per week to improve access for youth with identified mental health disorders. IHR served many more children and adolescents last year over baseline. We began administering the Youth Outcome Questionnaire in both the mental health center and the schools to monitor the progress of youth receiving individual therapy. Results on the measure can be viewed by therapists associated with a given child across agencies, thus facilitating coordination of treatment. IHR and LCSSU are responsible for this component, and no grant funds are needed to maintain it.

AT TIER IV

- The Comprehensive Inter-disciplinary Assessment (CIA) team meets to discuss children and youth:
  1) who tend to be deteriorating despite the best and coordinated efforts of the treating providers,
  2) whose providers have questions about how best to understand the client and proceed clinically,
  3) who have multiple siblings and parents with needs that interact, resulting in a sense that the family should be staffed as a unit and all parties clinical needs considered in the treatment plan, and
  4) whose families are involved with DCFS, SASS, domestic violence, probation, or other social service agencies, all of which hold some clues to the best path forward.

  The CIA continues to streamline its referral form and its staffing process and engage in additional standardized assessments for a small number of cases. The CIA continues to prioritize staffing children served at the county's self-contained ED/BD programs, looking for ways to combine resources across sectors to keep youth from more restrictive settings. The CIA is a relatively costly enterprise in that it involves three hours every other week of an average of eight to ten providers. In addition to the direct service providers in schools, mental health, and probation, core members of the team include an individual from DCFS, the Resource Link Care Coordinator as medical liaison, the Family Support Specialist from Court Services, the Family Resource Developer from SASS. All entities have budgeted to maintain support of the co-leaders employed by IHR (Clinical Director) and LCSSU (Project Manager). In addition, the time of the licensed psychologist takes to complete the CIA evaluations has been grant funded. LCSSU has assumed the bulk of this expense, with support from IHR.

- The Family Support Specialist provides screening and case management for all court-involved youth. The Regional Office of Education, Probation, and the Mental Health Board have jointly budgeted to sustain this position; no grant funds are needed to maintain it.

- We have been able to expand the role of the Family Resource Developer. She provides in-home parent coaching for the highest need families, including children placed in self-contained programs for emotional and behavioral disorders. She is highly effective, and families respond well to her services. The community mental health center is responsible for this role; similar to other mission critical roles, Sustainability Gap funds have helped maintain this role.

In summary, the members of the Executive Council have analyzed the various grant-funded expenses associated with the system of care, as we now know it, and projected commitments to one another based on what they believe at this time to be feasible. In many cases, the implementation of our plan has involved training, improved coordination and collaboration, and changing how and where services are delivered; maintaining these developments is not expected to be too costly. Expenses associated with the project director and the cross-site program evaluation will be eliminated. While FTE associated with some positions may be slightly reduced, in general, the costs for the majority of services and supports deemed necessary for the continued success of the initiative will be absorbed by the current employing and/or responsible entity. Collectively, the members committed $450,000–$500,000 to be used annually to sustain personnel and direct costs associated with the four-tiered public health model of children's mental health care. Moving forward, all direct costs previously funded by the grant have been assumed by local entities, including LCCN office space/equipment/technology, professional education/training, community outreach, travel, clinical/screening materials, office operations, and clerical/administrative support.

12.0. Information management

12.1. Protecting child/family privacy

CONFIDENTIALITY AND PRIVACY REMINDERS

Except as required by law, providers refrain from sharing information with one another without a current, signed exchange of information form documenting the parent/guardian's consent. Clinicians use considerable professional judgment when determining bounds of a child's confidentiality with parents and other adults significant in the child's life. They discuss limits to confidentiality with both the client and parent/guardian as a part of informed consent for treatment. These limits of confidentiality, at a minimum, include when children are at risk of harming themselves or others or when children are at risk of being harmed.

All services are documented in writing. Client records must be maintained in a secure medium consistent with the sector's privacy regulations. For example, a locked file cabinet in a locked room for paper records is used, as is a protected data base on a secure server for electronic data. Removing records from the premises is highly discouraged. However, when these documents are necessary for reference at meetings, confidentiality is maintained with the utmost care. If documents are transported in electronic format, they are on password protected flashdrives.

While children 12 and older have authority under certain conditions to release their records under the Illinois Mental Health Code, educational (FERPA) and medical (HIPAA) regulations require parent/guardian consent for children under the age of 18. Thus, there could arise a situation where one provider can release information to another, while reciprocal communication is not allowed. Similarly, while under Illinois Mental Health Code, minors are allowed up to five sessions without parent/guardian consent to treat, it is customary to involve parents whenever possible. While it is legal to provide services to a minor with consent from one parent, best practice encourages the involvement of the other parent, except under special circumstances (e.g., there is a court order against it, in some cases of domestic violence, or when parental rights have been terminated). In addition, unless parental rights are terminated, a parent continues to have legal right to mental health records of offspring, regardless of custody arrangements.

When consulting around "hypothetical scenarios," providers refrain from including any identifying information about clients that could inadvertently result in the identification of the client, thus breeching the clients' right to privacy.

Electronic communication regarding clients must be done with caution. Identifying information (including names or initials) should be in password protected attachments only and not in the text of an e-mail. Passwords should be developed verbally in advance and not included in the e-mail. Faxes should contain a notice of confidentiality on the cover sheet, and best practice would include a confirmatory fax from the receiver.

E-mail communication with consumers is highly discouraged and should be limited to scheduling purposes only. Messages should not be left on consumer voice mail without advance permission.

12.2. Sharing information between systems

Communication between systems has improved tremendously as a result of providers becoming much more familiar with one another's services, and growing respect for one another has led to increased collaboration at both the individual and systems levels. The universal exchange of information form was an early success of the LCCN Leadership Team (Attachment Six); the process of creating it opened lines of communication and an understanding of the parameters within which the various entities work. The form is used in all child-serving sectors.

Protocols for a "warm handoff" between entities was developed and institutionalized, with steps listed on a universal referral form. A universal communication form triggers periodic communication from the therapist to the referral source. Both of these forms are used but perhaps not as consistently and uniformly.

Communication across sectors is greatly facilitated by the four liaisons. For example, the results of a positive screen in primary care is delivered to the parents/guardians in person and a signed exchange of information is signed that includes all the entities serving the child. A referral within the healthcare sector is made to the Resource Link Care Coordinator. She connects with the family to do a brief intake and gather information about the parents'/guardians' desire for follow-up services. She then connects with the liaison in the schools, community mental health center, and courts, as appropriate. Those liaisons, in turn, identify the provider most proximal to the child and provide the request for follow-up services. The provider then works directly with the family, with communication back to Resource Link regarding attendance and progress. Resource Link documents this information in the electronic medical record, keeping the referral source informed. A similar, but reversed, process is followed, if the youth's needs are identified in one of the other three sectors.

12.3. Electronic medical records

Each sector has its own unique electronic record system. Generally speaking, this rural community has become much more comfortable in knowing that information about them is stored electronically, although there are still families that refuse to allow their child's vaccinations to be in the Health Department's state database. During the final years of the grant, the Youth Outcome Questionnaire was purchased. This instrument is the gold-standard in progress monitoring; brief self- and parent- report measures are administered using a smart phone or iPad, and they are instantly graphed and stored in a secure file. With signed exchange of information forms, school, healthcare, court, and community mental health providers can all log into the youth's record and monitor progress. We anticipated collecting parent-report data in non-school settings and youth-report at school. In addition, the parent-report measure was approved for use by teachers. To date, this resource has not been widely used. Anecdotally, providers report being overwhelmed with other assessment and intervention responsibilities.

13.0. Quality improvement

The "process data" portion of the local evaluation plan was overseen by the Project Director and was intended to answer the following questions in an iterative fashion, so that the data collected informed community stakeholders at each stage of implementation.

- Are we doing what we proposed to do?
- Are we on-target to accomplish our goals and objectives?
- Are there other important things we didn't plan for initially that must be taken into account, in order to achieve our short-term outcomes?

During the initial needs assessment, stakeholders identified a number of metrics that were of particular concern and importance to the community. We predicted that successfully implementing the four-tiered public health model to address children's mental health would ultimately bring about measurable gains. We articulated four goals with subsequent objectives and strategies to be implemented across inter-connected systems. The program evaluation team was charged with monitoring whether all providers were making the changes as agreed and whether or not these changes were bringing about the desired effect. The data was intended to be used to inform course adjustments over the life of the grant. The universal implementation of the evidence-based social-emotional learning curriculum, Positive Action, in all the county's schools was viewed as incredibly ambitious and likely very important to the overall success of the model. The program evaluation team devised a formal quasi-experimental study design to evaluate the added benefit of the curriculum over all the other components of the model. The longitudinal design and the wealth of data collected has provided the opportunity to explore several variables in our rural population, as well.

In Year 3, the program evaluation team was able to compile a large document describing the community's progress toward the attainment of its four goals and objectives; an updated version is attached. It also assisted in updating a "community scorecard" that is being used in a variety of venues to engage various constituent groups in the overall vision of the LCCN. There were also several changes in the program evaluation. First, there was a shift from collecting self-, teacher-, and parent-report data in schools where considerable "data collection fatigue" had been observed. Rather than focusing exclusively on the outcomes of Positive Action, the team focused its attention on understanding the process and barriers to implementing the curriculum. On several occasions, community stakeholders were puzzling over a question and asked the program evaluation team to see if they could find answers within the data set. For example, the presiding judge has become increasingly concerned about truancy. The program evaluation team was able to provide information about children in the county who have poor attendance, and they helped improve efforts by the local truancy board to address this problem. In years three and four, the program evaluation team began studying outcomes of the new diversion, as well as treatment strategies being implemented in the juvenile court system. They continued the cross-site data collection.

GOAL 1. Increase capacity of system of care

Objectives

- Increase workforce to meet needs
- Increase skills of current personnel
- Fill identified service gaps
- Identify funding sources

Methodology

- NTI Annual Gap Analysis (number of providers vs. need for providers)
- Wait time for psychiatry
- Service activity log
- Percentage of children screened during doctor visit
- Follow-up services provided to court-involved youth
- *Frequency Counts:* Number of children served by IHR, psychiatrist, Resource Link Care Coordinator, Developmental Interventionist, Family Resource Developer, Family Support Specialist and Comprehensive Inter-disciplinary Assessment team; average Number of Positive Action lessons; Number of families receiving dyadic/family systems treatment; Number of professionals receiving training

Similar to other rural communities, recruitment and retention of highly-skilled providers are on-going challenges. The entities have found engaging with institutions of higher education to provide pre-service learning opportunities to be a highly effective strategy that has allowed for on-going infusion of new

knowledge and much low-cost service provision. Providing opportunities for part-time employment and flexible schedules has also allowed partners to retain employees who are looking for work-life balance. For example, the community has retained several professional child psychologists who are competent to provide comprehensive inter-disciplinary assessments, a previously-identified service gap. Continuing professional development is sometimes a challenge. Innovative methods of accessing training such as group staffing of complicated cases and an on-line book group, have been used to incorporate training into clinicians' days and limit the impact on revenue. In rural communities, all employees need to be generalists first; yet, some providers have received additional training to address specific identified gaps, such as dyadic treatments for young children and evidence-based strategies to resolve trauma. Members of the Executive Council have developed a sustainability plan that focuses on each entity's plans to maintain human resources necessary to maintain the system of care. While all entities experienced the natural ebb and flow of providers during year five, Livingston County Special Services Unit lost several school psychologists and were unable to fill all their positions. The cooperative was shorter staffed than ever before, which put an enormous strain on the remaining school psychologists and social workers to sustain all the components of the four-tiered model. Most specifically, Dr. Shelvin, the Program Manager, who was slated to absorb many leadership and administrative duties of the Project Director, had to spend much more time in direct service and clinical supervision than expected, which made the transition at this time particularly difficult for her and the LCCN.

GOAL 2. Increase accessibility of services

Objectives

- Identify barriers to utilization
- Decrease stigma barrier
- Decrease financial barrier
- Decrease transportation barrier
- Increase awareness of services and how to access them

Methodology

- *Frequency Count:* Number of families assisted with securing Medicaid/Health Insurance; special education students on Medicaid, clients served in community settings
- List of barriers reported by parents during case management
- Cohort parents' self-reports of stigma, personality, and parenting

The community has successfully increased access to services. In schools, elementary children are in classrooms with teachers trained in Positive Action and equipped with the evidence-based curriculum. Implementation continues to vary; however, 66% of teachers report being in the Action or Maintenance stage in their readiness to adopt their new role as instructors of social-emotional learning. Students receive an average of 25 lessons per year, which is considered by the publisher to be the bronze level of fidelity.

The number of youth served by the community mental health center, Institute for Human Resources, peaked in 2015, 1,266 vs. 464 in 2011. The number of youth served annually has leveled off at about 8% of the total population of 0- to 18-year-olds, which has been interpreted as a sign that youth who need care are getting it, and meeting the mental health needs of youth has become manageable. The number of parents of 0- to 5-year-olds and 6-18-year-olds accessing parent consultation and support has doubled.

After our DHS office closed, the Livingston County Health Department helped families access Medicaid and other health insurance; however, funding for this purpose has ended. The number of special education students on Medicaid increased from 470 in 2011 to 651 in 2015, but in 2016 this figure dropped to 416, suggesting that families are having difficulty maintaining enrollment. Increased access to services is due in

part to the community's efforts to place providers in natural settings, such as home, church, doctors' office, library, park, and school to overcome stigma, finances, and transportation, as well as reliance on local 708 dollars for uninsured or underinsured families. For example, there are part-time clinicians in six primary care practices and the suite of providers at St. James Hospital, which includes OB. IHR has begun billing insurance for some of these clinical services to offset the growing burden on the 708 board's resources. Therapists employed by schools, mental health center, courts, and primary care have tablets to assist clients in accessing on-line resources.

GOAL 3. Increase coordination of services

Objectives

- Promote linkages to the medical home
- Increase likelihood of successful transition from one setting/provider to another
- Increase collaboration between providers serving same clients
- Utilize data to evaluate process and outcomes

Methodology

- Percentage of pre-school students with medical homes in-county, in practices with implementing provider, out-of-county.
- *Frequency Counts:* Number of families connected to medical home, physicians utilizing tele-consultation, patients in emergency room without medical home, crisis calls/SASS screens/psychiatric hospitalizations, emergency room visits, graduation rates, juvenile police reports

As seen above, families all across the community are accessing services at greater rates, owing in part to the "care coordinator" individuals in each of the sectors (education, medical, mental health, and juvenile justice). The Comprehensive Inter-disciplinary Assessment team continues to staff our highest need families, planning and providing cohesive and seamless treatment.

We have been monitoring the percentage of preschool children without an identified medical home; the percentage has bounced between 1-6%, with no clear patterns in the data. We are also monitoring the number of children and adolescents in the Emergency Department without an identified physician; these percentages are similar, suggesting that the population utilizing this setting for medical care may not be substantially more likely to lack a medical home. Each year, the Resource Link coordinator has provided assistance to families needing a medical provider, and that number has remained consistent and low (i.e., 6-9). The number of visits to the Emergency Room has fluctuated between 2,200–2,500 over the first three years of the initiative; however, there was a substantial drop in 2015 to 1,571 visits. This figure has remained low, at 1,882 and 1,743 in 2016 and 2017 respectively, despite the closing of St. Mary's Emergency Room in a neighboring county.

GOAL 4. Decrease rates of risk behaviors and frequency and severity of mental disorders

Objectives

- Promote child and adolescent social-emotional skill development
- Nurture protective factors (e.g., adult-child relationships and school engagement)
- Identify and support at-risk children and adolescents

Methodology

- Youth self-report of risky behaviors, beliefs/acts of aggression, psychological functioning, perceptions of school climate
- Parent and teacher ratings of children's psychological functioning

- School archival attendance and discipline data
- *Frequency counts:* Number of children screened, Number and percent positive, Tier II and III services in schools

We have conducted an average of 9,397 screens on our 9,500 youth per year. We expect that very young children will be screened more than once per year, and we suspect some youth may be screened in more than one setting (e.g., primary care and schools); thus, it is difficult to accurately state the number of youth screened. The percentage of positive screens dropped from 17% in 2012 and has hovered between 9-11% since. In parallel, juvenile police reports have dropped from 448 to 231 over the same time period and recidivism is down to 14%. These outcomes suggest that the prevention and early intervention efforts are having a positive impact. Many children in PK-8th grade are in classrooms with a teacher trained in Positive Action and equipped with the curriculum. Of children who screen positive, on average 72% receive group or individual services in schools. High school graduation rates are on a steady climb from 82.8% in 2012 to 88.2% in 2015.

14.0. Evaluation

We received the first draft of the proposed cross-site program evaluation plan from NTI in January of 2011. Significant concerns surfaced as it appeared that the cross-site evaluation 1) would require a great deal of time, energy, and money that had already been intellectually committed to the implementation plan that had been developed, and 2) did not appear to really align with the goals and objectives that had been developed over the last 12 months of community planning. One problem with the cross-site evaluation was its heavy focus on screening; for some of the communities with larger populations, the entire grant award could have been devoted to screening with little left over for treatment. One complicating factor was that we did not yet know the level of funding that would be committed.

As a result, the Executive Council went line-by-line through the plan to determine components that could be cut without unraveling the original draft Plan and removed them. Subsequently, the Project Director conducted a series of meetings where she brought a prepared power point of the Implementation Plan to each entity that was part of the Leadership Team and presented alongside a representative from that organization. We were able to elicit feedback and buy-in from direct care staff, teachers, and various groups of citizens who were invested in children's outcomes.

When it became clear that the requirements for the cross-site evaluation were going to be extensive, a decision was made by the program evaluation work group: the Project Director would assume responsibility for the collection and analysis of process data so that the remainder of the university-based program evaluation team could devote its considerable expertise to more formal studies that had the potential to truly answer the question, "Are the children getting better, and why or why not?" For example, they conducted a quasi-experimental study of the effectiveness of the Tier I curriculum, Positive Action, to improve child functioning. They determined the level of fidelity necessary when conducting the Tier II intervention, Strong Kids, to yield significant improvements from pre- to post- test. In addition, as indicated by the LCCN Vision Statement, the community was very interested in several protective factors and their relationship to risk behaviors. Thus, the team measured and monitored parents and adolescents reports of stigma and its relationship to youth functioning. School climate, most specifically, teacher-student relationships was closely examined for its role in preventing adolescents' engagement in at-risk behaviors.

The local evaluation team responded to questions raised by the community throughout the project. When the implementation of Positive Action was resisted to a greater extent in some buildings than others, the team began an investigation of teachers' readiness to change their behavior and adopt the role as instructor of social-emotional skills as part of their professional identities and behavior. In addition, when it became apparent that the juvenile court played a sizable role in the long-term educational and mental health out-

comes of higher need youth and families, the team analyzed school attendance data and ultimately mined data from the files of all court-involved youth over the last five years. To date, they have been able to study the impact of community service as an alternative to detention, the impact of substance abuse on youth prognosis, the impact of mental health treatment on recidivism, and the relationship of parental incarceration on youth offenses. The findings of the local evaluation is reflected throughout this manual including in the LCCN Community Scorecard.

The implementation of a local evaluation, in addition to the cross-site evaluation, was a requisite element of the ILCHF grant. At the outset, ILCHF did not require any specific reporting on the local evaluations. In 2013, as the project was being implemented and there was a change in leadership at ILCHF, the Foundation required annual local evaluation reports. A local program evaluation template was developed which required the communities to provide data that in some instances was not currently being collected; as a result, the Project Director developed a more formal and comprehensive local evaluation reporting process. Unfortunately, some of the specific numbers requested in the template were unable to be calculated, for example, the number of children in the community served by the CMHI. Given the Tier I efforts, nearly all children were served. However, when required to report the number who received therapy, the community was able to report the number served in the various sectors and unable to account for an unknown amount of duplication of services across sectors.

15.0. Outcomes for children/families from the care system improvements

The most notable change in our community is that children's mental health has become the business of all sectors. First, the change began within our professional culture. To begin with, the providers at the mental health center accepted that this job was too much responsibility for one sector; they were willing to yield some of their established "turf" to medical and educational professionals. In turn, medical providers and educators incorporated social-emotional-behavioral health promotion, early identification, targeted intervention, and referral as an integral part of their professional identities. Even within the court system, which, by definition, is designed to punish "bad behavior," children's mental health has been prioritized in pre-trial paperwork; probation officers participate in clinical staffings and subsequently plan their interactions with youth based on a clinical understanding of the child's mental health needs.

These changes across sectors have not only changed the professional community; families have begun to expect that their child's overall health and well-being is important to their community. As the medical, juvenile justice, and educational sectors have begun to faithfully screen and respond to children and adolescents' mental health concerns, families have begun to understand that mental health is inextricably linked to physical health and educational attainment. Communication across sectors demonstrates the importance each sector places on the child's growth in the others. Families have also come to realize that help for mental health difficulties is valued and available in their child's medical and educational homes. These changes appear to have decreased the stigma associated with help-seeking and increased the likelihood that parents will consent to services; thus, bringing the community closer to fulfilling its articulated vision. In addition to these powerful and meaningful changes, we'd like to focus on three broad changes in the system of care: Access, Coordination, and Pro-activity.

Access. In 2009, the vast majority of individual therapy services were delivered either in school settings, as dictated by an IEP (as frequent as once weekly) or at IHR (typically once monthly). Medical and educational providers in the outlying areas bemoaned barriers, such as transportation, cost, and stigma inhibiting families from pursuing services in the county seat. Consumers complained about long waits to see a therapist or the child psychiatrist and found the system difficult to navigate. There were very few interventions that supported the parent-child dyad or that targeted the family system. Parenting classes for those ordered by the court existed but were poorly attended. In addition, some informants felt that the community lacked enough providers with expertise in complex child and adolescent problems.

Currently, with screening in medical, juvenile justice, and educational sectors, parents are invited for their children to participate in services; in most cases, these are services that would not otherwise have been initiated by the parent. Because many children are accessing those Tier II and Tier III services, without charge, and in natural settings, it does not seem like "a big deal" and, thus, unnecessarily stigmatizing. More providers with more training are available to provide services in homes, community settings, doctors' offices, and schools, which increases both confidence and the convenience of the parents. IHR has restructured so that there is no wait for an intake, and there are more immediate ways to secure child psychiatric services. Youth who may have fallen through the proverbial cracks are ultimately connected with services, as a result of their court involvement. Finally, families who may qualify for Medicaid or universal health insurance are connected with the health department, who scaffolds the family to coverage.

Coordination. At the time of our original needs assessment, key informants cited obstacles associated with privacy regulations and releases, as well as confusion about funding streams. They also confessed knowing little about exactly what services existed, what to expect in treatment, and how to access care. There were many examples of good programming across the county, but the system was fragmented. It was common for multiple providers to be treating various aspects of the child's functioning without being aware of one another, so that duplication occurred or families received contradictory information. Doctors sent prescriptions for special education IEPs. School providers referred families to their doctor or IHR, but they often never knew if the family followed through. Generally speaking, providers got their information about each other from their clients and did not necessarily trust one another.

Today, all entities in the county recognize a universal release of information form, and there are communication protocols across sectors. Nearly all children and youth have a medical home. School-based providers routinely ask for release to speak to the medical provider for any child entering Tier III. For zero-to-five-year-olds, this information is acquired even earlier, at screening. We are considering the merits of asking that release to medical provider forms for 6- to 18-year-olds be signed at school registration. Resource Link Care Coordinator, Court Family Support Specialist, SASS Family Resource Developer, and IHR therapists all have a list with contact information for the school psychologists and school social workers assigned to each building. They ask parents to sign consent to communicate with these providers, as a matter of course at intake. This consistent exchange of information and our inter-disciplinary staffing process have increased providers' knowledge of one another and the services available across sectors. As respect and confidence for one another has increased, this has led to better coordination. In addition, providers have begun to engage in common continuing professional development topics, which has contributed to more seamless treatment across settings and providers.

Serving on the Comprehensive Inter-disciplinary team is a core group consisting of IHR Clinical Director, LCCN Director and Project Manager, co-employed licensed psychologist, DCFS worker, Resource Link Care Coordinator, Court Family Support Specialist, and SASS Family Resource Developer. Various IHR therapists, school psychologists and social workers, and probation officers participate when their clients are being staffed. A uniform treatment plan is developed, which ensures that all providers understand and have predetermined roles in addressing the treatment objectives. There are a number of other changes in our system of care that have also served coordination by removing duplication. For example, our developmental therapist does very little screening, reserving her skills for global assessment and intervention. As another example, IHR therapists rarely provide individual therapy at schools during the school day where school-based providers already exist; rather, they more often provide dyadic and family systems services when parents are available and children are not in schools.

Proactivity. In 2009, there were virtually no Tier I and Tier II services in the community, resulting in a reactive service delivery system. As a result, we had an upside-down public health triangle with only Tier III needs being addressed; what's more, many of those being treated with Tier III level supports really needed Tier IV intensity, but the system simply did not have the capacity. The mental health and juvenile justice

systems were always playing "catch up," "putting out fires," and never able to strategically position themselves to turn things around. After four years, our triangle was hour-glass shaped. With persistence, at the seven-year point, it is becoming the triangle we intended with most children receiving an effective Tier I, promoting health, and a portion of children receiving Tier II targeted interventions, leaving fewer who actually meet criteria for diagnosis and a small percentage at the top of the triangle requiring our most intensive family system interventions.

PREVENTION (TIER I): OUR POSITIVE SCREEN RATE HAS DECREASED FROM 17% TO 9-11%.

- Parents and educators know and utilize practices that increase children's resilience.
- Children feel safe, valued, and engaged in home, school, and community.
- Children engage in fewer risk behaviors.

Screening

We performed 56,384 screens, an average of 9,397 per year, on approximately 9,500 children and youth.

- Children in need of early intervention services are identified.

Assessment

59 of the highest need youth have received fully coordinated care as a result of a comprehensive assessment staffing process.

- Comprehensive inter-disciplinary assessments are conducted to inform treatment.
- Medical, educational, and mental health services are coordinated.

Referral

Nearly three times as many parents in both the 0-5 and 6-17 age ranges are accessing dyadic interventions or parent coaching; nearly twice as many youth are accessing therapy at IHR.

- Adults access services for children when needed; barriers to utilization are overcome.

Treatment

Juvenile police arrests are nearly cut in half, while graduation rates have steadily improved.

- At-risk children benefit from active involvement of the medical home.
- Children's needs are monitored, and treatment is adjusted accordingly.
- Services are delivered in natural settings where generalization is optimal.
- Providers utilize evidence-based practices across the system of care.
- Children with mental health disorders receive high quality services with sufficient frequency and intensity to make measurable progress.

16.0. External technical assistance and consultation

The community has consistently been impressed with ILCHF's commitment to children's mental health and to the LCCN. One example of their attention to detail was the lengthy period of time allotted for community collaboration after the release of the RFP and the grant submission (September 2009 release; January 2010 due date). Another extremely valuable resource was the document entitled, "What makes a good plan" that was provided during the planning year and prior to submission of the implementation plan proposal.

NTI Upstream provided technical assistance and consultation throughout the planning year, implementation years, and one year of the progress monitoring years. Ira Chasnoff, MD, and Rich McGourty, PhD, complemented each other. Dr. McGourty, a psychologist, was an excellent facilitator, while Dr. Chasnoff often provided research regarding other communities with which they had worked. The two visited the communities 1-2x a year and engaged in periodic phone calls with the Project Director. Although the Executive Council members often felt there was a mismatch between the team's experience and priorities and that of the rural community, the fact that the two consultants remained consistent throughout the life of the grant endeared them to the community. Dr. McGourty's skills as facilitator were especially valuable as the Executive Council discussed sustainability. One struggle was NTI's emphasis on comprehensive assessment, as a follow-up to a positive screen. The community had extremely limited access to psychologists to complete comprehensive assessments and chose instead to implement a public health model that nested increasingly more thorough assessment procedures at each tier, parallel to the degree of clinical need. This difference of opinion compromised the cross-site evaluation, but it did not limit the value of the on-site technical assistance to a great degree.

The first event, which was hosted by ILCHF with NTI, was a Leadership Institute (mentioned earlier), which occurred during the planning year. The community developed its vision statement and conducted an inventory of the continuum of care (using the Screening Assessment Referral and Treatment model) for each age group. Each year, the community attended a Learning Collaborative hosted by ILCHF. The LCCN found more value in some than in others. The opportunities to talk with others within the CMHI were highly prized. Towards the latter part of implementation, we had a Learning Collaborative and follow-up visit from a consulting firm intended to help with sustainability planning, in particular. This firm asked different questions than either the local Project Director or the NTI consultants. While the community, generally speaking, did not find much value in their suggestions, several very positive things came out of those two interactions. For example, the community identified all the components they were determined to sustain in the long-term and also generated the idea for a Community Scorecard and Annual Summit, which have been quite instrumental.

17.0. Cultural competence

With a population that is 92.8% white, Livingston County is not a racially, ethnically, and linguistically diverse community. Cultural competence, however, still remains a concern when working in this community. As a moderate-sized, rural community, non-natives needed to increase their understanding of the rural lifestyle. Stigma around mental health concerns is a substantial deterrent to services. This rural community has a long history of partnering with the university for pre-service training and professional development. They remain relatively slow to trust non-natives, though, and react strongly when individuals leave the community. The members of the LCCN Executive Council acted as cultural brokers or liaisons between the project staff and the community. One cultural aspect that we addressed was related to the faith community. During our universal screening process, we received a few consents returned by parents forbidding children from being screened or receiving psychological testing. A small number of community members objected to psychological testing and interventions being delivered at school. Some attributed their objection to religious concerns. While we respected the families' decisions in regard to screening and intervention, these objections prompted us to clarify our message about screening. We made sure to communicate to parents that the screening was not designed to diagnose mental illness but rather to identify behavior that warrants intervention. In the event that the child exhibited significantly concerning behavior, we took care to explain the potential benefit of Tier 2 interventions as skill-building groups. We made the skill-building groups available for these students at the parents' request. In the end, if the parents were still uninterested in the service, we respected their decision. In many instances, however, the faith community was on board with the messages in the Positive Action curriculum. In one instance, the LCCN coordinator taught the Positive Action curriculum to church youth leaders. They were interested in using the curriculum in their afterschool program and youth group.

18.0. Sustainability/longevity of the leadership

When the community applied for the grant in 2010, all of the individuals who later comprised the Executive Council had been in their positions over 15 years. The Project Director had served the community for ten years. The Executive Director of the Institute for Human Resources, the community's mental health center, retired and his replacement took over during the Leadership Institute at the start of the planning year. This transition was fairly seamless. In the first implementation year, the lead school psychologist, who was serving as Project Manager, abruptly left. This departure had a powerful and long-term negative impact on implementation, since it left the school implementation team without a lead to coordinate the project during the first of the four years. Another sizable loss occurred with the VP of OSF St James who served as the medical sector representative; he was replaced by the OSF Regional Medical Group Manager, and that transition went smoothly. Similarly, the Executive Director of the Livingston County Mental Health Board retired after several decades in her role. She carefully selected a protégé, an employee who had some knowledge of the LCCN. Finally, the Executive Directors of the domestic violence service and court services also transitioned successfully.

19.0. Plans for preparing the next generation of system leaders

The Project Director, located on the campus of Illinois State University, played a fairly comprehensive role in the project. She managed the budget and budget reporting; wrote the grants and grant reports; and planned, led, and summarized the Executive Council, Leadership Team, and Work Group meetings. She provided clinical consultation and/or supervision to school-based and integrated behavioral health providers and the Comprehensive Inter-Disciplinary Assessment Service. Finally, she coordinated the Program Evaluation Team and collected local data and compiled the Local Evaluation Report and Community Scorecard.

There were two extremely beneficial factors that led to the success of having a university-based project director. First, the fact that the Project Director was not an employee of any of the local entities allowed her to maintain a "birds-eye" view of the initiative at all times; this perspective was particularly helpful when problem-solving around coordination and the use of resources. In Executive Council meeting discussions, the Executive Directors were all on equal footing and each member's perspective and institutional needs carried equal weight. Secondly, because her focus was on administration of the grant, rather than the implementation of clinical services or the administrative demands of one of the local organizations, when time and energy were in short supply, she never had to choose between serving consumers and completing her administrative responsibilities.

At the conclusion of the implementation years, however, the transition of several of duties occurred. All Work Group meetings, save the Zero-to-Five group, were transitioned to lead clinicians in the various sectors, and the Program Manager took leadership of Community Outreach and Professional Education. Many of the LCCN duties that the Project Manager planned to adopt have been difficult to manage, in addition to her duties within the educational sector. As it turned out, the special education cooperative was severely under-staffed during the 2016–2017 academic year, and many of the cross-sector and program evaluation components suffered. Going forward, she plans to step up e-mail correspondence to the team to keep all parties informed as to what others are doing and to facilitate an on-going sense of cohesion among the group.

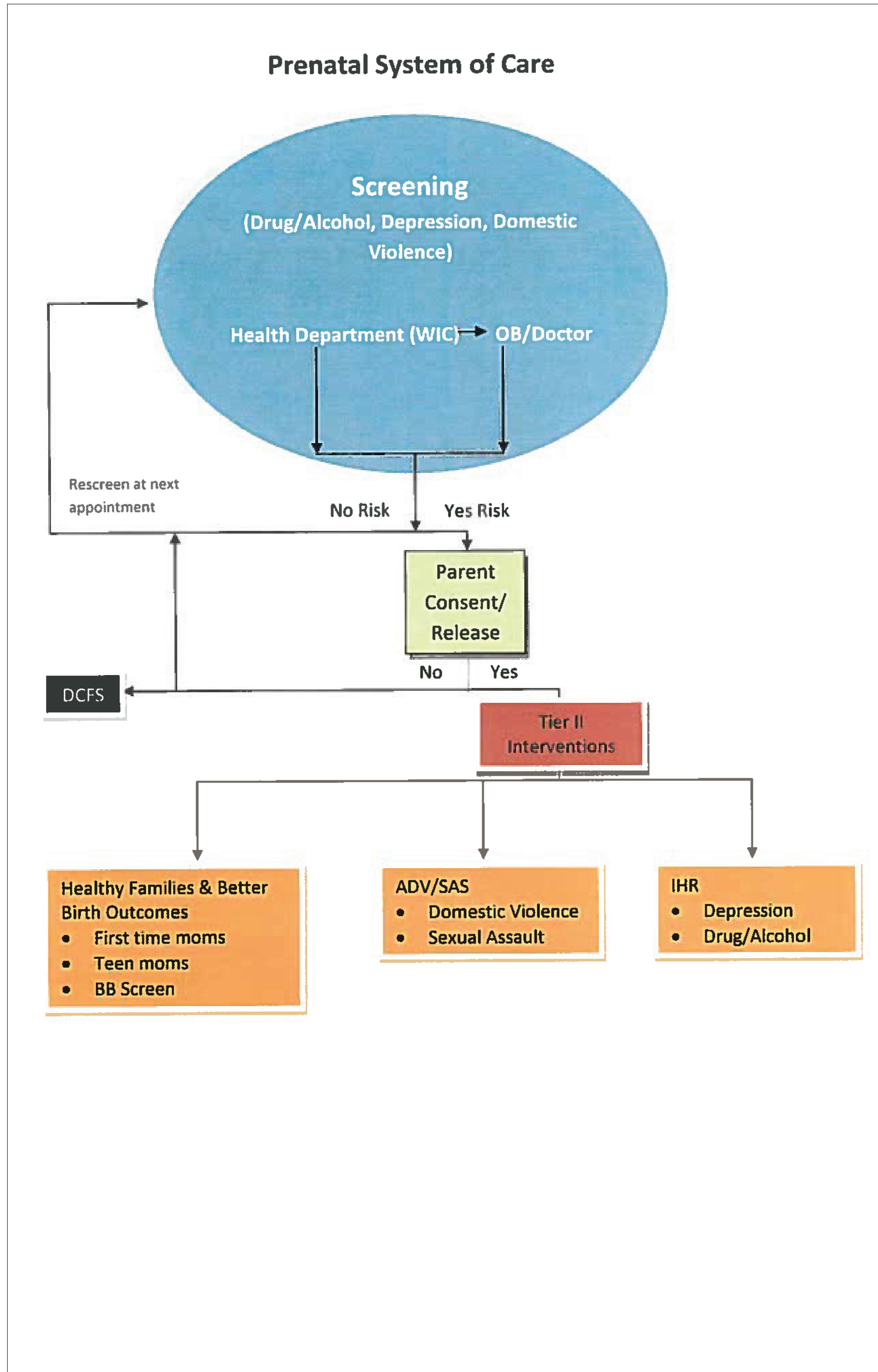
Over the next five years, the Executive Directors of the special education cooperative and the Health Department will retire, and that will conclude 100% turnover of the Executive Council. It has been extremely important for the philosophy, values, and priorities of the initiative to be communicated in a very personal way as the baton is passed. While grooming one's own replacement has been an avenue for thoughtful one-on-one transition, the larger system, with its many layers of service providers and administrators, has developed an annual "booster session" for all practitioners and their supervisors. This consistent review of LCCN policies and procedures has served to institutionalize them. Written orientation manuals have been helpful, as well.

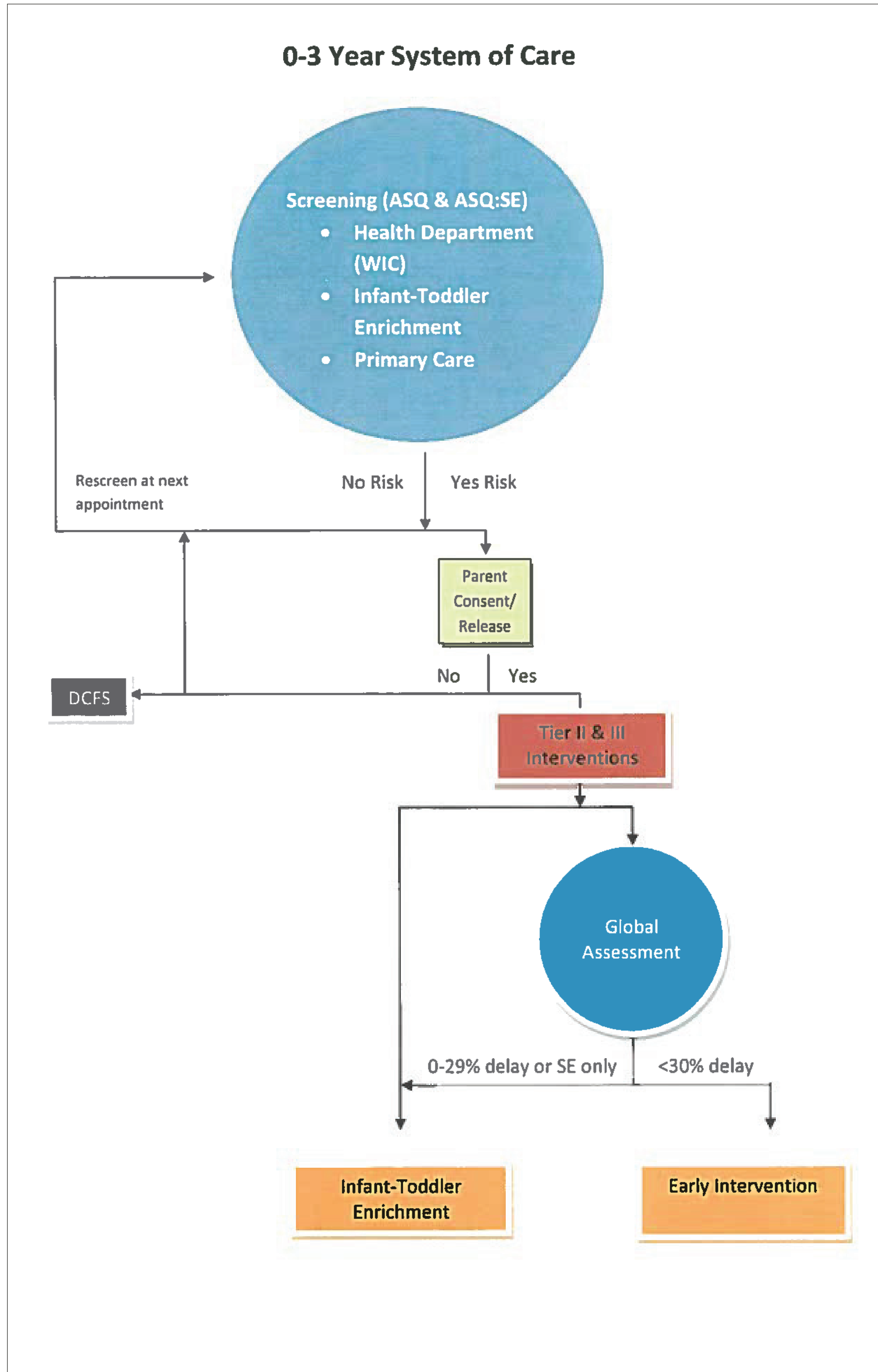
Livingston County Children's Network

System of Care Development
and Implementation Manual

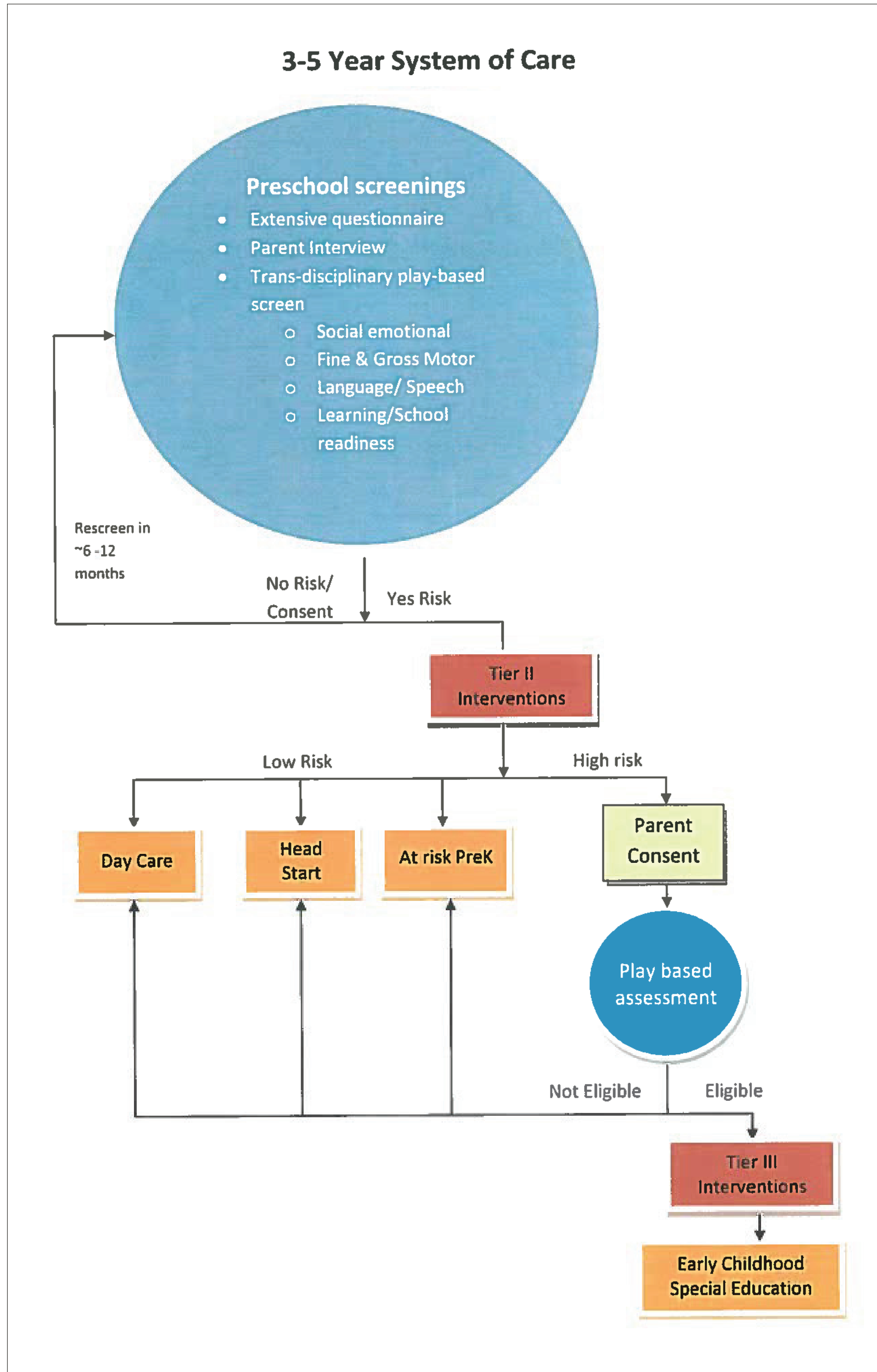
Appendices

Appendix A.1. Pre-existing intervention flow charts by age

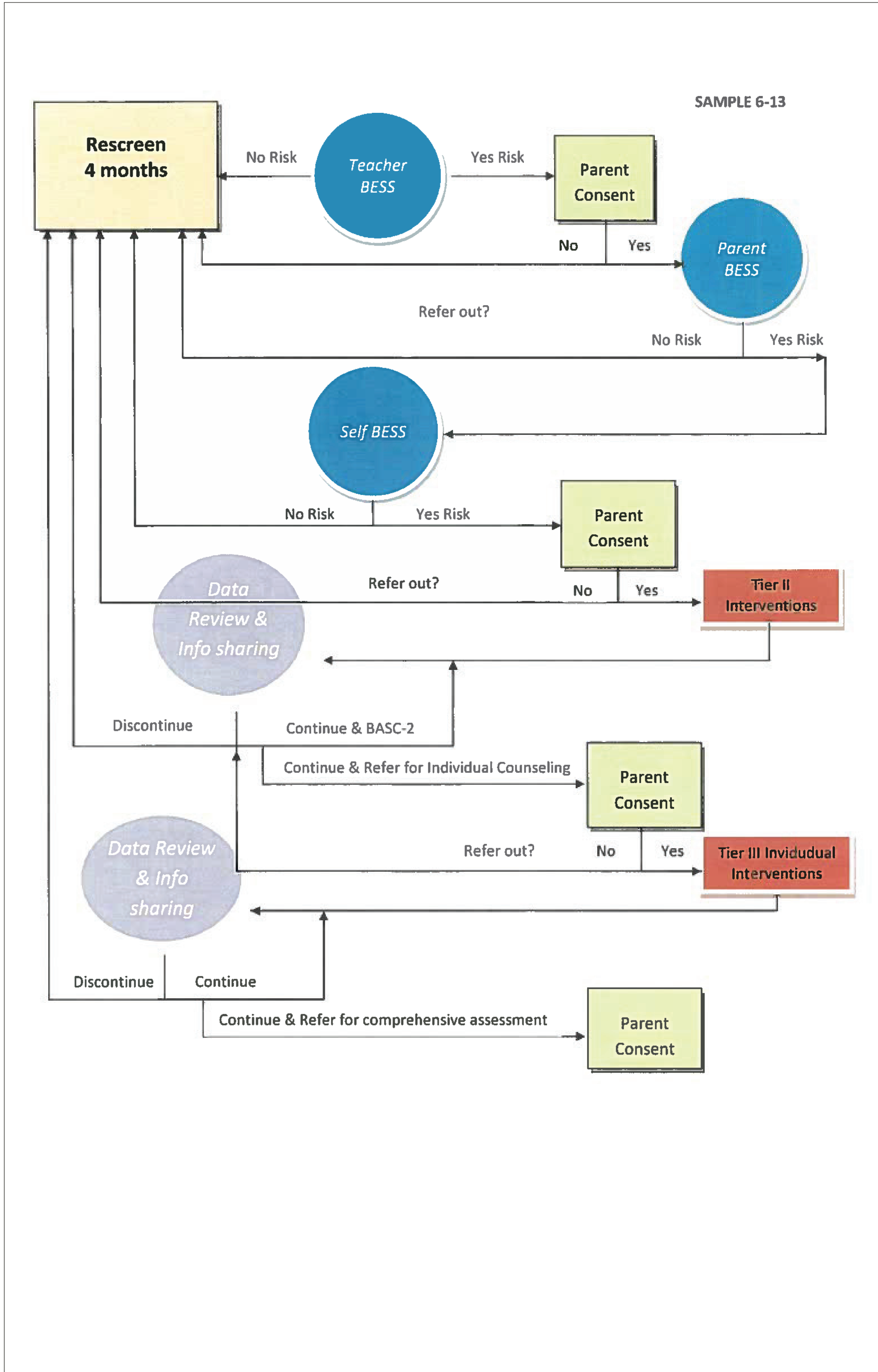



0-3 Year System of Care
Screening (ASQ & ASQ:SE)
Health Department (WIC)
Infant-Toddler Enrichment
Primary Care
Rescreen at next appointment
No Risk
Yes Risk
Parent Consent/ Release
No
Yes
DCFS
Tier II & III Interventions
Global Assessment
0-29% delay or SE only
<30% delay
Infant-Toddler Enrichment
Early Intervention

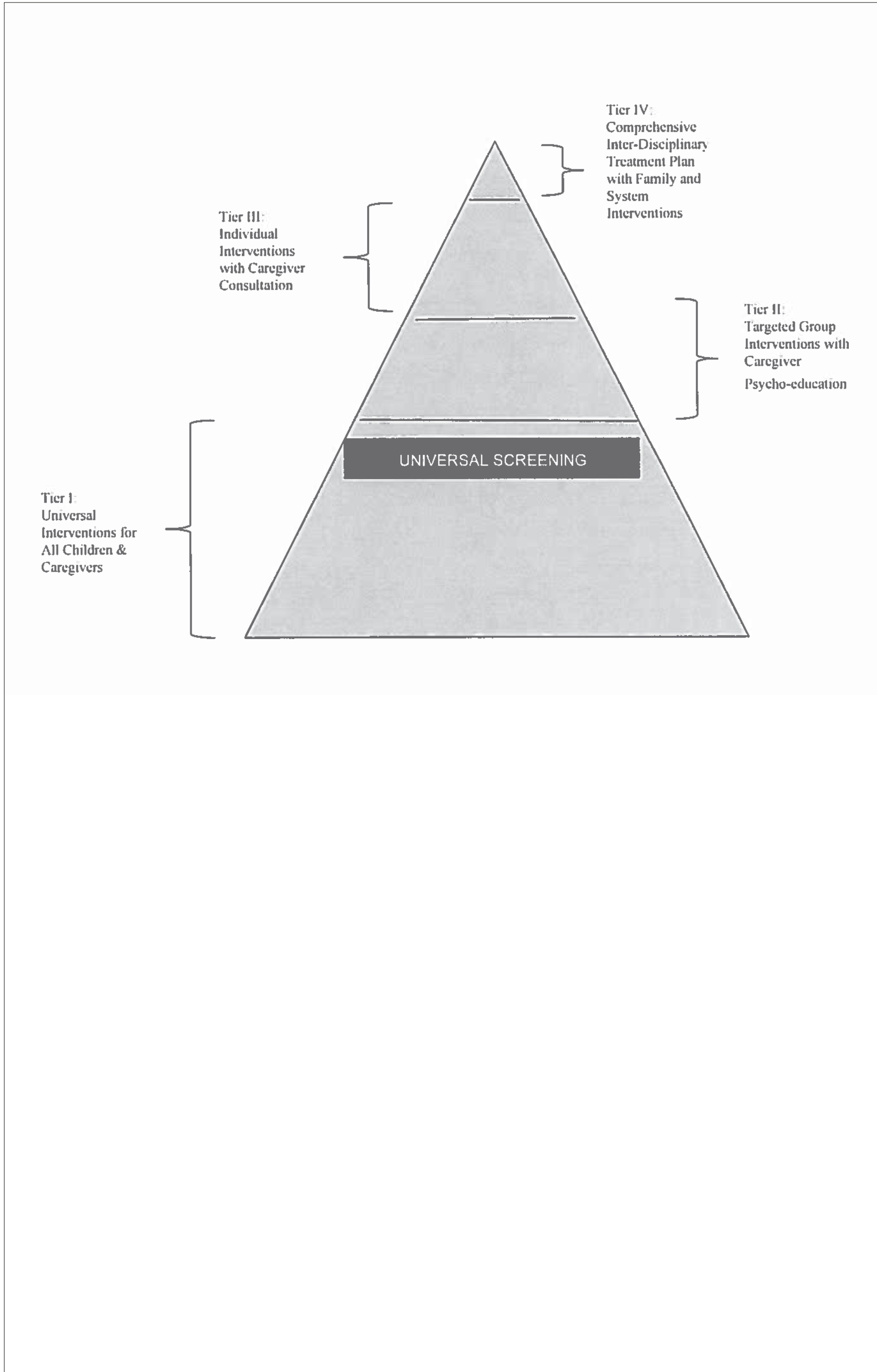
Appendix A.1. Pre-existing intervention flow charts by age, *continued*



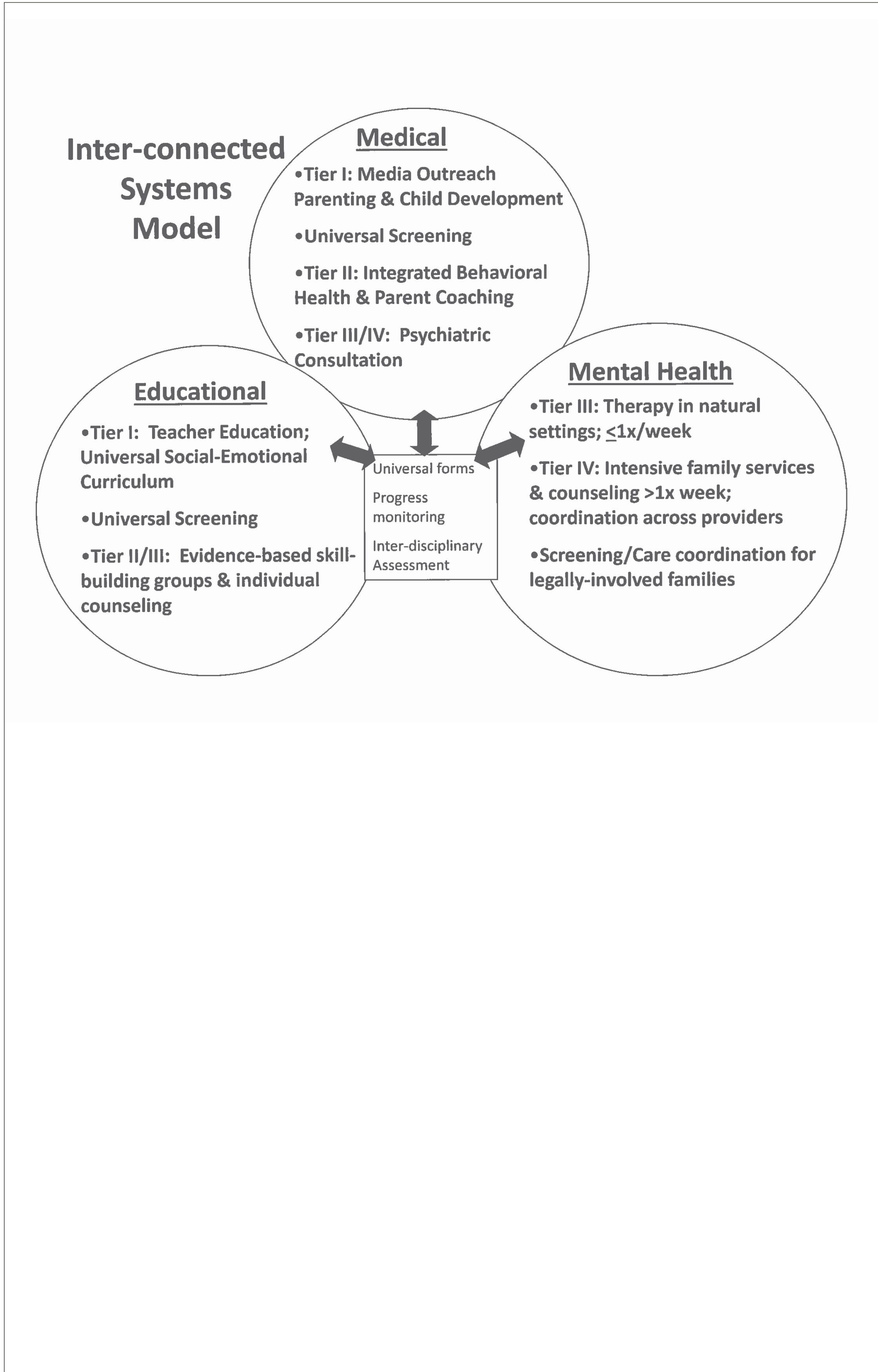
Appendix A.1. Pre-existing intervention flow charts by age, *continued*



Appendix A.2. Modified four-tiered model and implementation plan graphics



Appendix A.2. Modified four-tiered model and implementation plan graphics, *continued*



Tier III Interventions

Anxiety

- Coping Cat (age 7-13)
  - Workbook Publishing
  - Cognitive-Behavioral Therapy for Anxious Children: Therapist Manual, 3rd Edition (ISBN 978-1-888805-22-2): $24.00
  - Coping Cat Workbook, 2nd Edition (ISBN 978-1-888805-21-5): $26.95
- C.A.T. Project (age 14-17)
  - Workbook Publishing
  - "The C.A.T. Project" Manual for the Cognitive-Behavioral Treatment of Anxious Adolescents (ISBN 978-1-888805-18-5): $24.00
  - The C.A.T. Project Workbook for the Cognitive-Behavioral Treatment of Anxious Adolescents (ISBN 978-1-888805-17-8): $26.95

Depression

- FRIENDS for Life: Children (age 7-11)
  - Australian Academic Press
  - FRIENDS for Children – Group Leader's Manual (ISBN 9781875378258): $49.50
  - FRIENDS for Children – Workbook (ISBN 9781875378241): $17.60
- FRIENDS for Life: Youth (age 12-16)
  - Australian Academic Press
  - FRIENDS for Youth – Group Leader's Manual (ISBN 9781875378319): $49.50
  - FRIENDS for Youth – Workbook (ISBN 9781875378326): $18.70
- Adolescent Coping with Depression Course (CWD-A; groups age 14-18): manual & workbook FREE at http://www.kpchr.org/research/public/acwd/acwd.html
- Modified CWD-A (age 14-18): FREE from Anna
- STEADY Program (individual adolescents): manual & workbook FREE at http://www.kpchr.org/research/public/acwd/acwd.html

Anger & Aggression

- Think First (age 14-18)
  - Guilford Press
  - Think First: Addressing Aggressive Behavior in Secondary Schools (ISBN 978-1-59385-126-2): $25.50
  - Supplemental student workbook: FREE from Anna
- Helping Schoolchildren Cope with Anger (elementary/early middle school)
  - Guilford Press
  - Helping Schoolchildren Cope with Anger, 2nd Edition: A Cognitive Behavioral Intervention (ISBN 978-1-60623-973-5): $25.50

Substance Use

- Teen Intervene (age 12-19)
  - Hazelden

- Teen Intervene, 2nd Edition (ISBN 9781616491956): $249.00

Trauma

- Cognitive Behavioral Intervention for Trauma in Schools (age 11-15)
  - Sopris/Cambium Learning
  - Cognitive-Behavioral Intervention for Trauma in Schools (ISBN 978-1570359750): $43.49
  - Online training & support resources available http://cbitsprogram.org/
- Trauma-Focused Cognitive Behavioral Intervention (age __-__): FREE http://tfcbt.musc.edu

ADHD/Executive Functioning

- Homework, Organization, & Planning Skills (HOPS) Interventions
  - NASP Publications (www.nasponline.org/publications/booksproducts/N1108.aspx)
  -

Externalizing

- Check and Connect
  - http://checkandconnect.org/manual/default.html
  -
- Why Try
  - http://www.whytry.org/index.php?option=com_virtuemart&page=shop.browse&category_id=15&Itemid=24
  - Why Try Secondary Teachers Manual ($325). . .the complete curriculum set has extra fluff that we probably don't need
  - Still haven't gotten a response about the license for copying student workbooks

Asperger's Social Skills

- Superflex (grades 3-5)
  - http://socialthinking.com/books-products/superflex-curriculum
  - Book titled "You Are a Social Detective" and the package called "Superflex: A Superhero Social Thinking Curriculum Package"

Getting Help for Students with Emotional Concerns: A Guide for School Personnel

1. Consult with the social worker, school psychologist, and/or guidance counselor (i.e., the school-based clinicians) assigned to your building.
2. School-based clinician, in conjunction with relevant adults, determines if community-based services are needed. Community-based services are typically recommended for family/ parenting concerns, attendance problems, and/or substance abuse issues.
3. If community based services are needed, the school-based clinician refers the student and family to the Institute for Human Resources (IHR) by faxing a LCCN Universal Referral Form, a LCCN Universal Release of Information *and a* Fax Coversheet to **Amy Duffy** at 815-844-3561 (fax).
4. After 7-10 days, the school-based clinician contacts the IHR receptionist at **815-844- 6109** (phone) to ask if the initial appointment has been made. (Please inform the receptionist that consent has been obtained.)
5. Within 14 days of referral, the IHR clinician updates the school-based clinician on the referral status. The IHR clinician and school-based clinician communicate regularly through phone calls and/or sharing progress notes.

*** In case of imminent risk of suicide or harm to self or others,**
call IHR at
815-844-6109

When you call IHR after business hours, you will be connected to Providing Access to Help (PATH) by pressing #3 when prompted

You may also call PATH directly at
1-800-570-PATH (7284)

Crisis Contact Protocol

Crisis Team, not SASS does screenings in Livingston Co

SASS does screenings in McLean Co

- Janet is the Crisis Team worker during the day
- Amanda is the SASS worker during the day

A.CRISIS PROTOCOL

(i.e., Child needs screening for hospitalization due to presenting danger to self or others)

		Child's home is:		**Child's medical coverage is provided by:**	
		Livingston County	**Outside of Livingston County**	**Private Insurance**	**Medicaid**
Location of Crisis	**Crisis occurs in Livingston County**	Call IHR	Call child's local MHC*	Call local MHC* (may not receive SASS)	If active with SASS call IHR If not active with SASS, call CARES
	Crisis occurs out of Livingston County	Call IHR (if not available) Call local MHC*	Call child's local MHC*	Call local MHC*	If active with SASS call local MHC* If not active with SASS call CARES
When you're in doubt		**Call IHR** • State that screening is needed (rather than asking for a specific clinician) • Please be aware that your call may be directed to another person or agency • Please note that an IHR clinician is not always available or appropriate to handle every situation in person			

*Mental Health Center that serves the county where the child resides

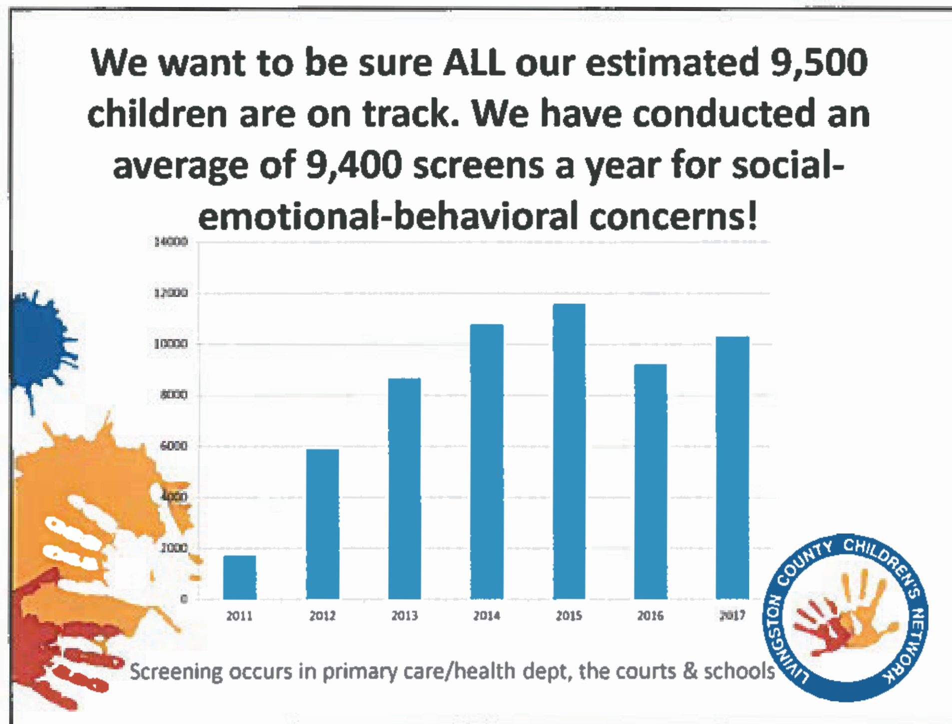
BEHAVIORAL CONCERNS/ INTERVENTION SUPPORT

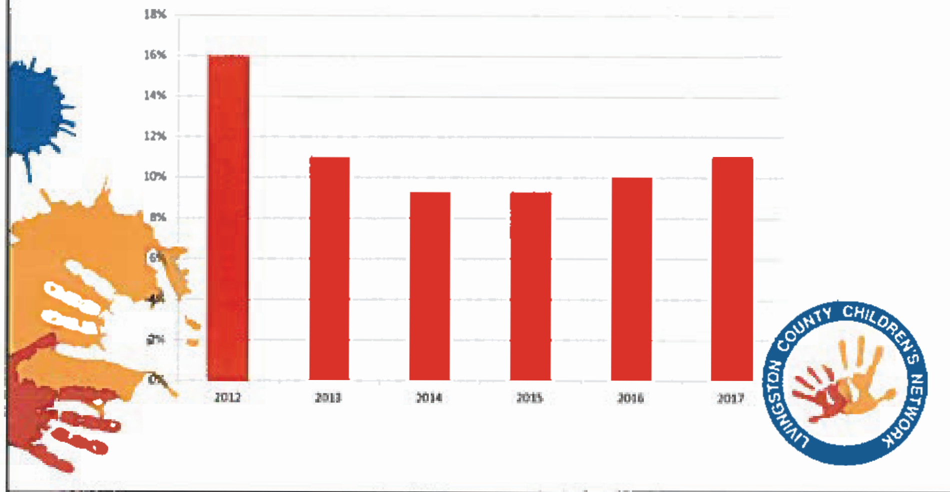
(i.e., student not presenting as a danger to self or others but demonstrates emotional or behavioral difficulty)

Situation occurs in or out of Livingston County	Call assigned School Psychologist/ School Social Worker
Client has an active SASS case	Call assigned School Psychologist/ School Social Worker If SP/ SSW is not available, call SASS therapist to determine **possible** availability to come for support Send a summary of the event to the SASS worker (if there is an active consent to release/ exchange information is signed)
Client does not have an active SASS case	Call assigned school psychologist/ school social worker If SP/ SSW is not available, call program supervisor
Client has an assigned therapist (at IHR)	Call assigned Send a summary of the event to the assigned IHR therapist (provided a release is signed)
Client has an assigned therapist (at a non-IHR office)	Encourage parent to communicate a summary of the event to the therapist and obtain consent to exchange information with the therapist
Client does not have an assigned therapist	Consider a referral to IHR

* local Mental Health Center

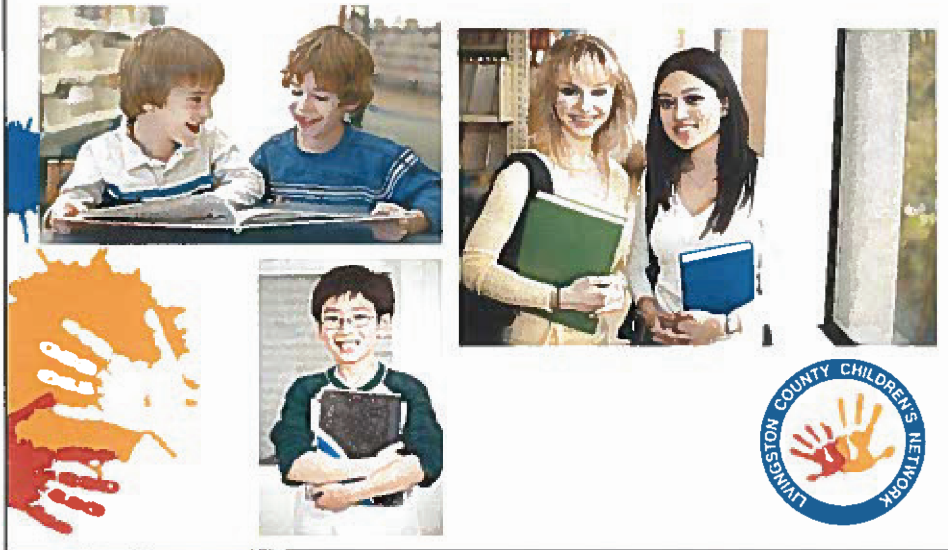
Appendix A.5. LCCN community scorecard




The percentage of children who are at-risk for social-emotional-behavioral concerns has decreased and have stabilized around 9-11%!
18%
16%
14%
12%
10%
8%
2012
2013
2014
2015
2016
2017
LIVINGSTON COUNTY CHILDREN'S NETWORK

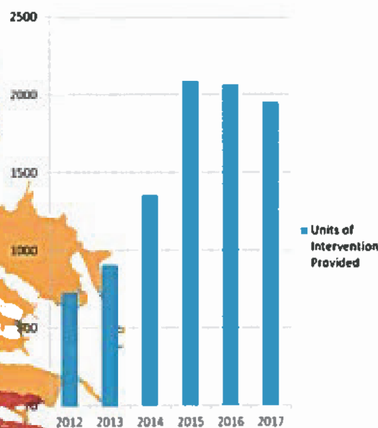
This decrease suggests that our prevention and early intervention strategies are working.
We implemented a universal, teacher-led social-emotional curriculum, Positive Action©.
LIVINGSTON COUNTY CHILDREN'S NETWORK

On average, 72% of at-risk children and youth receive individual or group services at school.

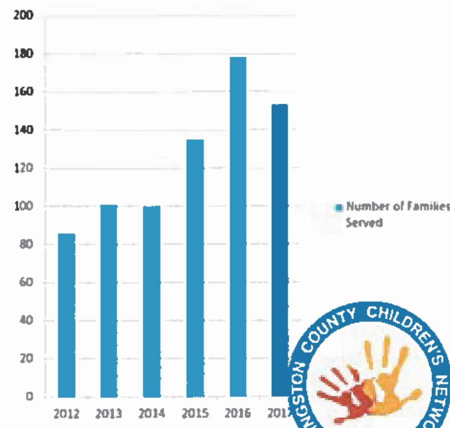


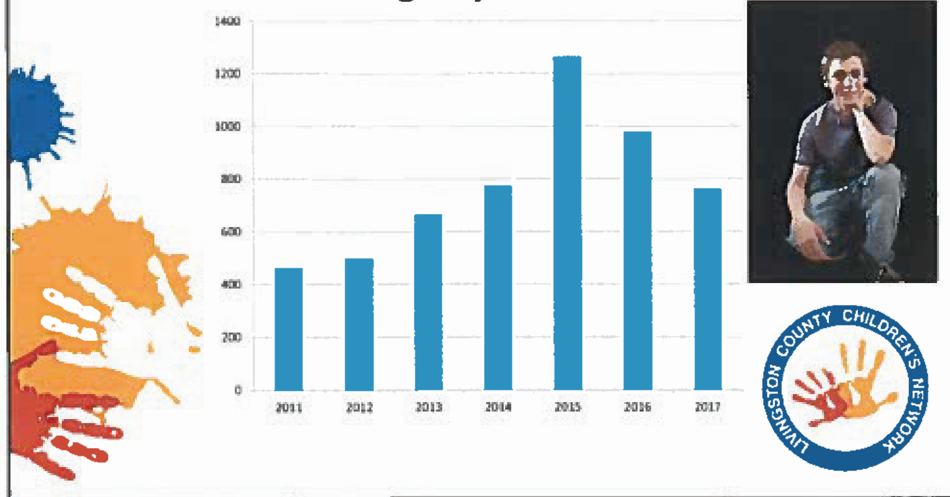
Many more families who need parenting supports are accessing them.

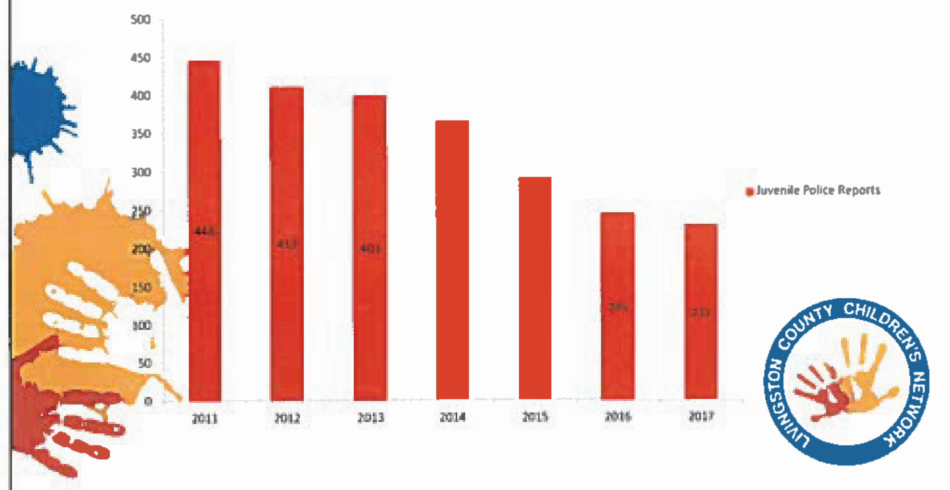
Support for parents of 0-5 yr olds



Support for parents of 6-18 yr olds




The number of children and adolescents provided therapy by Institute for Human Resources (IHR) has increased and leveled off at about 13% of school-aged youth!
1400
1200
1000
800
600
400
200
0
2011
2012
2013
2014
2015
2016
2017
LIVINGSTON COUNTY CHILDREN'S NETWORK


Even our Juvenile Police Reports are decreasing...
further evidence of our progress.
500
450
400
350
300
250
200
150
100
50
0
2011
2012
2013
2014
2015
2016
2017
Juvenile Police Reports
LIVINGSTON COUNTY CHILDREN'S NETWORK

Use of the "Exchange of Information" Form

The form on the next page is intended to obtain parent/guardian consent for providers to communicate. The page after it contains a script that is to be read to the individual. It should be copied on the back of the "exchange of information" form so that the two pages stay together.

Section one: Mark the reason for the exchange of information; it is ok to mark all three boxes. While it is required to include the 3 reasons we may want to communicate, it is not that important which ones you check.

Section two: Ask family to mark all relevant entities. When possible, inquire about a specific person with whom they have worked. In most cases, you can find phone numbers for these entities in your hard-copy Resource Directory or on the LCCN website. Please get the name of the school and obtain release to talk to LCSSU where the schools' social workers and school psychologists are typically employed. If they provide an "other" get both the name of a contact person and contact information.

Section three: Some families may wish to allow providers to communicate verbally but not to share documents. If that is the case, just check "verbal communication" (and referral paperwork and screening data if appropriate) and move on to the next section. Or, alternatively, you can use a second form to indicate fewer entities that would exchange written documents. One way to approach both section two and three is to ask families if there are any of these they would NOT wish to be included rather than the other way around.

Section four: If the family wishes to allow communication for a period briefer than a year, you should include that on line 3.

Section five: Obtain parent/guardian consent, date the page, sign your name as witness, and note the agency you work for. If the child is older than 12 years of age, he/she can also sign to indicate agreement.

Once complete, contact by telephone the entities of interest and fax the form.

For children 0-5: It is recommended to request consent for all of the following:

- LCSSU (Livingston County Special Services Unit employs school psychologist, social workers, and early childhood program coordinators who will assist with children 2.5-5 years of age)
- LCCN Database (the database, which is housed at LCSSU, will include information on many children receiving services in the county. The de-identified data will assist leaders in evaluating the effectiveness of treatments and determining allocation of resources).
- Child's Doctor (in the medical home model, physicians are kept in the loop regarding all aspects of their patients' development)

- Resource Link (for children who do not have a medical home, Resource Link will assist in making a connection with a provider)
- Health Department (the HD can provide numerous kinds of support to the family through Healthy Families, WIC, Family Case Management and other programs.)
- Child & Family Connections (CFC out of Danville is contracted by Department of Human Services to provide early intervention services to children with greater than 30% delays)
- OSF Early Intervention Program (Locally, CFC often utilizes this program to meet children's developmental delays; it also serves children with 0-29% delays)
- Head Start and/or Day care provider as appropriate
- IHR (if the child's needs are likely to require mental health treatment, you may include Institute for Human Resources which is our community mental health center)

For children 6-18: It is recommended to request consent for all of the following:

- LCSSU (Livingston County Special Services Unit employs school psychologist, social workers in all public schools except District429)
- LCCN Database (the database, which is housed at LCSSU, will include information on many children receiving services in the county. The de-identified data will assist leaders in evaluating the effectiveness of treatments and determining allocation of resources).
- Child's Doctor (in the medical home model, physicians are kept in the loop regarding all aspects of their patients' development)
- Resource Link (for children who do not have a medical home, Resource Link will assist in making a connection with a provider)
- IHR (if the child's needs are likely to require mental health treatment, you may include Institute for Human Resources which is our community mental health center)
- Boys & Girls Club and/or Day care provider as appropriate
- Any other agencies involved in the child's care as appropriate

LIVINGSTON COUNTY
CHILDREN'S NETWORK

Exchange of Mental Health, Medical, Legal and/or Educational Information

Name: ______________________ **Birth Date:** ______________

I am allowing these providers to communicate and exchange information for the purpose of:
☐ Coordinating Services ☐ Assisting in Treatment ☐ Assessing treatment effectiveness

If I check the box, I consent to information exchange with that provider. I have provided the name and number of a contact person where possible:

☐ School District ______________
☐ LCCN Database ______________
☐ Medical Provider ______________
☐ Resource Link ______________
☐ Institute for Human Resources ______
☐ LC Mental Health Board ________
☐ Commission on Children & Youth____
☐ Boys & Girls Club____________
☐ Police Dept______________
☐ Livingston County Special Services Unit__________
☐ Child & Family Connections______________
☐ OSF Early Intervention Program____________
☐ Head Start ______________
☐ LC Health Department ______________
☐ Probation/Court Services______________
☐ Dept of Children & Family Services__________
☐ A Domestic Violence/Sexual Assault Service_______
☐ Other______________________

Nature of Information:

☐ Verbal Communication
☐ Referral Paperwork
☐ Classroom Observations
☐ Psychiatric Consultations
☐ Psychological Evaluations
☐ Emergency Dept Records
☐ Sexual abuse/assault Records
☐ Diagnosis
☐ Attendance
☐ Social History
☐ Medications
☐ AIDS/HIV
☐ Prognosis
☐ Legal Records
☐ Other______________________
☐ Intake Summary
☐ Recommendations
☐ Hg/Lead Labs
☐ School Records
☐ Genetic Testing
☐ Treatment Plan
☐ Court Service Reports
☐ Screening Data
☐ Medical History
☐ Developmental History
☐ Academic Reports
☐ Discipline Record
☐ Discharge Summary
☐ Substance Abuse
☐ Progress Notes

MY SIGNATURE BELOW WILL INDICATE THAT I HAVE READ AND UNDERSTAND THE INFORMATION THAT FOLLOWS. I understand:

1. That information will only be disclosed when this document is completed and signed by me and witnessed, except as provided by Federal and State Regulations on confidentiality.
2. That this consent may be modified or revoked by me at anytime upon written request to the party releasing the information, except to the extent that action has already been taken in reliance on this authorization.
3. That this consent automatically expires one year from date of signature or on ________________ whichever is earlier.
4. That I have the right to inspect or copy information to be released.
5. That failure to consent to such a release of information may have an impact on the quality of services to be provided, but will not be grounds for termination of services.
6. The agency/person receiving information under the terms of this consent are not allowed to further release or disclose said information to any other entity without my specific written consent.

EFFECT OF GRANTING THIS AUTHORIZATION: The protected health information described above may be disclosed to and/or received by persons or organizations that are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws. They may further disclose the protected health information, and federal health information privacy laws may no longer protect it. However, any mental health, substance abuse, genetic testing, or HIV/AIDS information disclosed pursuant to this authorization may not be further disclosed except pursuant to your authorization.

I am willing that a reproduction of this consent be accepted with the same authority of the original.

SIGNATURE OF CLIENT: ______________________________

SIGNATURE OF PARENT/GUARDIAN: ______________________

DATE: _____ WITNESS:________________ AGENCY: ____________

Dear Parent or Guardian,

I am a member of **Livingston County Children's Network** which is made up of all the groups listed on the back of this page. We are working together to support all parents in Livingston County as they raise their children to be happy, healthy, and successful citizens. We have come to realize that it is becoming harder and harder for families to do this because of all of the stress we and our children are facing in the world today. We are eager to get to know your child and want to be able to offer whatever kinds of support might be helpful to him or her over the next year. In order for us to talk about the needs of your child and all the possible resources which might be available, we need to ask your consent to communicate with one another. You can give us permission by checking the boxes next to the different team members.

You also have the opportunity to indicate the kinds of information you would like for us to share. If you check the "verbal communication" box, that means we can discuss your child's needs and progress and coordinate opportunities for him or her. If you wish, you can also instruct us to share various documents by checking the boxes provided. This form allows us to exchange information for a year, but you can change your mind about any part of it whenever you want.

Thanks for giving us the opportunity to get to know your child and allowing us to partner with you in fostering healthy development! We hope you will share with your family and friends our vision…

"Families across Livingston County will utilize and value a comprehensive continuum of services to promote children's social and emotional development which will, in turn, effectively reduce at-risk behaviors and strengthen relationships."

Parent/Guardian Name(s): ____________________________________
Address: ____
Phone Number(s): ______________________________________
E-mail: ____
Medicaid Number/ Insurance Provider & Number __________________

FOR MORE INFORMATION

Brenda J. Huber, *PhD, ABPP, Director*
Illinois State University
Psychological Services Center
Livingston County Children's Network
Campus Box 4625
Normal, IL 61790
309.438.7407 *office*
bjhuber@ilstu.edu

Kristal H. Shelvin, *PhD*
LCCN Coordinator
Livingston County Children's Network
920 Custer Avenue
Suite A
Pontiac, IL 61764
815.844.7115 *x210*
kshelvin@lcssu.org

Livingston County Children's Network
www.lcchildrensnetwork.org