Illinois Children’s Mental Health Partnership

Strategic Plan for Building a Comprehensive Children’s Mental Health System in Illinois

June 30, 2005

Rod R. Blagojevich
Illinois Governor

Barbara Shaw
Partnership Chair
Research clearly demonstrates that children’s healthy social and emotional development is an essential underpinning to school readiness, academic success, health, and overall well-being. Prevention and early intervention efforts have been shown to improve school readiness, health status, and academic achievement, and to reduce the need for more costly mental health treatment, grade retention, special education services, and welfare supports.
Many mental health problems are largely preventable or can be minimized with prevention and early intervention efforts. Yet, the current children’s mental health system in Illinois places little or no emphasis on prevention or early intervention, and only a small percentage of Illinois children who need mental health treatment receive it.
## Children’s Mental Health Partnership Members

### Partnership Chair
Barbara Shaw  
Illinois Violence Prevention Authority

### Executive Committee
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Amy Zimmerman | Office of the Attorney General
The mental health needs of Illinois children and adolescents are very real and evident. You don’t have to look any further than the daily newspaper headlines to find them – teen suicide, toddler expulsions from child care because of behavior problems, school violence and bullying. The mental health needs of our State’s most precious resource – children and adolescents – has reached epidemic proportions and is a public health crisis for our State and the nation. Illinois became a nationwide leader in addressing this crisis when it enacted the Children’s Mental Health Act of 2003, forming the Illinois Children’s Mental Health Partnership and charging it with developing a statewide strategic plan to reform the Illinois children’s mental health system.

It is with great pleasure that the Illinois Children’s Mental Health Partnership (ICMHP) presents its Strategic Plan for Building a Comprehensive Children’s Mental Health System in Illinois. The Plan represents the work of over 250 individuals and groups and the endorsement of ICMHP members. It is a statewide strategic blueprint or “roadmap” that outlines the recommendations and strategies identified by the ICMHP as critical to reforming the children’s mental health system in Illinois.

In crafting this strategic Plan, the Illinois Children’s Mental Health Partnership set out to identify the key issues facing children, youth and their families and the challenges to and gaps in mental health programs and services for children. The Partnership heard from parents, grandparents, advocates, teachers, school administrators, doctors, child care workers, school nurses, public health professionals, psychologists, psychiatrists, law enforcement, special education teachers, school social workers and counselors, child welfare workers and many others. What we learned was striking and sobering.

- Opportunities are often missed for educating new parents, caregivers such as grandparents, and child-serving professionals about the impact of children’s social and emotional development on overall health, well-being and academic outcomes.
- An alarming number of young children have mental health needs yet many early childhood programs, health care providers and others who come into regular contact with young children and their families are ill-equipped to identify and address these needs.
- Many schools lack sufficient and appropriately trained staff to handle the numbers of students with mental health needs.
- There are not enough mental health providers available to meet the demand for mental health services, particularly in rural and other underserved areas.
- Families who have children with severe mental health disorders must navigate multiple and complex, uncoordinated service delivery systems in order to obtain mental health services.
- A significant proportion of youth in the juvenile justice system have mental health problems and evidence suggests that many were placed in this system because of a lack of community-based mental health services.
- A significant proportion of children and youth entering the child welfare system are suffering from the impact of exposure to trauma, violence and neglect.

Fortunately, we know from the research that by investing in mental health promotion efforts and intervening early when mental health needs first appear, poor outcomes can be dramatically prevented and minimized. Prevention, promotion and early intervention efforts are cost effective and have been shown to build resilience and improve health, mental health and academic outcomes in children and youth.
The Partnership envisions a comprehensive, coordinated children’s mental health system comprised of prevention, early intervention and treatment programs and services for children ages birth – 18 years. This also includes concerns about children transitioning from systems such as child welfare, juvenile justice and mental health. The Children’s Mental Health Plan is a statewide strategic “roadmap” that can help Illinois achieve this vision. It covers a range of recommendations and strategies necessary to reform the children’s mental health system in Illinois that include the following:

• Working with and engaging families in all aspects of the system.

• Promoting children’s optimal social and emotional development.

• Identifying mental health needs and intervening early.

• Ensuring that mental health programs and services meet the needs of diverse communities.

• Promoting multi-agency collaboration at the state, regional, and local level to maximize scarce resources, minimize duplication of services, and facilitate access to services.

• Increasing mental health programs and services, especially in underserved areas of the state.

• Building a culturally-competent, qualified and adequately trained workforce with a sufficient number of professionals to serve children and their families.

In submitting this Plan, the ICMHP recognizes that we have just begun our work. True reform of the children’s mental health system will require engaging families, communities, policymakers, educators, health care and mental health providers and many others in a collaborative effort to achieve these recommendations. And, while many of these recommendations and strategies are readily achievable many others will entail a phased-in approach that is implemented over time. It is a task that we are deeply committed to and collectively ready to undertake.

We urge the Governor to fully support the Plan and to continue to make children’s mental health a priority in Illinois.

Barbara Shaw

Chair, Illinois Children’s Mental Health Partnership
Acknowledgements

The Children’s Mental Health Plan was developed as a result of the diligent work and thoughtful contributions of over 250 individuals and groups committed to and concerned about the health and well-being of Illinois children, adolescents and their families. Under the leadership of Barbara Shaw, ICMHP Chair and Committee Co-Chairs, members of the Partnership and its six standing Committees spent a year-and-a-half examining the latest research, learning about the needs of Illinois children and their families, deliberating about the strategies necessary to achieving true system reform, and obtaining public input to drafts of the Plan. These individuals and groups – families and caregivers, educators, health care and mental health providers, child advocates, legislators, and professionals from early childhood, child welfare, juvenile justice and other systems – are commended for their tireless dedication to this effort.

This Plan could not have been achieved without the important work of the Illinois Children’s Mental Health Task Force. The Task Force developed a groundbreaking report, Children’s Mental Health: An Urgent Priority for Illinois, highlighting the significant mental health needs of Illinois children and calling for reform of the Illinois children’s mental health system. This Plan builds on the work of the Task Force report.

Voices for Illinois Children, under the leadership of Gaylord Gieseke, provides critical support to the ICMHP including serving as its fiscal and physical home.

The ICMHP is supported by the Illinois Violence Prevention Authority, the Illinois Department of Children and Family Services, Illinois Children’s Healthcare Foundation, Association of Community Mental Health Authorities of Illinois, The Spencer Foundation, and Michael Reese Health Trust. Blue Cross/Blue Shield of Illinois graciously provides the facilities for many of the ICMHP meetings. Voices for Illinois Children contributed a monetary award to the ICMHP in recognition and support of ICMHP work. In addition, the ICMHP would like to thank the National Governors Association and the National Association of State Mental Health Program Directors for providing technical assistance and support on key issues covered in the Plan.

Finally, Laura Hurwitz and Karen VanLandeghem, ICMHP, Carey McCann, Ounce of Prevention Fund, Kimberly Fitzgerald Moran, Voices for Illinois Children, and John Payton, University of Illinois at Chicago (CASEL) provided critical staff support to the work of the ICMHP Committees. In addition, Vikki Rompala, mental health fellow, provided important staff support to the work of the ICMHP.

This report was written by Karen VanLandeghem, ICMHP, associate director, with assistance from Laura Hurwitz, ICMHP project coordinator, and designed by Steve Hartman, president, Creativille, Inc. (www.creativille.net).
Illinois became a nationwide leader in recognizing the importance of mental health to children’s overall health, well-being and academic success when the Illinois General Assembly passed the Children’s Mental Health (CMH) Act of 2003 and Governor Rod Blagojevich signed the bill into law. With the passage of the CMH Act, the Governor and General Assembly made a clear and critical commitment to children’s mental health and to the need for reforming an existing mental health system that is highly fragmented, under-resourced, and inadequately coordinated to meet the needs of Illinois children and their families.

Among other key areas, the CMH Act created the Illinois Children’s Mental Health Partnership (ICMHP) and charged it with developing a Children’s Mental Health Plan containing short-term and long-term recommendations for providing comprehensive, coordinated mental health prevention, early intervention, and treatment services for children from birth to age 18. The ICMHP is pleased to submit this “Strategic Plan for Building a Comprehensive Children’s Mental Health System in Illinois” to Governor Rod Blagojevich.

This Plan is a comprehensive vision and strategic roadmap for achieving the goals set forth in the Illinois Children’s Mental Health Act of 2003. It embodies the collective vision and tireless work of over 250 individuals representing families, children and youth, policymakers, advocates, and key systems including mental health, education, early childhood, health, child welfare, substance abuse prevention, violence prevention, and juvenile justice.
ICMHP Vision for a Reformed Children’s Mental Health System

Research clearly demonstrates that children’s healthy social and emotional development is an essential underpinning to school readiness, academic success, health, and overall well-being. Prevention and early intervention efforts have been shown to improve school readiness, health status, and academic achievement, and to reduce the need for more costly mental health treatment, grade retention, special education services, and welfare supports. Unfortunately, a significant number of Illinois children experience serious mental health problems and many of them do not receive the services they need.

Nationally, suicide is the leading cause of death for adolescents and young adults; over 90 percent of these youth have experienced a mental disorder. More toddlers are expelled from pre-kindergarten programs due to behavioral concerns than are students in grades K-12. Over 20 percent of children have a diagnosable mental health problem yet only one in five of these children receive services. Mental health programs and services for children in Illinois – like that of most states – are highly fragmented, under-resourced and limited in scope and place little emphasis on promoting children’s social and emotional well-being, and preventing mental health problems.

Many mental health problems are largely preventable or can be minimized with prevention and early intervention efforts. Yet, the current children’s mental health system in Illinois places little or no emphasis on prevention or early intervention, and only a small percentage of Illinois children who need mental health treatment receive it. While many agencies and systems in Illinois including child welfare, public health, education, human service and juvenile justice attempt to address children’s mental health, there is little coordination, and resources are not maximized, leaving children, families, schools and communities struggling to cope with children’s mental health needs. A comprehensive, coordinated children’s mental health system can help maximize resources and minimize duplication of services.

The Illinois Children’s Mental Health Partnership envisions a comprehensive, coordinated children’s mental health system comprised of prevention, early intervention, and treatment programs and services for children ages 0-18 years, and for youth ages 19-21 who are transitioning out of key public programs (e.g., child welfare, school, the mental health system). Programs and services should be available and accessible to all Illinois children and their families – whether they are a new parent adjusting to the demands of parenthood, a toddler struggling to master basic developmental tasks, an adolescent who is experiencing feelings of depression, or a youth with some other mental health need.

A comprehensive, coordinated children’s mental health system can help maximize resources and minimize duplication of services.

A comprehensive and coordinated children’s mental health system in Illinois should include the following key components.

- **Starts early, beginning prenatally and at birth, and continues throughout adolescence**, including efforts to support youth in making the transition to young adulthood, and through key transitions to adulthood and independent living.

- **Engages families/caregivers** in all aspects of promoting their child’s optimal social and emotional development, and overall mental health. Families should have easy access to needed information, resources and supports. Agencies and organizations should partner with families in policymaking, evaluation and resource decisions at the state, regional and local level.
• Educates families/caregivers, children, providers, public officials and the general public about the importance of children’s mental health.

• Adopts a child developmental approach that takes into account the changing needs of children and adolescents, and their families, as youth age.

• Provides quality programs and services that are grounded in evidence-based research and are affordable, family-centered, culturally-competent, and developmentally appropriate. Services and systems should be responsive to the cultural perspectives and characteristics of the diverse populations that are served.

• Delivers services in and across natural settings such as early childhood programs, homes, primary health care settings, and schools in order to successfully reach children and their families.

• Promotes individualized care for each child and their family guided by a comprehensive, single plan of care that is family-driven and addresses strengths as well as problems and needs.

• Supports smooth transitions between systems and services that are effectively implemented and family friendly.

• Assures that all professionals who come in contact with children are adequately prepared and trained to promote, identify, refer and/or address children’s mental health.

• Builds on and integrates existing systems (e.g., early childhood, health care, education, mental health, juvenile justice, substance abuse, child welfare) that serve children and their families.

• Maximizes public and private resources and invests sufficient resources over time.

• Ensures that programs and services are provided in accordance with existing Illinois and federal confidentiality, consent, reporting, and privacy laws and policies

The Importance of Supporting and Advancing the Children’s Mental Health Plan

The Partnership urges the Governor to continue to support and advance the priority recommendations and related strategies contained within this Plan. These recommendations are designed to maximize scarce resources, build on system strengths and model programs, expand resources over time, and ensure that the needs of children and their families are being met. True system reform will involve implementing these recommendations over time using a phased-in approach.

Since the passage of the CMH Act, the Partnership has made significant progress in key areas of the children’s mental health system. Ongoing support for this Strategic Plan will enable the Partnership and its member agencies and representatives to make further progress and improvements to the CMH system. The strategic priorities and recommendations outline the Partnership’s strategic vision for improving the CMH system.
ICMHP Strategic Priorities

The ICMHP has identified the following Strategic Priorities for focus in the coming year or two.

1) Promote ongoing family/consumer and youth involvement in administrative, policymaking and resource decisions regarding the Illinois children’s mental health system at the state, regional and local level.

2) Advocate for increased children’s mental health services and programs.

3) Develop culturally competent mental health consultation initiative(s) that educate, support and assist providers in key child-serving systems (e.g., early childhood, child care, primary care, public health, mental health and education).

4) Create a comprehensive, culturally inclusive, and multi-faceted public awareness campaign plan.

5) Build public and private sector awareness and response to maternal depression with attention to prevention and early intervention efforts, and necessary follow-up assessment and treatment services, where appropriate.

6) Build and enhance school-based activities focused on social and emotional educational and support services, and provide professional development and technical assistance to school administrators and staff.

7) Promote mental health screening and assessment and appropriate follow-up services of children and youth involved in the child welfare and juvenile justice systems.

8) Increase early intervention and mental health treatment services and supports for children:
   • Ages 0-5 years;
   • Transitioning out of public systems (e.g., child welfare, mental health, juvenile justice);
   • Who have been exposed to or experienced childhood trauma (e.g., violence);
   • Who need follow-up services in the SASS system beyond 90 days; and
   • Who have mental health problems that are not severe enough to qualify them for public programs.

9) Convene a multi-agency and multidisciplinary work group to examine how children’s residential mental health treatment services are funded and accessed in order to develop strategies for improving financing, cost-effectiveness, and access to residential services and alternative community services, where appropriate.

10) Initiate development of a policy and research center(s) to support research-based workforce development, best practice models and technical assistance on children’s mental health in such areas as cultural competence, family involvement and consumer-driven care.
Strategic Plan Recommendations

The following recommendations were identified by the Illinois Children’s Mental Health Partnership as key areas to be initiated, developed, or accomplished over the next few years. Detailed strategies for achieving these recommendations are identified in the main section of this strategic Plan.

GOAL I. DEVELOP AND STRENGTHEN PREVENTION, EARLY INTERVENTION, AND TREATMENT POLICIES, PROGRAMS AND SERVICES FOR CHILDREN

PREVENTION

A. Partner with families/caregivers and youth.
   I. Recommendation: Promote ongoing family/consumer participation in operations, policymaking and resource decisions regarding the Illinois children’s mental health system at the state, regional and local level.
   II. Recommendation: Develop a mental health system accessible to children ages 0-18 years that respects, supports and treats families/caregivers as key partners.
   III. Recommendation: Partner with existing youth leadership groups to advise the Partnership and engage youth in planning at the state, regional and local level.

B. Promote children’s mental health services and programs that are culturally and linguistically competent.
   Recommendation: Promote state and local agency children’s mental health policies and practices that are culturally and linguistically competent.

C. Establish a mental health consultation initiative that serves early childhood, child care, primary care, mental health, education and other key systems that come into regular contact with children and their families.
   Recommendation: Develop culturally and linguistically appropriate mental health consultation initiatives that are accessible and available to programs and providers in key child-serving systems including early childhood, child care, primary care, mental health and education.

D. Increase public and private sector response to maternal perinatal depression.
   Recommendation: Work in partnership with the Governor’s maternal depression task force to strengthen best practices, quality standards and training associated with efforts to address perinatal depression in women of child-bearing age.

E. Strengthen and develop best practices, quality standards and professional training associated with voluntary mental health screening conducted with parental consent and parental involvement and in accordance with existing Illinois and federal confidentiality, consent, reporting, and privacy laws and policies.
   Recommendation: Promote and support initiatives that strengthen and develop best practices, quality standards and professional training associated with voluntary mental health screening conducted with parental consent and parental involvement and in accordance with existing Illinois and federal confidentiality, consent, reporting, and privacy laws and policies.
F. **Incorporate the social and emotional development of children as an integral component to the mission of schools, critical to the development of the whole child, and necessary to academic readiness and school success, in accordance with existing Illinois and federal confidentiality, consent, reporting, and privacy laws and policies.**

I. **Recommendation:** Work with the Illinois State Board of Education (ISBE) to ensure that all Illinois school districts develop a policy for incorporating social and emotional development into the district’s education program. The policy shall address social and emotional learning, and protocols (i.e., guidelines) for responding to children with social, emotional, or mental health needs.

II. **Recommendation:** Work with ISBE to ensure that the plan, submitted to the Governor on December 31, 2004, is implemented to incorporate social and emotional learning standards as part of the Illinois Learning Standards.

III. **Recommendation:** Promote increased collaboration and partnerships among schools and school-based mental health, community mental health, health care, juvenile justice, substance abuse, developmental disability agencies, Early Intervention (Part C of IDEA), child care programs and systems, and families/caregivers and others to promote optimal social and emotional development in children and youth, and access to appropriate services.

**EARLY INTERVENTION**

A. **Build coordinated systems for early intervention and response to mental health needs that are responsive to children and their families.**

I. **Recommendation:** Expand on and build the capacity of child-serving systems and agencies (e.g., early childhood, health care, education, community mental health) to provide early intervention services that are accessible to children.

II. **Recommendation:** Promote and support initiatives that strengthen best practices, quality standards, and professional training associated with mental health screening and related follow-up assessment and treatment services, as appropriate, for children in the child welfare and juvenile justice systems, in accordance with existing Illinois and federal confidentiality, consent, reporting, and privacy laws and policies.

III. **Recommendation:** Promote the development of a coordinated community response to children exposed to trauma.

IV. **Recommendation:** Identify best practices for educating expecting families and the general public about the impact of substance abuse on children’s development and for addressing and treating substance exposed infants.

**TREATMENT**

A. **Promote that children have access to quality, coordinated, and culturally competent systems of care that provide comprehensive treatment and family supports.**

I. **Recommendation:** Build and strengthen a quality system of care in Illinois based on the mental health “System of Care” Principles to ensure that children once identified as needing services, have access to a comprehensive array of clinically appropriate assessment, treatment services and supports.

II. **Recommendation:** Develop mechanisms, as part of the System of Care design, to provide assistance and direct families/caregivers to culturally competent, gender and clinically appropriate services. The system will include clear referral pathways for children involved in the child welfare, juvenile justice, education, substance abuse, family violence, sexual assault, homeless shelters, and developmental disabilities systems.
GOAL II. INCREASE PUBLIC EDUCATION AND AWARENESS

Recommendation: Develop a comprehensive, culturally inclusive, and multi-faceted public awareness campaign to reduce the stigma of mental illness; educate families, the general public and other key audiences (e.g., educators, health and mental health providers, juvenile justice system officials, faith-based organizations, local health department officials) about the importance of children’s social and emotional development; inform families/caregivers, providers, and others about how to access services; and educate policymakers and others about the need for expanding mental health resources.

GOAL III. MAXIMIZE CURRENT INVESTMENTS AND INVEST SUFFICIENT FISCAL RESOURCES OVER TIME

I. Recommendation: Maximize the use of key federal and state program funds for children’s mental health, integrate multiple federal and state funding streams, and promote the use of local matching funds, where appropriate.

II. Recommendation: Make effective use of Medicaid and KidCare to ensure that children receive appropriate mental health services.

III. Recommendation: Initiate development of state funding sources and mechanisms, including incentive-based funding structures and community-based pilot projects and models, to promote best practices in prevention, early intervention, and treatment.

IV. Recommendation: Make policy and planning recommendations to the Governor regarding a state budget for prevention, early intervention, and treatment across all state agencies.

V. Recommendation: Initiate development of state and local mechanisms for integrating federal, state, and local funding sources for children’s mental health.

VI. Recommendation: Explore mechanisms and strategies for increasing private insurance coverage of children’s mental health services.

GOAL IV. BUILD A QUALIFIED AND ADEQUATELY TRAINED WORKFORCE WITH A SUFFICIENT NUMBER OF PROFESSIONALS TO SERVE CHILDREN AND THEIR FAMILIES THROUGHOUT ILLINOIS

A. Expand and develop the mental health workforce.

I. Recommendation: Initiate efforts to expand the mental health workforce to ensure a diverse, adequately trained and qualified workforce that meets the needs of children and their families throughout Illinois.

II. Recommendation: Increase the capacity of programs and providers who work with children (e.g., early childhood, health care, education, mental health, education, child welfare, juvenile justice) to promote and support the social and emotional development and mental health needs of children and their families.
GOAL V. CREATE A QUALITY-DRIVEN CHILDREN'S MENTAL HEALTH SYSTEM WITH SHARED ACCOUNTABILITY AMONG KEY STATE AGENCIES AND PROGRAMS

Recommendation: Initiate development of outcome indicators and benchmarks including links to and integration of early childhood and school learning standards, for ensuring children’s optimal social and emotional development, and improving overall mental health.

GOAL VI. INVEST IN RESEARCH

I. Recommendation: Initiate a Children’s Mental Health Resource Center(s) to collect and facilitate research on best practices and model programs; share information with Illinois policymakers, practitioners and the general public; develop culturally and linguistically competent training and educational materials; provide technical assistance; and implement other key activities.

II. Recommendation: Develop and conduct process and outcome evaluations that measure changes to the children’s mental health system and in child outcomes as a result of implementation of the Illinois Children’s Mental Health Plan.
Introduction

The Illinois Children’s Mental Health Partnership (ICMHP) is pleased to submit the “Strategic Plan for Building a Comprehensive Children’s Mental Health System in Illinois” to Illinois Governor Rod Blagojevich. The Children’s Mental Health Plan is a comprehensive vision and strategic roadmap for achieving the goals set forth in the Illinois Children’s Mental Health Act of 2003. It embodies the collective vision and tireless work of over 250 individuals representing families, children and youth, policymakers, advocates, and key systems including mental health, education, early childhood, health, child welfare, substance abuse prevention, violence prevention, and juvenile justice.

These and many other groups recognize and support the need for creating a comprehensive children’s mental health system of prevention, early intervention, and treatment for children ages 0 to 18. Bold reform is needed to ensure that the social and emotional well-being of children is a top priority – as important as their physical health – and to address the significant fragmentation, duplication, and inadequacies within the existing children’s mental health system. Children’s mental health is indeed an urgent priority for Illinois.

The ICMHP urges the Governor to support and help advance the recommendations and related strategies contained within this Plan. These strategies are designed to maximize scarce resources, build on system strengths and model programs, expand resources over time, and ensure that the needs of children and their families are being met. True systems reform will involve implementing these priority strategies over time using a phased-in approach.

Collaborative Process for Development of the Plan

Since being established in February 2004, the ICMHP and its working Committees have met to prioritize the recommendations set forth in the Illinois Children’s Mental Health Task Force Report, “Children’s Mental Health: An Urgent Priority for Illinois”—the landmark report that formed the basis for the Children’s Mental Health Act of 2003. Committees developed short-term and long-term strategic activities necessary for providing comprehensive, coordinated mental health prevention, early intervention, and treatment services for children from birth through age 18. Recommendations that were not identified as a short-term priority will be addressed in future years by the ICMHP. (See Appendix A for a list of the long-term recommendations.)

Public Input to the Plan

In July 2004, the ICMHP held five public forums across the state—in Champaign, Chicago, Edwardsville, Mt. Vernon, and Rockford—to seek public input on the content and direction of an initial draft of the Preliminary Plan. Over 400 participants including families/caregivers, youth, health and mental health providers, educators, advocates, parks and recreation staff, social workers, members of the faith-based community, and others attended and provided comment. The majority of public forum participants provided overwhelmingly positive feedback on the scope, content, and strategic priorities of the draft Preliminary Plan. All public input was considered by the ICMHP, and the Preliminary Plan was modified to address recurrent comments and major concerns. The Preliminary Plan was submitted to Governor Blagojevich on September 30, 2004 and received positive response from the Administration.

Since the submission of the Preliminary Plan, the ICMHP and its six Standing Committees have worked to further describe and clarify several of the strategies necessary to advance key priority recommendations. These areas include development of further financing strategies, discussion and identification of best practices in voluntary mental health screening, and a framework for developing mental health consultation initiatives. A revised draft of the strategic Plan recommendations and strategies was posted on the web in June 2005 for public comment and recurring input has been incorporated into this final Plan.

1. “Children” is used throughout this document to refer to infants, children and adolescents ages 0-18 years.
Research clearly demonstrates that children’s healthy social and emotional development is an essential underpinning to school readiness, academic success, health, and overall well-being. Prevention and early intervention efforts have been shown to improve school readiness, health status, and academic achievement, and to reduce the need for more costly mental health treatment, grade retention, special education services, and welfare supports. Unfortunately, a significant number of Illinois children experience serious mental health problems and many of them do not receive the services they need.

• The current Illinois children's mental health “system” is highly fragmented, under-resourced, and ill-equipped to proactively address children's mental health needs. Few resources are available to adequately promote children’s mental health and implement needed early intervention services. Where prevention and early intervention programs are offered, most are not integrated with other related efforts. The system of care for children with severe mental health problems is grossly under funded resulting in a lack of capacity to serve the children and families most in need.

• Early prevention and intervention efforts can save significant state costs. Untreated mental health problems in children have serious fiscal consequences for the state. Exposure to violence, trauma, depression and other mental health problems affect children’s ability to learn and increase their propensity for school failure, violence, alcohol and substance abuse, and other delinquent behaviors that are extremely costly to treat. Nearly 70% of those in the juvenile justice system have mental health problems. Many of these problems could have been prevented or ameliorated with appropriate intervention early in life.

• A significant number of Illinois children experience serious mental health problems. One in 10 children in Illinois suffers from a mental illness severe enough to cause some level of impairment. Yet, in any given year only about 20% of these children receive mental health services. A recent study in Chicago found that nearly 50% of inner-city adolescents demonstrated signs and symptoms of depression. Another study revealed that 23% of Illinois adolescents and 34% of Chicago adolescents exhibited signs of depression for two or more weeks in a row that kept them from participating in usual activities. Nationally, over 20% of youth experience a diagnosable mental health problem.

• Many mental health problems are largely preventable or can be minimized with prevention and early intervention efforts. While many of the emotional and behavioral problems that children face can be prevented or minimized, the majority of children and youth with mental health needs do not receive preventive or early interventions—evidence-based interventions that are known to be effective.

• Children's social and emotional development is an essential underpinning to school readiness and academic success. According to national estimates, one-quarter to one-third of young children are perceived as not being ready to succeed in school. For a significant number of these children, concerns center on social and emotional issues. A recent Illinois survey found that 42% of childcare programs had to ask a family to withdraw a child because the staff were unable to manage the child’s behavior. The social and emotional development of children is a fundamental part of their development from early childhood through adolescence.

• A comprehensive, coordinated children’s mental health system can help maximize resources and minimize duplication of services. Mental health promotion and prevention programs in schools and early childhood programs are not an established part of these systems and are usually provided only if the school or program is able to capture special grant funds for these purposes. Screening, identification, and service systems for children are currently fragmented, under-resourced, and inadequate to address the number of children and their families who need mental health support. A comprehensive, coordinated and collaborative system in Illinois can maximize resources and ensure that planned and focused efforts achieve the maximum results possible.
A Vision for Children’s Mental Health in Illinois

The Illinois Children’s Mental Health Partnership envisions a comprehensive, coordinated children’s mental health system comprised of prevention, early intervention, and treatment for children ages 0-18 years, and for youth ages 19-21 who are transitioning out of key public programs (e.g., school, child welfare, mental health). Programs and services should be available and accessible to Illinois children and their families – whether they are a new parent adjusting to the demands of parenthood, a toddler struggling to master basic developmental tasks, an adolescent who is experiencing feelings of depression, or a youth with some other mental health need.

A comprehensive and coordinated children’s mental health system in Illinois should include the following key components.

- **Starts early, beginning prenatally and at birth, and continues throughout adolescence**, including efforts to support adolescents in making the transition to young adulthood, and through key transitions to adulthood and independent living.

- **Engages families/caregivers** in all aspects of promoting their child’s optimal social and emotional development, and overall mental health. Families should have easy access to needed information, resources and supports. Agencies and organizations should partner with families in policymaking, evaluation and resource decisions at the state, regional and local level.

- **Educates families/caregivers, children, providers, public officials and the general public** about the importance of children’s mental health.

- **Adopts a child developmental approach** that takes into account the changing needs of children and adolescents, and their families, as youth age.

- **Provides quality programs and services** that are grounded in evidence-based research and are affordable, family-centered, culturally-competent, and developmentally appropriate. Services and systems should be responsive to the cultural perspectives and characteristics of the diverse populations that are served.

- **Delivers services in and across natural settings** such as early childhood programs, homes, primary health care settings, and schools in order to successfully reach children and their families.

- **Promotes individualized care for each child and their family** guided by a comprehensive, single plan of care that addresses strengths as well as problems and needs.

- **Supports smooth transitions between systems and services** that are effectively implemented and family friendly.

- **Assures that all professionals who come in contact with children are adequately prepared and trained** to promote, identify, refer and/or address children’s mental health.

- **Builds on and integrates existing systems** (e.g., early childhood, health care, education, mental health, public health, juvenile justice, substance abuse, child welfare) that serve children and their families.

- **Maximizes public and private resources** and invests sufficient resources over time.

- **Ensures that programs and services are provided in accordance with existing Illinois and federal confidentiality, consent, reporting, and privacy laws and policies.**

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2 “Families/caregivers” is used throughout this document to refer to parents or anyone acting on behalf of a child and/or adolescent in a parental role (i.e., legal guardian).
Building an effective children’s mental health system requires a unified, short- and long-term plan that builds upon existing programs and services proven to be effective. Scarce funds are maximized, programs and services are integrated, and investments are made for the future. The ICMHP recognizes the following key principles as core components of this Strategic Plan.

- A successful children’s mental health system engages and actively involves families and caregivers. Parents and caregivers have an enormous impact on the social and emotional well-being of their children. Most understand the important role they play in their child’s development, but many lack critical knowledge and information. To be effective, a children’s mental health system must engage and partner with parents and caregivers at every point on the continuum of services from prevention and early intervention, to treatment.

- Prevention and early intervention efforts should start early, beginning prenatally and at birth, and continue throughout adolescence (i.e., children ages 0-18) and through key transitions to adulthood. Childhood, beginning at birth, is the time to promote optimal healthy development and prevent mental disorders and emotional/behavioral problems to help ensure success in school and in life. Programs and services should build on the strengths of children, youth and their families.

- Children and their families should have access to affordable, quality, family-centered, culturally competent interventions and services. Prevention, early intervention and treatment services should be tailored to reach children living in rural, suburban and urban areas, and must address language, income, and other possible barriers that can affect access to services.

- Public and private resources must be maximized and coordinated, and should build on existing state and local systems and programs. A statewide, collaborative, multidisciplinary, community-based systems approach ensures that Illinois children and youth receive a cost-effective continuum of prevention, early intervention, and treatment services.

- Children’s mental health services should be delivered in and across natural settings if they are to successfully reach children, youth and their families. Providing services in and across natural settings, like homes, primary care environments, community programs, early childhood programs, schools, or school-linked programs, increases the likelihood of reaching and maintaining contact with children, youth and families who face many barriers to receiving those services in the community.
Framework for a Coordinated Mental Health System* in Illinois for Children Ages 0-18

Prevention

Coordinated Systems for Promoting Healthy Social and Emotional Development in Children

• Public education and awareness
• Mental health consultation with providers
  • Voluntary home visits
• Parent education and support services
• Social and emotional development programs and curricula for community services and schools

Early Intervention

Coordinated Systems for Early Detection, Identification, and Response to Mental Health Needs

• Mental health consultation with providers
  • Student support services
• Early identification, assessment, referral, and follow-up
  • Short-term counseling and support groups
• Skills-building classes (e.g., problem-solving, anger management)
  • Ongoing and crisis support

Treatment

Coordinated Systems of Care for Providing Comprehensive Treatment and Family Supports

• Therapy and support groups
• Comprehensive assessment, diagnostic and referral services
• Hospitalization and inpatient mental health treatment services
  • Respite and other support services for families
  • Drug treatment

*These systems include early childhood, education, mental health, juvenile justice, health, human services, substance abuse, violence prevention, corrections, and other relevant systems.

Adapted from: Minnesota Children’s Mental Health Task Force, Minnesota Framework for a Coordinated System to Promote Mental Health in Minnesota; Center for Mental Health in Schools, Interconnected Systems for Meeting the Needs of All Youngsters.
ICMHP Strategic Priorities

The ICMHP has identified the following Strategic Priorities for focus in the coming year or two.

1) Promote ongoing family/consumer and youth involvement in administrative, policymaking and resource decisions regarding the Illinois children’s mental health system at the state and local level.

2) Advocate for increased children’s mental health services and programs.

3) Develop culturally competent mental health consultation initiative(s) that educate, support and assist providers in key child-serving systems (e.g., early childhood, child care, primary care, public health, mental health and education).

4) Create a comprehensive, culturally inclusive, and multi-faceted public awareness campaign plan.

5) Build public and private sector awareness and response to maternal depression with attention to prevention and early intervention efforts, and necessary follow-up assessment and treatment services, where appropriate.

6) Build and enhance school-based activities focused on social and emotional educational and support services, and provide professional development and technical assistance to school administrators and staff.

7) Promote mental health screening and assessment and appropriate follow-up services of children and youth involved in the child welfare and juvenile justice systems.

8) Increase early intervention and mental health treatment services and supports for children:
   - Ages 0-5 years;
   - Transitioning out of public systems (e.g., child welfare, mental health, juvenile justice);
   - Who have been exposed to or experienced childhood trauma (e.g., violence);
   - Who need follow-up services in the SASS system beyond 90 days; and
   - Who have mental health problems that are not severe enough to qualify them for public programs.

9) Convene a multi-agency and multidisciplinary work group to examine how children’s residential mental health treatment services are funded and accessed in order to develop strategies for improving financing, cost-effectiveness, and access to residential services and alternative community services, where appropriate.

10) Initiate development of a policy and research center(s) to support research-based workforce development, best practice models and technical assistance on children’s mental health in such areas as cultural competence, family involvement and consumer-driven care.
The Children’s Mental Health Plan is a comprehensive vision and strategic roadmap for achieving the goals set forth in the Illinois Children’s Mental Health Act of 2003.
The Plan
GOAL I. DEVELOP AND STRENGTHEN PREVENTION, EARLY INTERVENTION AND TREATMENT POLICIES, PROGRAMS, AND SERVICES FOR CHILDREN

PREVENTION

Many mental health problems can be prevented or ameliorated through prevention and early identification. The promotion of children’s optimal social and emotional development should be embedded into every system, program, and service that serves children and their families. These systems include early childhood, education, child care, public health, mental health, child welfare, juvenile justice, health, human services, substance abuse prevention, and violence prevention. Prevention efforts should help families and caregivers establish early, strong parent-child relationships and attachments, and help children and youth navigate key developmental milestones, and develop important life and social skills.

A. Partner with families/caregivers and youth.

Families/caregivers are the most important factor in the social and emotional development and well-being of children and adolescents. A successful and effective children’s mental health (CMH) system effectively engages families/caregivers at every point on the continuum of services from prevention and early intervention, to treatment. This system also builds on family/caregiver strengths and supports their efforts.

As Illinois develops a new approach to addressing children’s mental health, families/caregivers and consumers need to be considered as key partners at every level of program and service development and delivery. Foremost, families/caregivers from all cultures, ethnicities, and socioeconomic levels must have access to appropriate programs and services. Research has shown that when families/caregivers are involved, children achieve more and exhibit more positive behavior, regardless of socioeconomic status, ethnic/racial background, or the family/caregiver education level.

Partnering with youth in the planning, development and implementation of the children’s mental health system at the state and local level is also critical and mutually benefits the system and the youth themselves. Initiatives that value and involve youth gain important youth investment and ownership, creative ideas, outreach, enhanced program activity, and experience. In addition, youth develop leadership skills, self-confidence, expanded views of adult roles, and knowledge about adult decision-making processes. Providing positive development opportunities is essential to youth succeeding at developmental tasks, academic endeavors, and social and emotional learning.

3 “Children” is used throughout this document to refer to infants, children and adolescents ages 0-18 years.
I. **Recommendation:** Promote ongoing family/consumer participation in operations, policymaking and resource decisions regarding the Illinois children’s mental health system at the state, regional and local level.

*Short-Term Strategies and Action Steps:*

1. Mobilize, train and support families/caregivers and consumers to become key advocates for their children and the Illinois CMH system.

2. Encourage local mental health boards to involve families/caregivers and consumers as full board participants.
   a. Amend state contracts with providers to require that families/caregivers and consumers serve as full members on local boards and other decision-making bodies of not-for-profit agencies with assurances that the local boards reflect the racial and ethnic composition of a community’s population.
   b. Promote training and support of families/caregivers and consumers to be full, participating members of local boards of directors and other decision-making bodies.

3. Ensure that substantial numbers of families/caregivers and consumers are involved in any organized children’s mental health effort or leadership entity.

4. Promote the availability of stipends and/or other incentives to encourage family involvement in CMH planning activities.

II. **Recommendation:** Develop a mental health system accessible to children ages 0-18 years that respects, supports and treats families/caregivers as key partners.

*Short-Term Strategies and Action Steps:*

1. Provide training and supports to early childhood and mental health programs, educators, health and mental health providers, schools, families/caregivers and others in order to promote meaningful family involvement in CMH programs and services, using a family strengths perspective.
   a. Identify an assessment tool that professionals and families/caregivers can use to evaluate how they work together, and educate professionals about how to involve families/caregivers in decision making and establish a system of continual feedback to and from families/caregivers.
   b. Promote funding to train professionals and families/caregivers on the importance of family-driven care and potential biases of both professionals and families in the partnering process, with families/caregivers serving as co-trainers.
   c. Institute family leadership training and support in child-serving systems including schools, mental health, early childhood and after-school programs.

2. Expand access to and promote the availability of culturally-competent family education and support groups (e.g., parent-to-parent, peer groups).
   a. Develop and strengthen ongoing, culturally competent parent education, parent-to-parent, and peer support groups across the continuum of services, including Early Intervention (Part C of Individuals with Disabilities and Education Act (IDEA) and Special Education (Part B of IDEA).
3. Develop and strengthen education, support services, and linkages to services for all families/caregivers, especially new and at-risk families/caregivers.
   a. Develop and implement services in or linked to healthcare settings to support and educate new families/caregivers regarding the adjustment to parenthood and ways to promote a child’s healthy social and emotional development.
   b. Build on existing systems and develop appropriate family support services and linkages between and within systems during key life transitions for children (e.g., hospital to home, 0-3 to 3-5 programs, 3-5 programs to kindergarten, kindergarten to school, grade school to high school, etc.).
      i. Identify and link with current efforts dealing with statewide and national transition issues.
      ii. Hold a summit of representatives from key state agencies and organizations regarding transition issues between and within systems that results in a statewide strategic plan.
      iii. Broaden awareness of current statewide transition resources and initiatives (e.g., Starnet, Special-Ed Co-Ops, DHS, ISBE).
   c. Promote inclusion in school orientations and/or school open houses information for families about appropriate social emotional learning and development milestones in the coming school year.
   d. Research, compile and disseminate best practice models of parent education and support in school settings (e.g., Families and Schools Together).
   e. Strengthen transitional support programs and linkages for specific populations who are most at-risk and need access to targeted mental health services (e.g., DCFS wards returned to families/caregivers’ custody, the impact on children when families/caregivers enter or leave prison, family transition when there is a traumatic loss of caregiver, families fleeing from domestic violence).
   f. Establish formal partnerships between schools and community behavioral health providers to support families and caregivers.

4. Develop, maintain and widely distribute through innovative and creative strategies culturally and linguistically appropriate mental health resources for families/caregivers.
   a. Create and maintain a “hot-list” of developmentally appropriate questions families/caregivers can use when concerned about their child’s behavior and mental well-being, with information about key resources.
   b. Provide an 800 number to guide families/caregivers through key questions and locate resources.

5. Build on statewide prevention efforts (e.g., Prevention First) to develop and distribute user friendly handouts for family members regarding substance use.

6. Develop mechanisms to ensure families/caregivers receive adequate information, assistance, and skills to effectively navigate the children’s mental health system.
   a. Design and disseminate family/caregiver handbooks for mental health services, as well as access to care management services.
   b. Explore development of a comprehensive database of mental health providers by geographic area to increase families and providers access to these providers.

7. Strengthen the capacity of providers to conduct outreach and engagement with very isolated families (e.g., geographic).
III. **Recommendation:** Partner with existing youth leadership groups to advise the Partnership and engage youth in planning at the state, regional and local level.

*Short-Term Strategies and Action Steps:*

1. Identify existing youth leadership groups and opportunities for collaboration, and coordinate related efforts.
2. Develop mechanisms to involve youth in planning at the state and local level, including in the IC-MHP.
3. Develop and support the leadership skills of members of the youth leadership groups.
4. Develop mechanisms to educate youth about social and emotional development, substance abuse, and mental health.
5. Promote the availability of stipends and/or other incentives to encourage youth involvement in CMH planning activities.
6. Seek youth input about how to best educate other youth about their rights to access mental health and substance abuse services in the state.

B. **Promote children's mental health services and programs that are culturally and linguistically competent.**

The population of the United States is growing and changing dramatically. Reports from the United States Census Bureau project that in the year 2030, diverse racial and ethnic groups will compromise 40 percent of the total U.S. population. The changes in America’s composition challenge the capabilities and capacities of many systems, including the children’s mental health system. In addition, significant racial and ethnic disparities exist in access to and availability of culturally competent care, with children experiencing unmet mental health needs as a result.

In Illinois, disparities can be reduced by promoting culturally competent services and programs that are sensitive and responsive to cultural differences. This means encouraging organizations to develop a set of policies, practices and structures that result in a children’s mental health system that works effectively in cross cultural situations. Children’s mental health services should be adapted to fit a family’s values and customs and respond appropriately to unique cultural backgrounds, including race and ethnicity, national origin, religion, age, gender, gender identity, sexual orientation, or physical disability. Integrating cultural competence throughout the children’s mental health system can help address poor access to care, societal stigma, isolation and alienation of children and families in most need of care.

**Recommendation:** Promote state and local agency children’s mental health policies and practices that are culturally and linguistically competent.

*Short-Term Strategies and Action Steps:*

1. Promote coordination and collaboration between existing cultural competence initiatives focused on children’s mental health.
2. Identify national and statewide cultural competence standards (e.g., Culturally & Linguistically Appropriate Services, SAMHSA) that agencies can implement to ensure cultural and linguistic competence.
3. Address cultural competence in strategic planning for children’s mental health.
4. Promote that state and local CMH agencies and organizations perform periodic and ongoing cultural competence assessments.
a. Identify uniform self-assessment checklists that can be used by organizations to conduct cultural competence assessments in CMH services and programs.
   i. Encourage state agencies to use assessment tools such as the State Mental Health Agency Cultural Competence Activities Assessment developed by the National Association of State Mental Health Program Directors.

b. Recommend that state agencies which support CMH systematically collect and analyze data that accurately reflects the populations served including: race, ethnicity, gender, gender identity, poverty level, languages spoken, disabilities and sexual orientation while maintaining confidentiality of those served.

5. Encourage that research-based curricula, and developmentally, culturally, gender and linguistically appropriate materials and approaches that enhance social and emotional development are incorporated into all children’s mental health programs and services.

6. Conduct ongoing evaluation of cultural and linguistic competence related to CMH programs and services at the state and community levels.

7. Promote development of staff capacity in cultural and linguistic competence in community-based organizations that provide CMH programs and services.
   a. Provide cross training between mental health agencies and culturally diverse organizations (e.g., ethnic associations).
   b. Assess language skills of staff.
   c. Provide training on how to interpret and on the effective use of interpreters.

8. Advocate for and build the capacity of interpretive services in CMH programs and services.
   a. Evaluate the current availability of and resources for interpretive services (including telephonic) across the state.
   b. Develop guidelines regarding the use of interpreters in mental health settings.
   c. Educate providers about the availability of interpretive services and about the federal laws regarding use of interpreters.

C. Establish a mental health consultation initiative that serves early childhood, child care, primary care, mental health, education and other key systems that come into regular contact with children and their families.

Programs and professionals that serve children and their families have growing concerns about children who are showing early signs of emotional distress and behavioral problems. These professionals, however, are not always fully equipped to proactively and effectively address these problems. In addition, many providers often need assistance with understanding children’s social and emotional development, and mental health needs. Primary health care providers are challenged by the lack of skills to address specific mental health needs and lack of referral resources to ensure that identified problems can be addressed in a timely and efficient manner. Mental health consultation to caregivers, providers, and educators is a key strategy to help programs build capacity, promote social and emotional health, and better respond to the social and emotional needs of children and their families.

Mental health consultants can assist primary care providers, educators, early childhood programs and other key professionals to partner with parents to promote the social emotional development of their children. They also serve as an important resource to assist professionals in addressing children’s mental health needs and identifying appropriate referral resources.
**Recommendation:** Develop culturally and linguistically appropriate mental health consultation initiatives that are accessible and available to programs and providers in key child-serving systems including early childhood, child care, primary care, mental health and education.

*Short-Term Strategies and Action Steps:*

1. Define mental health consultation models that address the needs of various age groups of children and youth, and among various child-serving providers and systems.
   a. Identify the factors or standards of consultation that are consistent across settings.
   b. Identify challenges and address barriers to providing mental health consultation.

2. Expand current early childhood mental health consultation efforts into programs including early education, family support, health care, Early Intervention, public health and child care.
   a. Build on evaluation results and lessons learned from the Bureau of Early Intervention’s integration of the social emotional component, mental health consultation pilots in child care, and the proposed primary health care pilots of DPA’s ABCD Initiative to identify steps toward statewide expansion.
   b. Support the Illinois Early Learning Council’s recommendations for Preschool for All that include the provision of mental health consultation.

3. Explore development of a pilot that establishes a regional mental health consultant network for school-age children that includes: consultation in a variety of child-serving settings (e.g., schools, health care, community mental health, child welfare and juvenile justice); use of existing regional networks; creation of local advisory boards that include families; local needs assessments; and consultation on a range of clinical and systemic issues.

4. Explore development of a psychiatric consultation model between health care and mental health providers, building on the collaboration between primary care medical groups and professional child and adolescent psychiatry groups.

5. Support training efforts that will build mental health consultation capacity in Illinois.
   a. Support the DHS Early Childhood Mental Health Systems Workgroup that is exploring how to provide early childhood mental health consultation through the community mental health system.
   b. Develop and implement training for programs and providers on how to identify and use mental health consultants effectively.
   c. Create a cadre of trained consultants to facilitate the teaching of social and emotional development in any youth serving setting.

6. Increase the awareness of policymakers, providers and families regarding the importance of mental health consultation.
D. **Increase public and private sector response to maternal perinatal depression.**

Perinatal depression affects approximately 10 to 20 percent of new mothers (18,500 – 37,000 Illinois women) each year in Illinois. In addition to being debilitating and harmful to women suffering from the problem, perinatal depression also can compromise their ability to nurture their children. Studies have found that children of depressed women exhibit more problem behavior and have more difficulty achieving age appropriate developmental and cognitive milestones.

Because of the high rate of women who experience some form of perinatal depression, women of child-bearing age should have access to a range of programs and services designed to prevent or minimize this common mental health problem. This includes health promotion activities to educate women of child-bearing age about the effects of maternal perinatal depression on their ability to care for and nurture their child, public awareness efforts about how this problem impacts children, and early intervention activities designed to identify women who may be at-risk for the problem. In addition, providers and other “ frontend workers” need training to identify potential signs of depression, and know when and where to refer women in need of further assessment and treatment services.

**Recommendation:** Work in partnership with the Governor’s maternal depression task force to strengthen and develop best practices, quality standards and professional training to address perinatal depression in women of child-bearing age.

**Short-Term Strategies and Action Steps:**

1. Explore methods for building public and private sector awareness and response to maternal perinatal depression with attention to prevention and early intervention efforts, and necessary follow-up assessment and treatment services, where appropriate.
   a. Promote education of professionals in key systems (e.g., health care) and programs (e.g., Healthy Families, DCFS protective service workers) about how to recognize the signs of maternal depression and make appropriate referrals.

2. Integrate messages about maternal perinatal depression and how women can seek help into the ICMHP public awareness campaign efforts.

3. Expand availability of culturally and linguistically appropriate voluntary maternal perinatal depression screenings and follow-up services for women.
   a. Support recommendations and coordinate efforts between DPA’s Perinatal Taskforce and ABCD Initiative, the Postpartum Initiative, key public health programs such as WIC and Family Case Management, and other efforts currently underway in Illinois to improve mental health programs and services for women at-risk of or suffering from maternal perinatal depression.
   b. Research Illinois barriers that keep women from accessing screening during the peripartum period - pregnancy and the twelve months following the infant’s birth.
   c. Identify successful screening, assessment and treatment models for maternal perinatal depression in other states.
   d. Review maternal perinatal depression screening practices across Illinois, including in key public programs such as WIC and Family Case Management.
   e. Identify appropriate quality and evidence-based perinatal depression screening tools, their advantages and disadvantages, to help providers choose appropriate tools.
f. Disseminate best practice standards on referral protocols.

4. Expand Medicaid coverage to include the Edinburgh Postnatal Depression Scale.
   a. Disseminate information to primary care providers on Medicaid reimbursement for perinatal depression screening.
   b. Promote pediatricians’ use of the Edinburgh Postnatal Depression Scale during well-child visits as a risk assessment of the infant.

5. Examine and modify the state Medicaid plan to extend coverage for pregnancy-related care including family planning services beyond the current limit of 60 days postpartum to one year post partum.

6. Expand Medicaid coverage to include assessment and treatment services for perinatal depression up to one year post partum.

7. Establish funding mechanisms for public and private insurance reimbursement of perinatal depression screenings conducted by healthcare professionals.

E. Strengthen and develop best practices, quality standards and professional training associated with voluntary mental health screening conducted with parental consent and parental involvement and in accordance with existing Illinois and federal confidentiality, consent, reporting, and privacy laws and policies.

Voluntary mental health screening is a core component of an effective and comprehensive children’s mental health system, and of an overall approach to promoting health and wellness in children. It identifies social and emotional development needs in children and adolescents as early as possible, prevents potential mental health problems from developing or worsening, and can help identify unique strengths in children. Screening is conducted by an adequately trained professional (e.g., health care provider, social worker, psychologist, school counselor) and uses objective, accurate, reliable, and validated instruments and methods.

Screening is a commonly used method to inform parents and professionals about the physical, cognitive and emotional strengths and needs of a child. Voluntary mental health screening is conducted with parental consent and in accordance with existing Illinois and federal confidentiality, consent, reporting, and privacy laws and policies. How parental consent is obtained should be determined by professional standards and local policy. Finally, community support for screening should be promoted, as community buy-in is important to the success of a community approach to responding to children’s mental health needs.

Screening does not result in a definitive statement about a child’s needs nor does it draw a conclusion about a mental disorder or diagnosis. Families/caregivers should be informed if a screening indicates the child would benefit from further assessment. For children in the child welfare and juvenile justice systems, the state has a particular responsibility for social and emotional development screening since research shows that these children have a higher likelihood of having a mental health problem than other children.

**Recommendation:** Promote and support initiatives that strengthen and develop best practices, quality standards and professional training associated with voluntary mental health screening conducted with parental consent and parental involvement and in accordance with existing Illinois and federal confidentiality, consent, reporting, and privacy laws and policies.
**Short-Term Strategies and Action Steps:**

1. Explore integration of messages about the importance and benefits of mental health screening into the ICMHP public awareness campaign efforts.

2. Increase early childhood, mental health, and primary health care providers’ ability to use best practices when screening for social and emotional development (e.g., as part of well-baby and well-child visits, periodic pediatric exams, and other screenings), and to refer for early intervention services as appropriate.
   
   a. Review developmental screening practices across Illinois’ early childhood programs and health care services.
   
   b. Review and identify culturally, ethnically and linguistically appropriate, validated, quality and evidence-based social emotional screening tools.
   
   c. Identify referral protocol(s) for programs and providers to implement.
   
   d. Provide training to providers about appropriate screening and referral practices.
   
   e. Provide consultation to programs and providers in order to develop skills in administering the screen, interpreting results, and providing appropriate follow-up and referrals when needed.

3. Develop and fully implement policies and programs to ensure that children coming through child welfare and juvenile justice systems—children who according to research have a higher likelihood of having mental health problems—are screened and assessed for mental health concerns.

4. Explore best practice strategies (e.g., parental consent and involvement, professional training, community support and consultation) for voluntary screening in appropriate community child-serving settings.

5. Build on and strengthen social emotional developmental screening practices in key public programs including WIC and Family Case Management.

6. Promote effective use of Medicaid’s EPSDT benefit in Illinois to support voluntary screening of children ages birth to eighteen years.

7. Identify how children and families will be supported while waiting for services (i.e., other than for Part C services) when screening identifies concerns and the system is still building an adequate supply of intervention and treatment services.

8. Identify funding mechanism(s) in order to expand education and training efforts to appropriate professionals in the use of standardized developmental screening tools, including tools for the social emotional domain.

**F. Incorporate the social and emotional development of children as an integral component to the mission of schools, critical to the development of the whole child, and necessary to academic readiness and school success, in accordance with existing Illinois and federal confidentiality, consent, reporting, and privacy laws and policies.**

Schools play a central role in promoting children’s social and emotional development because most children ages 3-18 attend pre-school or school, and because social and emotional well-being is integral to children’s ability to learn and succeed in school. By integrating an emphasis on social-emotional learning in schools, students are better able to resolve interpersonal problems and prevent antisocial behavior, as well as to achieve positive academic outcomes.
1. **Recommendation**: Work with the Illinois State Board of Education (ISBE) to ensure that all Illinois school districts develop a policy for incorporating social and emotional development into the district’s education program. The policy shall address social and emotional learning, and protocols\(^4\) (i.e., guidelines) for responding to children with social, emotional, or mental health needs.

**Short-Term Strategies and Action Steps:**

1. Work with ISBE, local school districts, educators, and others to ensure implementation of school policies and administrative procedures that promote social and emotional development.

2. Disseminate to all Illinois school districts sample policies and administrative procedures to guide development of policies for incorporating social and emotional development into educational programs as well as protocols (i.e., guidelines) for responding to children with social, emotional, and mental health problems.

3. Administer a questionnaire to local school districts to determine the current status of practice in Illinois schools with regard to social and emotional development practices and related professional development needs.

4. Provide a range of technical assistance (e.g., electronic newsletter, trainings) and professional development opportunities (e.g., conferences) for educators, community agencies, families/caregivers, and other relevant groups related to promoting children’s social and emotional development and responding to children with mental health needs.

   a. Establish quality pre-service and in-service professional development programming for educators to facilitate their participation in the effective implementation of social and emotional development policies and practices.

   b. Train school personnel, including administrative, academic, pupil support, and ancillary staff, in age-appropriate social and emotional competencies and how to promote them.

   c. Develop informational materials (e.g., written, electronic and web-based) for educators related to promoting children’s social and emotional development.

   d. Develop resources (e.g., brochures) to educate families/caregivers about social and emotional learning (SEL).

   e. Promote access to readings, resources, and grant opportunities to support local district efforts in establishing quality SEL educational programming.

5. Work with ISBE to establish a system to evaluate and monitor school practices for promoting children’s social and emotional development and responding to children with mental health needs.

6. Work with ISBE to raise educator and public awareness about SEL policies.

\(^4\) Protocols (i.e., guidelines) for schools to identify and respond to students with social, emotional and mental health problems might include:

a. Appropriate steps for obtaining parent/caregiver consent, ensuring student privacy and confidentiality, and involving family members.

b. Determination of how a student suspected of having social, emotional or mental health problems is referred.

c. Determination of which school personnel (i.e. student support committee) responds to a referral.

\(\text{d.} \quad \text{Appropriate steps for review of a student's needs, referral and follow-up.}\

\(\text{e.} \quad \text{Explanation regarding how the referral process is different or similar to special education process.}\

\(\text{f.} \quad \text{How to establish linkages and partnerships with other systems and agencies.}\

\(\text{g.} \quad \text{How to support students going through transitions (e.g. new students, students coming/returning from other systems).}\

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7. Explore mechanisms and strategies for promoting and incorporating social and emotional development into the educational program and developing protocols for responding to the social, emotional, and mental health needs of children who do not attend public schools.
   a. Identify mechanisms and strategies (e.g., professional development programs and newsletters of regional associations for independent schools) for providing technical assistance and disseminating sample SEL policies and administrative procedures to private school systems.

II. Recommendation: Work with ISBE to ensure that the plan, submitted to the Governor on December 31, 2004, is implemented to incorporate social and emotional learning standards as part of the Illinois Learning Standards.

Short-Term Strategies and Action Steps:
1. Working with ISBE, ensure development and implementation of the plan to incorporate SEL standards as part of the Illinois Learning Standards.
2. Work with ISBE in drafting SEL standards for incorporation into the Illinois Learning Standards.
3. Work with ISBE in drafting performance descriptors, which build upon standards and benchmarks, to enable teachers to establish appropriate grade-specific, measurable performance expectations.
4. Work with ISBE to develop classroom-based assessments that measure progress towards achieving SEL standards.
5. Work with ISBE to provide professional development to school personnel, including administrative, academic, pupil support, and ancillary staff, in social and emotional competencies and learning standards and how to integrate them across disciplines.
6. Work with ISBE to develop a system to track school progress in implementing the SEL standards and measuring over time the impact of SEL programming on SEL and academic development, and make recommendations for changes in implementation and professional development strategies based on information collected.
7. Work with ISBE to raise educator and public awareness about SEL standards.
8. Promote the implementation of SEL standards implementation through supporting further development of links to advances in evidence-based SEL practices and funding sources on ISBE’s website.

III. Recommendation: Promote increased collaboration and partnerships among schools and school-based mental health, community mental health, health care, juvenile justice, substance abuse, developmental disability, Early Intervention (Part C of IDEA) and child care programs and systems, families/caregivers, and others to promote optimal social and emotional development in children and youth and access to appropriate services.

Short-Term Strategies and Action Steps:
1. Recommend that school districts, schools, and other relevant entities implement policies, programs, and services that support social and emotional competencies, promote mental health, and prevent risky behaviors (e.g., substance abuse, violence) in accordance with existing Illinois and federal confidentiality, consent, reporting, and privacy laws and policies.
   a. Integrate social and emotional education across subjects and for grades pre K-12.
   b. Integrate mental health curricula into all school health curricula and requirements.
   c. Support statewide efforts to introduce evidence-based substance abuse prevention into the school-age curricula.
d. Encourage and build the capacity of schools to maintain and/or expand their existing athletic, fine arts, and other extracurricular programs – programs that can play a key role in enhancing children’s social and emotional health.

e. Provide families/caregivers with learning opportunities related to the importance of their children’s optimal social and emotional development.

f. Recommend that children and youth have access to out-of-school programs that demonstrate best practice, promote children’s healthy social and emotional development, provide academic enrichment, and where possible include children and youth in the planning.

g. Establish guidelines for schools on how to develop partnerships with diverse community agencies, including non-traditional organizations, to ensure a comprehensive, coordinated approach to addressing children’s mental health, and social and emotional development.

h. Support school district efforts to establish, promote and provide access to school-based health/mental health centers by partnering with other agencies.

2. Research, compile and disseminate resource lists (e.g. Collaborative for Academic, Social and Emotional Learning, “Safe and Sound”) and best practices regarding evidence-based programs, curricula, and interventions for provision of school based services.

3. Add or supplement school support staff with providers from outside agencies to maintain best practice ratios (i.e., student support staff to student) and meet school and student needs.
   a. Build partnerships with community mental health and youth serving agencies to provide and offer school-based services.

4. Establish guidelines and processes that support the efforts of community behavioral health, social service agencies, and health care providers to develop ongoing collaborations on behalf of children in school settings.
   a. Incorporate the promotion of children’s social and emotional development into existing programs and services.
   b. Build organization and staff capacity, including staff training and professional development, to address the social and emotional development, and mental health needs of school-age children.
   c. Establish partnerships among early childhood programs, primary care providers, school districts and schools to ensure a comprehensive, culturally competent, coordinated approach to addressing children’s mental health, and social and emotional development.
   d. Explore methods for building partnerships with key school and community stakeholders (e.g., child welfare, community behavioral health, public health, health care, domestic violence, juvenile justice, law enforcement) for referral and follow-up, in accordance with existing Illinois and federal confidentiality, consent, reporting, and privacy laws and policies.

5. Encourage schools to identify a staff person or team to: serve as liaison to families and community agencies; define roles and functions of personnel providing support services to avoid duplication of services; establish appropriate referral mechanisms for students with social, emotional and mental health needs; develop a network of community resources that meet student needs; and educate students about the availability of school-based and school-linked mental health services.
   a. Identify current schools that have a school-family liaison position, including information on the roles and responsibilities of the position and funding for the position.
6. Promote opportunities for multi-disciplinary school personnel (e.g., social workers, psychologists and counselors, school nurses) to develop consistent protocols and coordinated approaches for providing mental health services in schools (i.e., prevention, early intervention, and treatment) for children ages 3-18.

7. Host interdisciplinary forum(s) for school and mental health professionals to promote increased collaboration, identify best practice models and develop common language between professions.

8. Promote collaboration, information sharing and partnerships between Early Intervention (Part C) and school district’s special education programs in order to ensure that families experience smooth transitions between community and school-based services.
   a. Support the implementation of the Birth to Five Project’s recommendations for smooth transitions between Early Intervention (Part C) to school districts’ pre-Kindergarten or Early Childhood Special Education programs.
   b. Identify strategies to improve the transition of families from pre-Kindergarten and Early Childhood Special Education to the K-12 school system.

9. Support the DCFS Strengthening Families pilot initiative to support early childhood centers building protective factors around young children and their families in order to prevent child abuse and neglect.

10. Explore use of guidelines for implementing a quality indicator system to examine the process of collaboration between mental health programs and providers and school settings.

11. Collaborate with the Center for Substance Abuse Prevention in promoting increased community participation in the Strategic Prevention Framework.

EARLY INTERVENTION 5

A. Build coordinated systems for early intervention and response to mental health needs that are responsive to children and their families.

Systemic, periodic, and voluntary early identification efforts can help ensure that children who have mental health needs are identified early and provided or referred to appropriate programs and services. Systems and programs that serve children (e.g., early childhood programs, schools, health care) should be equipped to identify the early warning signs of problems in social and emotional development. This includes addressing mental health needs that are not severe enough to result in a diagnosis but nonetheless require some type of mental health intervention such as counseling, support groups, or skills-building classes. Children should have access to these interventions even though eligibility for many public programs is based on having a mental health diagnosis. For children in the child welfare and juvenile justice systems, the state has a particular responsibility for screening and assessment since research shows that these children have a higher likelihood of having a mental health problem than other children.

1. Recommendation: Expand on and build the capacity of child-serving systems and agencies (e.g., early childhood, health care, education, community mental health) to provide early intervention services that are accessible to children.

   Short-Term Strategies and Action Steps:
   1. Identify early intervention services that do not require a diagnosis for eligibility of services for low and moderate-risk groups, and identify which services need to be expanded in Illinois.

5 In this section, “early intervention” is used as a general term to refer to a broader set of services and populations than are found in the IDEA Part C system, formally known as “Early Intervention.”
2. Expand eligibility criteria for Early Intervention and Special Education services for children with social and emotional delays, mental health diagnoses, substance abuse issues, and identified as high risk.

3. Encourage that children who are referred to the Special Education or Early Intervention system be screened for social and emotional concerns and receive appropriate follow-up services as part of the Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP).

4. Identify gaps in services, establish systems where services do not exist, and strengthen existing systems by promoting the development of formal linkages and collaboration at the community level (e.g., Local Area Network (LAN) structures with education included, All Our Kids Networks).

5. Establish and strengthen regional or LAN-based case management to assist families/caregivers in navigating the system and accessing early intervention services and/or support.

6. Develop collaboration and referral pathways with primary care providers to address the psycho-social and mental health needs of school-age children.

7. Promote that publicly funded mental health providers develop linkages with primary care providers and collaborate on providers’ roles in the systematic assessment process.

8. Integrate community needs assessment approaches that ensure connections between early childhood programs, schools, and community agencies (e.g., community behavioral health providers) and resources, and fully utilize existing school resources including school counselors, social workers, school nurses and psychologists to serve the non-special education populations.

9. Build the capacity of early childhood programs, schools, out-of-school programs, health care providers (e.g., pediatricians, local health departments), and other youth-serving systems to provide early intervention services and/or make appropriate referrals for services. This includes consultation with mental health providers, student support services, short-term counseling, skills building classes, and ongoing and crisis support.

10. Develop best practice strategies about how to provide support services to families whose children have been expelled from early childhood programs (e.g., child care, pre-K).

11. Disseminate information and referral protocols for the Special Education and Early Intervention systems, and community behavioral health care services to ensure that children are referred to the appropriate system, when indicated, and referring providers receive necessary feedback.

12. Build on evaluation and lessons learned from the Bureau of Early Intervention’s integration of the social emotional component in other systems.

13. Establish mechanisms for providing services and linkages to services for children identified as high risk for mental health problems (e.g., children exposed to trauma).

14. Strengthen information sharing processes between providers and agencies, in accordance with existing Illinois and federal confidentiality, consent, reporting, and privacy laws and policies.
II. **Recommendation:** Promote and support initiatives that strengthen best practices, quality standards and professional training associated with mental health screening and related follow-up assessment and treatment services, as appropriate, for children in the child welfare and juvenile justice systems, in accordance with existing Illinois and federal confidentiality, consent, reporting, and privacy laws and policies.

*Short-Term Strategies and Action Steps:*

1. Promote that children and youth involved in the child welfare, juvenile justice, substance abuse, and developmental disability systems, including children born to youth involved in these systems, are eligible for all relevant early intervention programs and services.

2. Establish as a core service and fully implement the DCFS Integrated Assessment Services Model for children in the child welfare system.
   a. Explore expanding the Integrated Assessment to intact DCFS families

3. Promote screening and assessment of children and youth involved in the juvenile justice system in order to determine the need for early intervention services or treatment including the following.
   a. Developing a standardized process for administering screenings and assessments completed by qualified mental health professionals across the continuum of service in the juvenile justice system.
   b. Promoting a menu of best practice screening and assessment tools for use by county probation departments.
   c. Promoting mental health screening at the time of pre-sentencing, in diversion programs and release from the Department of Corrections (DOC).
   d. Expanding the Mental Health Juvenile Justice Initiative (MHJJ) to cover a broader array of mental health needs.

4. Explore collaboration between DOC Juvenile Division and DHS, Division of Mental Health that would result in shared accountability and responsibility for evaluation and treatment of youth determined to have mental health conditions.

5. Assure collaboration between local community agencies, including schools, and child welfare or juvenile justice systems when youth are placed into custody in DOC or any other system.

6. Expand alternatives to incarceration for youth who have mental health needs through the promotion of diversion and deflection programs (e.g., consider establishment of mental health courts for youth who have mental illnesses in the juvenile justice system).

7. Identify the mental health needs of special populations including those children and youth who are: out-of-school or school dropouts; have experienced exposure to trauma and violence; pregnant and parenting teens; homeless; gay, lesbian, bisexual or transgender (GLBT); and have a parent with a mental health need.
III. **Recommendation:** Promote the development of a coordinated community response to children exposed to trauma.

*Short-Term Strategies and Action Steps:*

1. Develop strategies for providing support to child-serving programs to incorporate the emerging research and practice from the trauma field.

2. Through the DCFS Trauma Initiative, increase the availability and quality of mental health services for families involved with the child welfare system, and infants and children exposed to violence.

3. Develop a continuum of crisis response or management models so that schools, early childhood programs, community-based agencies and families are equipped to respond to local and/or national crises (e.g., school shootings, natural disasters, terrorism).

4. Explore strategies for building on existing efforts and funding the training of professionals working in child welfare, early intervention, child mental health treatment, education, juvenile justice systems and others to recognize and identify trauma in children and refer to appropriate services.

IV. **Recommendation:** Identify best practices for educating expecting families and the general public about the impact of substance abuse on children’s development and for addressing and treating substance exposed infants.

*Short-Term Strategies and Action Steps:*

1. Review substance abuse prevention practices in key public programs across Illinois.

2. Build on existing efforts to effectively educate expecting families about the impact of substances and develop messages to be part of public awareness efforts.

   a. Develop materials (e.g., issue brief) that explain the connection between substance abuse in adults and how it impacts children’s mental health (e.g., when children are born exposed to substances).

3. Explore effective responses to addressing and treating substance exposed infants.

4. Work with DHS and DCFS in implementing the reauthorized Individuals with Disabilities Education Act (IDEA) that now requires children under the age of three who have been identified as affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure be referred to Early Intervention (Part C).
TREATMENT

Children (i.e., children ages 0-18 and youth ages 19-21 who are transitioning out of the child mental health system) who have identified mental health problems and disorders, including those with co-occurring disorders, and their families should have access to a comprehensive system of care of developmentally appropriate mental health services and supports. Mental health services should be based on the needs of the child and their family; community-based and collaborative; developmentally, culturally and linguistically competent and responsive to the populations being served; and provided in and across natural settings and least restrictive and appropriate settings when possible.

A. Promote that children have access to quality, coordinated, and culturally competent systems of care that provide comprehensive treatment and family supports.

1. Recommendation: Build and strengthen a quality system of care in Illinois based on the mental health “System of Care” Principles to ensure that children once identified as needing services, have access to a comprehensive array of clinically appropriate assessment, treatment services and supports. Services and supports should include but not be limited to the following list.

   • Comprehensive assessment and diagnostic services
   • Access to a comprehensive list of available services and providers cross-referenced by geographic area, the child’s age and diagnosis, and specialty
   • Services based on evidence-based practices, including those practices shown effective with diverse populations
   • Psychiatric, psychological, social work and counseling services
   • Behavioral health intervention services provided in the child’s natural environments (e.g., home, child care center, school)
   • Comprehensive case management, provider integration and wrap-around services for community based treatment and intensive outpatient programs
   • Individual counseling/therapy, play therapy, parent-child relationship therapy, parent psycho-education/counseling, family and group psychotherapy
   • Array of therapeutic interventions or support services with particular expertise in working with children who have experienced environmental insults (e.g., abuse or neglect, exposure to substance abuse in the home environment, exposure to violence, trauma regardless of single or chronic occurrence, and loss of parent or primary caregiver)
   • Family support services for families (including siblings) of youth in the mental health system
   • Special education including therapeutic day schooling
   • Therapeutic nursery, after school and pre-school programs
   • Therapeutic recreation
   • Therapeutic respite (especially for evenings and weekends)
   • Transportation to and from services
   • Inpatient psychiatric treatment services and partial hospitalization services
   • Residential treatment including comprehensive case management by a community-based service provider
• Effective, appropriate and prudent medication as determined by a qualified professional with appropriate informed family/caregiver consent.

• Comprehensive transition services, particularly for youth in residential or hospital settings

• Discharge planning and transition to age appropriate services

Short-Term Strategies and Action Steps:

1. Promote increased resources for treatment services and develop a prioritized plan on how to distribute such resources.

2. Identify and replicate functional systems of care in Illinois (e.g., Local Area Network (LAN) geographic regions in Illinois).

3. Structure state contracts to support the incremental development of System of Care models and coordinate planning with local mental health authorities (e.g., Community Mental Health Boards) and other local funding bodies.

4. Promote community mental health services that utilize a System of Care framework that would include: treatment plans based on current assessment, appropriate identification of treatment needs, pre-discharge treatment plans, linkage to community services, monitoring of the linkages, and funding of services.

5. Utilize a best practice approach to integrate families/caregivers into the treatment planning and ongoing assessment, staffing and treatment of the child.
   a. Provide parent-to-parent advocacy training to help families/caregivers coordinate their services, as well as to advocate for needed services.
   b. Explore the development of child/family teams to assist in the development of an infrastructure for children’s mental health services.

6. Promote and support initiatives that promote excellence in and strengthen the treatment capabilities of residential treatment facilities in Illinois.
   a. Identify residential treatment models that produce long-term successful treatment outcomes and promote replication of successful models.
   b. Identify best practices and evidence-based models for residential treatment and incorporate requirements in contract program plans (e.g., family involvement, discharge planning, linkage and aftercare specifications).
   c. Integrate families/caregivers into the treatment planning and ongoing assessments, staffing and treatment of children in residential placement.
   d. Disseminate information regarding the range of services provided at residential facilities to enable best placement of child.

7. Expand relationship-based intervention and treatment services to meet community needs.
   a. Identify an array of intervention and treatment services that have demonstrated effectiveness with diverse populations.
   b. Identify strategies for documenting and promoting the need for more relationship-based services, using examples of successful programs (e.g., Early Intervention System Social Emotional Pilots).
c. Identify resources for increasing the availability of these services.

8. Develop protocols for implementing screening and assessment of children prior to any admission to an inpatient hospital for psychiatric services (i.e., the Screening Assessment and Support Services (SASS) system).
   a. Develop a comprehensive handbook covering the policies and procedures (e.g., eligibility, screening procedures, scope of services, billing and reimbursement) that all providers participating in the SASS system must follow.
   b. Provide technical assistance to SASS providers regarding development and implementation of the SASS system.

9. Build on existing programs such as the Screening Assessment and Support Services (SASS) service system.

10. Increase access and availability, and improve the quality of children’s mental health services for culturally and ethnically diverse groups.
    a. Contractually require all children’s mental health providers to develop cultural competence plans.
    b. Promote specific cultural competence training for front-line staff, administrators, and boards.
    c. Contractually require all mental health assessments of children to include a cultural formulation (i.e., DSM-IV, Appendix 1).

11. Recognize diagnoses for children described in the DC:0-3 and DSM-PC and promote payment by public and private health insurance programs for mental health treatment services for children with any of these diagnoses.
    a. Work with DPA’s Assuring Better Child Health and Development (ABCD II) Initiative to investigate how to best adopt the DC:0-3 and DSM-PC in Illinois.
    b. Host a work group with DPA to determine appropriate action steps to support the implementation of the DC:0-3 and DSM-PC.
    c. Assist DPA with communication re: the new reimbursement policies and guidelines for the DC:0-3 and DSM-PC.
    d. Clarify for providers the diagnoses that create eligibility for children to obtain Medicaid services.
    e. Identify how training can be provided to increase awareness and use of the DC:0-3 and DSM-PC by clinicians and primary health care providers.

12. Promote and support the sustainability, expansion, and development of school-based health centers equipped to provide mental health services.

13. Effect linkages to a System of Care for those children with behavioral health needs who are detained or confined.

14. Encourage that health and mental health providers receive training with regards to best practices within the System of Care.
II. **Recommendation:** Develop mechanisms, as part of the System of Care design, to provide assistance and direct families/caregivers to culturally competent, gender and clinically appropriate services. The system will include clear referral pathways for children involved in the child welfare, juvenile justice, education, substance abuse, family violence, sexual assault, homeless shelters, and developmental disabilities systems.

*Short-Term Strategies and Action Steps:*

1. Develop contract language that requires behavioral health providers to execute referral agreements with all child-serving systems in their LAN that assures rapid access to appropriate services.

2. Promote and support changes in the state’s administrative structure and policy to improve the quality and consistency of residential treatment and produce successful long term treatment outcomes for children and adolescents in Illinois.
   - a. Prioritize the provision of mental health services and supports that will maximize the ability of the community mental health system to provide care for the youth and family within the child’s home community, prevent the need for residential institutional care, and ease the transition for those returning to the community from residential treatment.
   - b. Develop mechanisms for the transition of older youth in residential treatment to the adult mental health system.
   - c. Support DCFS reform in promoting gradual transitions between settings for youth.

3. Develop accountability standards to monitor and improve implementation of referral agreements.

4. Amend state contracts with providers to include requirements for periodic community needs assessments for service planning.

5. Develop service-oriented pilots and models using a local coordinated approach (e.g. establish uniform referral process, central phone number for services, and establish formal linkages between providers).

6. Develop community-based pilots and models that establish local assessment and planning processes, including needs assessments, resource inventories, and identification of local priorities.

7. Encourage youth and family involvement in treatment planning and implementation of mental health services.

8. Develop best practices among mental health and health professionals on how to fully inform families about treatment options and potential alternatives so that families can make informed decisions about their child’s treatment.

9. Develop and strengthen statewide special recreation programs (e.g., therapeutic recreation, after-school programs, and overnight/weekend programs) and therapeutic respite services for children with serious emotional disturbances.
   - a. Build the capacity of community recreation programs to include and support children with mental health concerns.

10. Promote children involved in all aspects of the juvenile justice system to be eligible for access to all available and appropriate treatment programs and services.
    - a. Establish full range of effective mental health treatment services for youth in detention and confinement, in diversion programs, in residential care, and in the community based on individualized treatment plan goals and evidence based models of treatment.
b. Promote family/caregiver education regarding clinical services, needs, legal rights, and treatment planning in the juvenile justice system for youth who have mental health issues.

c. Educate youth about their rights to access mental health and substance abuse services in the state.

d. Promote coordination of services and continuum of care for youth transitioning through and out of different systems or aging out of the juvenile system to assure that they have continued mental health services if needed.

e. Promote effective mental health programming in juvenile detention/incarceration that addresses the unique needs of youth including: 1) girls, 2) pregnant girls and parenting youth, 3) gay, lesbian, bisexual, transgendered, and questioning youth, 4) youth being tried as adults, 5) sexually or physically abused youth, and 6) youth abusing substances.

f. Expand MHJJ initiative to include youth with less serious mental health diagnoses and to additional parts of system (e.g., those released from DOC, in detention, in juvenile courts, or at risk of commitment).

g. Explore best practices for integrating and balancing mental health/therapeutic interventions with correctional and security policies and practices.

11. Explore school-based models and policies that allow students in need of substance abuse services to access appropriate services as an alternative to disciplinary action.

   a. Promote collaboration between schools and other community agencies (e.g., law enforcement) to support these policies.

   b. Promote collaboration between schools and substance abuse providers to provide school-based or school-linked substance abuse services.

   c. Explore expansion of the Student Assistance Model to address needs of youth with substance abuse issues.

   d. Develop a coordinated approach to substance abuse treatment for youth involved in the juvenile justice system.

12. Explore the integration of mental health and substance abuse systems through activities including:

   a. Integrating Medicaid rehabilitation regulations (e.g. DASA Rule 2060 and DMH Rule 132).

   b. Co-locating substance abuse and mental health services.

   c. Providing and billing of services in natural environments (e.g., schools).

   d. Streamlining accreditation regulations and licensing requirements so that the regulations support best practice and access to care.
GOAL II. INCREASE PUBLIC EDUCATION AND AWARENESS

Mental health is a critical component of children’s health, well-being, and learning. Yet, mental health stigma and general misinformation about mental health are some of the most significant barriers to ensuring that children and their families have access to a quality, comprehensive children’s mental health system. Promoting children’s social and emotional development as an essential part of child health is critical to addressing stigma, and educating diverse families and the general public about the importance of mental health, early identification, and treatment. Public education and awareness efforts are necessary to strengthen and build knowledge of and confidence in the children’s mental health system among families/caregivers and the general public.

Recommendation: Develop a comprehensive, culturally inclusive, and multi-faceted public awareness campaign to reduce the stigma of mental illness; educate families, the general public and other key audiences (e.g., educators, health and mental health providers, juvenile justice system officials, faith-based organizations, local health department officials) about the importance of children’s social and emotional development; inform families/caregivers, providers, and others about how to access services; and educate policymakers and others about the need for expanding mental health resources.

Short-Term Strategies and Action Steps:

1. Develop a multi-year plan for developing a comprehensive, culturally inclusive, and multi-faceted public awareness campaign.

2. Ensure that families, youth, caregivers, business leaders, policymakers, educators, juvenile justice officials, leaders from the faith community, local health department officials, primary care providers, and other key groups are engaged in the development, design, and pilot testing of the campaign.

3. Ensure that the public awareness campaign is based on research and information regarding knowledge and perceptions about areas including: stigma; importance of promoting mental health in children and adolescents; the prevalence of mental health disorders in children and adolescents (including as it relates to youth in the juvenile justice system and the importance of providing mental health treatment rather than placement in correctional settings); the factors that can cause and/or contribute to mental health disorders; the availability of services and resources among the target audience(s); and understanding of concepts relating to mental health versus mental illness.

4. Ensure that, by using both traditional and non-traditional mediums, that the public awareness campaign provides recognition of and attention to children and families who live in geographically isolated regions of the state, have low literacy skills or are limited-English speakers, from culturally and economically diverse communities, and from special populations with unique needs (e.g., homeless, developmentally disabled, GLBT youth).

5. Identify and partner with existing statewide mental health public awareness efforts (e.g., Illinois Suicide Prevention Task Force, Fight Crime Invest in Kids Illinois).

6. Measure the impact of the public awareness campaign on the target audiences’ (e.g., families/caregivers, educators, health and mental health providers, juvenile justice system officials) knowledge, perceptions, and relevant behavior change.

7. Create support for building the capacity of the mental health system to serve children and adolescents, and that families/caregivers, providers, and others are informed of availability of services and programs.

8. Provide policymakers with regular communication about children’s mental health including key aspects of the public awareness campaign and efforts to improve the mental health system.
9. Inform and disseminate information to policymakers, providers, families/caregivers, the general public, and other key groups about the impact of changes to the CMH system in key benchmark areas.

10. Develop a plan for ongoing strategies to support and sustain the public awareness campaign efforts, including fundraising.

**Long-Term Strategies and Action Steps:**

1. Implement a comprehensive, culturally inclusive, and multi-faceted public awareness campaign that includes and expands the components developed in years 1-2.
   
   a. Implement the most effective, accessible, and available informational and resource system (e.g., state-wide hotline, web-based system) to provide families/caregivers, providers, and others with information about CMH (e.g., availability of providers).

2. Implement an ongoing comprehensive study and evaluation of the public awareness campaign.

3. Inform and disseminate information to policymakers, providers, families/caregivers, the general public, and other key groups about the impact of changes to the CMH system in key benchmark areas.

4. Establish plans and strategies are in place to sustain the public awareness campaign effort beyond the 3-5 year period of the campaign.

**GOAL III. MAXIMIZE CURRENT INVESTMENTS AND INVEST SUFFICIENT FISCAL RESOURCES OVER TIME**

Numerous federal programs provide Illinois with funds that are either directly targeted to children’s mental health or could be used to support an array of services in some capacity. Many of these federal resources offer flexibility in the use of funds and program design, within federal parameters. Efforts that maximize and coordinate federal program funds, state general revenue funds (GRF), and local and private funds can result in better ways of using scarce resources and create new investments for children’s mental health. For instance, savings and revenues obtained through additional Federal Financial Participation related to ICG grants and the expansion of the pre-psychiatric hospitalization screening program could be directed to support children’s mental health programs and services.

Illinois could be using Medicaid more effectively through efforts including implementation of cost-saving measures and enhancement of service delivery components within the current state program. Because Medicaid is one of the largest funding sources for children’s health and mental health services, it is an important program to examine.

1. **Recommendation:** Maximize the use of key federal and state program funds for children’s mental health, integrate multiple federal and state funding streams, and promote the use of local matching funds, where appropriate.

   **Short-Term Strategies and Action Steps:**

   1. Advocate for an increased appropriation for children’s mental health (CMH) services and programs.

      a. Increase the state’s investment in children’s mental health by targeting existing resources and increasing resources in the state’s budget.

      b. Over the next 2-3 years, allocate $19.5 million in increased funding targeted for children’s mental health prevention, early intervention and treatment programs as outlined below:
i. $2 million for a mental health consultation initiative to enhance the capacity of providers of children’s programs and services (e.g., primary care, early childhood, school, mental health) to address the mental health needs of children.

ii. $1 million for a statewide public education and awareness campaign.

iii. $6 million for school-based activities focused on social and emotional educational and student support services.
   1. $2 million for professional development related to implementation of the Illinois Social/Emotional Learning Standards and school district policies.
   2. $3 million in grants to school districts to implement social/emotional development curricula and increase in-school student mental health support services or purchase of community mental health services for students.
   3. $1 million for expansion of the Positive Behavior and Supports Program (PBIS) to additional schools.

iv. $10 million for increased early intervention and treatment services for children:
   1. $2 million for Transitional Services: social/emotional support services for 18-20 year old youths transitioning out of public systems (i.e., child welfare, mental health, juvenile justice).
   2. $1.5 million for Trauma Services: services for children exposed to childhood trauma, and infrastructure development to support identification and service provision.
   3. $2 million for SASS Aftercare Services: services provided to children who need follow-up services beyond the 90 day SASS period.
   4. $1.5 million for Birth to Five Treatment Services: mental health treatment services for children ages 0-5 years.
   5. $3 million for early intervention services: services (e.g., individual or group counseling, skills-building services) for children and adolescents that do not require a DSM-IV diagnosis.

v. $500,000 for a policy and research center(s) to support research-based workforce development, best practice models and technical assistance on CMH.

2. Identify funds from multiple state and local agencies, including those that can be braided or pooled, to support children’s mental health prevention, early intervention and treatment efforts at the community, LAN, regional and state levels.

3. Develop a coordinated strategy between state agencies and local mental health authorities for application to the federal Substance Abuse and Mental Health Services Administration (e.g., additional System of Care grants in targeted communities).
   a. Participate in the development of the SAMHSA Transformation state Infrastructure Grant application to advance the ICMHP Children’s Mental Health Plan.
   b. Encourage Illinois to apply for additional System of Care grant funds from SAMHSA.

4. Explore the use of various federal programs (e.g., Title V MCH Services Block Grant, Juvenile Justice) to support children’s mental health programs and services.
   a. Maximize the use of SAMHSA’s Drug Free Community Support grants.
5. Advocate for adequate resources to enable key state agencies to build capacity for implementing new and enhanced programs and services related to children’s mental health prevention, early intervention and treatment.
   a. Advocate for increased resources to enable Illinois school systems to implement the Illinois Learning Standards and social and emotional development policies and practices.
   b. Advocate for increased funding for community-based substance abuse outpatient care for youth.

6. Advocate for increased federal funding to support comprehensive children’s mental health programs and services.

II. **Recommendation:** Make effective use of Medicaid and KidCare to ensure that children receive appropriate mental health services.

**Short-Term Strategies and Action Steps:**

1. Explore various Medicaid waiver options to maximize the availability of federally matched mental health services for Illinois children.

2. Expand the number of Medicaid/KidCare application agents, particularly within the education system, through expanded training activities.

3. Based on an analysis of the existing system, consider expansion of the eligibility criteria for Individual Care Grants to include children in the autistic spectrum with profound behavioral problems.

4. Expand Medicaid coverage for family practitioners and pediatricians to conduct social/emotional screening and referral services.

5. Explore whether services provided to troubled and homeless youth could be used as Medicaid match.

6. Advocate for Medicaid coverage for services for undocumented families.

7. Explore expanding Medicaid reimbursement for children’s mental health services on a continuum for children with moderate to severe mental health disorders.

8. Modify Medicaid rules to expand the number and type of providers (e.g., licensed clinical social workers and psychologists, licensed clinical professional counselors, nurse practitioners, and nurses) who are eligible to receive reimbursement for assessment and treatment services under Medicaid.

9. Explore strategies for covering mental health services provided by social workers and recognized trained mental health professionals.

10. Review and monitor implementation of the Screening Assessment and Support Services (SASS) system designed to screen children prior to all admissions for psychiatric hospitalizations that are funded by Medicaid.

11. Monitor the financial outcomes of implementation of Medicaid reimbursement for Individual Care Grants and the SASS screening system.
III. **Recommendation:** Initiate the development of state funding sources and mechanisms, including incentive-based funding structures and community-based pilot projects and models, to promote best practices in prevention, early intervention, and treatment.

*Short-Term Strategies and Action Steps:*

1. Convene a multi-agency and multidisciplinary work group to examine how children’s residential mental health treatment services are funded and accessed in order to develop strategies for improving financing, cost-effectiveness, and access to residential services and alternative community services, where appropriate.
   a. Explore consolidation to a single state agency for responsibility of monitoring and evaluating residential treatment with focus on appropriate utilization, safety and stability, improved client functioning, effective transitions, and post-discharge stability. Data from these processes should be made available to family members, payers, and providers.
   b. Explore consolidation of all rate-setting and licensing for residential treatment facilities to a single state agency.

2. Explore mechanisms necessary to employ or purchase the services of child/adolescent psychiatrists who would provide services to children participating in public systems (e.g., DCFS, DHS) particularly for children residing in rural areas, through funds identified in appropriate agency budgets, with FFP where possible.

3. Identify federal, state, local, and private funding mechanism(s) to ensure families, programs and providers have access to mental health consultation.
   a. Create a collaborative funding initiative involving DHS, ISBE, DCFS, DMH (and any other relevant agency) to expand access to mental health consultation, including support for pilot programs.
   b. Explore Medicaid reimbursement for consultation between primary care providers, health professionals, and psychiatrists.
   c. Explore mechanisms necessary to purchase mental health consultation services for primary care providers serving children in rural and underserved areas.

4. Explore expanding provision of mental health services in schools.
   a. Explore development of a program to place licensed clinical social workers in schools who are eligible and certified to bill Medicaid for services.
   b. Promote expanded use of federal funding (through reauthorization of IDEA) for students who are not in special education.
   c. Determine opportunities for social and emotional learning and student support in reauthorization of IDEA.
   d. Advocate that any change in the school funding formula bolsters student support services that address the social and emotional development of students.

5. Identify and implement strategies including incentives for increasing local funding for mental health and for better integrating local, state and federal funds.

6. Coordinate with the Redeploy Illinois program to ensure that an appropriate amount of funding is directed toward assessing and meeting the mental health needs of children involved in this program.

7. Improve the quality of pharmaceutical care for children who are served in public programs and require psychotropic medications, and demonstrate improved stewardship of public funds by encouraging collaboration between communities and the State Pharmacy to identify and develop more cost effective purchasing strategies.
IV. **Recommendation:** Make policy and planning recommendations to the Governor regarding a state budget for prevention, early intervention, and treatment across all state agencies.

*Short-Term Strategy and Action Step:*

1. Develop a plan and strategy for policy and planning recommendations regarding a state budget for prevention, early intervention, and treatment across all state agencies.

V. **Recommendation:** Initiate development of state and local mechanisms for integrating federal, state, and local funding sources for children’s mental health.

*Short-Term Strategy and Action Step:*

1. Develop strategies for establishing state and local mechanisms for integrating federal, state, and local funding sources for children’s mental health.

2. Create child mental health systems that cover and serve children across geographic boundaries.

VI. **Recommendation:** Explore mechanisms and strategies for increasing private insurance coverage of children’s mental health services.

*Short-Term Strategy and Action Step:*

1. Explore and develop strategies to increase private coverage of children’s mental health services.

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**GOAL IV. BUILD A QUALIFIED AND ADEQUATELY TRAINED WORKFORCE WITH A SUFFICIENT NUMBER OF PROFESSIONALS TO SERVE CHILDREN AND THEIR FAMILIES THROUGHOUT ILLINOIS**

Families and caregivers rely on mental health and health care providers, educators, child care providers, and other professionals for needed information, expertise, and guidance about their child’s social and emotional development. Yet, national surveys indicate that many of the professionals who have regular contact with children (e.g., primary health care providers, teachers) are not always adequately prepared to address children’s social and emotional development, and mental health needs.

Mental health and health care providers, educators, social workers, school counselors and nurses, and other professionals play a critical role in addressing children’s mental health needs. Because of their regular contact with children, these professionals need to have the knowledge and skills to effectively serve children and youth, and intervene appropriately when problems surface or risk factors are evident. This requires appropriate training and qualifications, and opportunities to continually learn new, evidence-based, and culturally-competent practices.

A. **Expand and develop the mental health workforce.**

1. **Recommendation:** Initiate efforts to expand the mental health workforce to ensure a diverse, adequately trained and qualified workforce that meets the needs of children and their families throughout Illinois.

*Short-Term Strategies and Action Steps:*

1. Expand and diversify the workforce of children’s mental health providers and services with a focus on ensuring cultural and linguistic competencies and family involvement.

   a. Identify barriers that prevent a more diverse workforce (i.e., cultural, ethnic and linguistic) from entering the children’s mental health field.
b. Explore and work with mental health-related professional associations to offer CEU credits in children’s mental health.

c. Determine the number of higher learning institutions that offer coursework and specialized tracks in early childhood mental health within psychology, clinical social work, and other counseling programs.

2. Develop incentives to attract professionals and paraprofessionals, particularly those from diverse backgrounds and underrepresented groups (e.g., immigrants, non-citizens) to enter the mental health field and serve underserved populations and in underserved areas.

a. Explore development of a student loan forgiveness program(s) for mental health professionals (e.g., social workers, psychologists, school counselors) to increase the number of these professionals available to serve children and their families and to encourage these professionals to serve in underserved areas of the state.

b. Explore credential equivalence and reciprocal licensure for mental health professionals from other countries.

c. Explore creation of a state-based scholarship program for students entering the mental health profession such as those created by the Diversifying Higher Education Faculty in Illinois Program (DFI).

d. Expand the definition of “underrepresented minority groups” in state programs to include those with skills in languages other than English.

e. Expand access to and development of mental health training for paraprofessionals from other countries.

f. Support the work of the Birth to Five Project’s Bilingual Committee.

3. Provide training to mental health professionals on the mental health needs of special populations including homeless children; children with disabilities; children who have experienced family violence and/or sexual assault; GLBT youth; youth in the juvenile justice system; and children who have a parent with a mental health need.

a. Promote programs staffed by qualified mental health professionals including: psychiatrists, psychologists, counselors, and social workers in juvenile detention/confinement.

b. Promote training and provide resources to staff at juvenile justice access points (e.g., probation, detention, judges, attorneys, law enforcement) regarding mental health “best practice,” gender bias concerns, and cultural competency issues (e.g., Chicago Intervention Team law enforcement training).

c. Promote cross-training among professionals in the mental health, child welfare, schools, and juvenile justice systems.

4. Identify core competencies, qualifications and skill sets of mental health professionals, including competencies in cultural competence.

a. Collaborate with institutions of higher education to ensure that the training of mental health professionals includes core competencies in children’s mental health and children’s development, especially the domain of social and emotional development.

5. Build and strengthen efforts that use video technology for training purposes, and for providing mental health consultation, and psychological and psychiatric services, particularly to underserved areas of the state.

6. Include social and emotional development in curricula used for professional education and training in mental health.
II. **Recommendation:** Increase the capacity of programs and providers who work with children (e.g., early childhood, health care, education, mental health, education, child welfare, juvenile justice) to promote and support the social and emotional development and mental health needs of children and their families.

**Short-Term Strategies and Action Steps:**

1. Increase the qualifications of professionals working with young children and their families to promote and address social emotional health.
   
   a. Coordinate current training efforts in social emotional development across the state.
   
   b. Train personnel in health, education, special education, family support, child care, occupational therapy, physical therapy, speech, etc. to work with young children and their families in reflective practice and in promoting social emotional health.

2. Explore and develop a plan that includes cultural and ethnic competence for cross-training between mental health and health, early childhood development, special education, education, family support, child care and other professionals.
   
   a. Establish core competencies that should be included in any cultural competency training.
   
   b. Build collaborations among professional organizations and designate CEUs for cultural competency training.

3. Develop the capacity of primary care providers to serve the mental health needs of children and their families in areas including social and emotional development screening, appropriate referrals, and cultural competence.

4. Develop the capacity of child care programs to promote social and emotional development and serve the mental health needs of children and their families.
   
   a. Explore training licensed-exempt and family child care providers about early childhood and children’s mental health.
   
   b. Work with the Strengthening Families Initiative to explore the role of child care state licensing to encourage child care programs to use mental health consultants.

5. Develop the capacity of school systems and school administrators and staff to promote social and emotional development and serve the mental health needs of children and their families.
   
   a. Establish guidelines for schools to conduct local team-based assessments that determine staff capacity, organizational climate, student needs, staff competencies and available resources in children’s mental health.
   
   b. Utilize existing professional development mechanisms to train school administrators and staff on the assessment process.
   
   c. Assure that mental health training is available to all school staff and includes how to identify risks and resiliencies, the relationship between mental health/social emotional development and learning, how to make referrals and collaborate with outside agencies.
   
   d. Explore ways to include family involvement and mental health training in continuing education for school personnel, including teachers, administrators, support service personnel and others.
   
   e. Explore strategies and mechanisms for making children’s mental health trainings and resources available to non-public schools.
6. Incorporate substance abuse prevention and education into professional training, continuing education, and curricula across settings (e.g., mental health, child welfare) and disciplines.

7. Promote training of key programs and providers who work with children (e.g., child care, primary care) on the mental health needs of special populations including homeless children; children with disabilities; children who have experienced family violence and/or sexual assault; GLBT youth; and children who have a parent with a mental health need.

8. Review the Illinois Codes related to training and include family involvement and mental health where appropriate.

9. Work with institutions of higher education, professional associations, and state agencies to provide training regarding children’s mental health, including the impact of exposure to violence, to health care, community behavioral health care, and early childhood providers, teachers, paraprofessionals, and others.

GOAL V. CREATE A QUALITY-DRIVEN CHILDREN’S MENTAL HEALTH SYSTEM WITH SHARED ACCOUNTABILITY AMONG KEY STATE AGENCIES AND PROGRAMS

At least seven state entities (i.e., state agencies, divisions, and departmental units) in Illinois have some type of responsibility for addressing the social and emotional development of children. However, the degree to which these entities address children’s mental health varies. Among many other identified barriers, these entities have little ability to assess overall system needs and to determine whether programs and services are meeting the needs of children and their families. Illinois needs a quality-driven children’s mental health system with shared accountability among key state agencies and programs that conducts ongoing needs assessments, uses outcome indicators and benchmarks to measure progress, and implements quality data and reporting systems to capture summary information that can be used to make improvements to programs.

**Recommendation:** Initiate development of outcome indicators and benchmarks, including links to and integration of early childhood and school learning standards, for ensuring children’s optimal social and emotional development, and improving overall mental health.

**Short-Term Strategies and Action Steps:**

1. Develop a set of core outcome indicators and benchmarks for which data is readily available and that can be measured over time.
   a. Promote the adoption of professional standards of care for services delivered in residential treatment facilities, county juvenile detention centers and Illinois Youth Centers.

2. Promote that the set of core outcome indicators and benchmarks are linked to and integrated with existing systems for collecting summary data related to children’s mental health.
   a. Work with key state agencies to determine and assess what summary data related to children’s mental health is currently collected.

3. Develop and implement a plan to identify a system that: obtains the core indicator and benchmark data; regularly reports findings to policymakers, the general public, and other key groups; and makes recommendations for quality improvement in programs and services, as identified.

4. Identify data sets necessary to document need, service utilization, and outcomes.
GOAL VI. INVEST IN RESEARCH

Children’s mental health research significantly lags behind research on adult mental health needs and best practices in prevention, early intervention, and treatment. Moreover, mental health providers and others who come into contact with children need up-to-date and timely information on best practices and evidence-based practices in children’s mental health.

I. Recommendation: Initiate a Children’s Mental Health Resource Center(s) to collect and facilitate research on best practices and model programs; share information with Illinois policymakers, practitioners and the general public; develop culturally and linguistically competent training and educational materials; provide technical assistance; and implement other key activities.

Short-Term Strategies and Action Steps:

1. Identify existing research centers and research projects that address children’s mental health and engage these Centers in the work of the ICMHP.

2. Develop an inventory of children’s mental health research projects within Illinois and related resources.

3. Develop a statewide multi-cultural resource center that would serve as a clearinghouse for resources that promote cultural and linguistic competence in children’s mental health. Such a center would provide and/or coordinate activities including: information and resources in multiple languages organized by geographic regions; consultation services; development and distribution of uniform, multi-lingual materials that are understood by a range of literacy levels; and guidance on selection and use of translation and interpretive services.

II. Recommendation: Develop and conduct process and outcome evaluations that measure changes to the children’s mental health system and in child outcomes as a result of implementation of the Illinois Children’s Mental Health Plan.

Short-Term Strategies and Action Steps:

1. Develop a multi-year process and outcome evaluation to measure the impact of the Children’s Mental Health Plan on improving the Illinois children’s mental health system.
Appendices
The following recommendations and strategies will be considered and addressed in the Children’s Mental Health Plan in future years.

GOAL I. DEVELOP AND STRENGTHEN PREVENTION, EARLY INTERVENTION AND TREATMENT POLICIES, PROGRAMS AND SERVICES FOR CHILDREN

A. PREVENTION

1. Explore how non-state funded early childhood programs can access and fund mental health consultation.

2. Explore best practices for providing at least two voluntary home visits by a registered nurse to Illinois families following the birth of a child to determine the physical, social and emotional health of the new family, and link them to appropriate follow-up services as needed to prevent the emergence of developmental, behavioral and psychosocial problems.

B. EARLY INTERVENTION

1. Develop interagency provider agreements between adult-centered programs and programs for children 0-18 years, as appropriate, to ensure the availability of early intervention services for the entire family.

   a. Train providers in adult systems to infuse parent education and support into the work with adults, when appropriate, and provide funding for pilot models.

2. Identify and promote the use of policies and support services within substance abuse treatment centers, domestic violence, homeless shelters and other appropriate programs so that children can remain with their primary caregiver, when appropriate.

3. Increase the availability and quality of respite services to families with a child who has a developmental delay or disability, to families involved in the child welfare system, and to families with a child or parent who has a mental illness.

4. Integrate messages about substance exposed infants and how women and their families can seek help into the public awareness campaign.

5. Provide training and education to foster families, child care providers, educators and other key groups about strategies in caring for substance exposed infants.
C. TREATMENT

1. Establish comprehensive quality management standards for all levels of mental health care as a means of addressing inconsistency and uneven mental health service development and delivery across Illinois, and to improve accountability by establishing outcome management expectations.
   a. Develop contract language that clearly defines expectations by setting standards for assessment, care management, and service delivery.
   b. Contractually require evidence-based approaches with demonstrated effectiveness.
   c. Link quality management efforts to related children’s mental health benchmarks.
   d. Provide periodic reports on the status of benchmarks across the state.
   e. Develop high quality standards and expected outcomes along with monitoring components for all residential, medical, and/or confinement (correctional and detention) facilities holding children and adolescents with mental health issues.
   f. Contractually require use of the least restrictive setting and least intrusive treatment for youth in any state system with mental health issues.
   g. Adopt and enforce professional standards/accreditation for residential, hospital, detention, and confinement facilities.
   h. Provide technical assistance, training, and support for professionals in developing, implementing, maintaining, monitoring, and reporting on quality management standards.

2. Improve and expand the eligibility criteria for Early Intervention and Special Education services for children with social and emotional delays and psychosocial diagnoses and increase the capacity of these systems to treat children with emotional and behavioral problems.

3. Ensure that new mothers who have a long standing mental illness, depression or substance abuse problem receive appropriate treatment and follow-up.

4. Decrease and eliminate the psychiatric hospitalization of children under age five by developing crisis management, respite support systems and treatment services (e.g. crisis nurseries) for these children and their families.

5. Increase children’s access to school-based and school-linked treatment services and supports by building linkages with community organizations and agencies, and through use of new technologies such as tele-psychiatry (i.e., via use of long-distance video technology).

6. Implement strategies for the adoption of DC:0-3 and DSM-PC in private insurance programs and non-Medicaid insured populations.

7. Fund a long-term (i.e., 5-10 years) evaluation regarding the utilization of short and long-term residential services in order to: determine the adequacy, effectiveness and efficiency of services, identify needed transitional support services following discharge; and determine if there are appropriate alternative community-based services to meet the needs of children requiring this level of care.
GOAL II. INCREASE PUBLIC EDUCATION AND AWARENESS
(See Plan contents.)

GOAL III. MAXIMIZE CURRENT INVESTMENTS AND INVEST SUFFICIENT FISCAL RESOURCES OVER TIME

1. Create a Children’s Mental Health Fund in the State Treasury from which funds can be appropriated to expand prevention, early intervention, and treatment programs and services available to children ages 0 - 18 years.

2. Strengthen the financing of children’s mental health services within the Division of Mental Health (DMH).
   a. Appropriate adequate and proportionate funding across the age span for children ages 0-18 years, in the DMH budget.
   b. Significantly increase funding and coordinate financing of children’s mental health services.

3. Make effective use of Medicaid and KidCare.
   a. Develop a targeted funding plan to maximize the use of Medicaid, including EPSDT, and the strategic use of state dollars as matching funds. The plan should include identification of previously untapped or under-utilized sources of state and local resources, including 708 Mental Health Boards, to be used to match federal Medicaid dollars.
   b. Capitalize on federal Medicaid reimbursement to federally qualified community health centers (FQHCs) by providing behavioral health services to children in these settings.
   c. Improve Medicaid reimbursement for prevention, early intervention and treatment services:
      i. Clarify for providers the diagnoses that create eligibility for children to obtain Medicaid services.
      ii. Change the Illinois KidCare and Medicaid eligibility procedures to allow for self-attestation of a family’s financial circumstances in lieu of current financial documentation requirements.
      iii. Change the state’s Medicaid plan to obtain federal reimbursement for administrative costs for coordination of systems.

4. Strengthen the private funding of children’s mental health services.
   a. Broaden the current Illinois parity law to require private insurance companies to cover all mental health diagnoses and services of children ages 0-18 years.
   b. Explore methods of increasing other private sector support.
GOAL IV. BUILD A QUALIFIED AND ADEQUATELY TRAINED WORKFORCE WITH A SUFFICIENT NUMBER OF PROFESSIONALS TO SERVE CHILDREN AND THEIR FAMILIES THROUGHOUT ILLINOIS

1. Expand and strengthen the professional preparation and workforce of children’s mental health professionals. Efforts should include:

   a. Expand the workforce of individuals trained to provide mental health consultation to programs, providers and treatment services for children ages 0 - 18 years and their families.

      i. Work with institutions of higher education to expand the number of programs that offer coursework and specialized tracks in children’s mental health.

      ii. Create a mentoring system to promote and support experienced professionals entering the Early Intervention or DCFS system who need a larger workforce offering mental health services.

   b. Identify funding mechanisms to support the variety of needed professional development and training with the early childhood and mental health fields.

   c. Expand university offerings through extension programs that reach rural communities.

   d. Increase the number of mental health providers available to serve children and adolescents in Chicago and downstate.


2. Improve relevant certification requirements in key professions to ensure a qualified and adequately trained workforce. This includes:

   a. Support and promote an endorsement system for various levels of early childhood mental health practitioners and encourage relevant programs to require the endorsement, once available. Any endorsement system should build on or incorporate the social emotional competencies development by Gateways to Opportunity, the early childhood career lattice.

3. Assure continuing education, training, and staff development.

   a. Provide information and training to staff in family and adult-focused programs regarding early childhood development, and programs, services, and resources available in the community to families with young children (e.g., Head Start and Early Head Start, Healthy Families, EI, WIC, Parents Too Soon, Early Childhood Education Block Grant).

   b. Build on and strengthen efforts to infuse early childhood mental health principles and relationship-based service strategies into pre-service and ongoing training of Special Education and Early Intervention providers.

   c. Build on and strengthen efforts to provide staff development on the planning and implementation of school-wide, classroom-based activities that focus on building assets and addressing problems in school-age children.

      i. Create training and staff development opportunities that help establish positive and supportive relationships among all school staff, students and families/caregivers.

   d. Develop a statewide database of qualified early childhood mental health practitioners and make it available to local communities.
GOAL V. CREATE A QUALITY-DRIVEN CHILDREN’S MENTAL HEALTH SYSTEM WITH SHARED ACCOUNTABILITY AMONG KEY STATE AGENCIES AND PROGRAMS

1. Establish the capacity to conduct ongoing statewide assessments to identify the mental health needs of children ages 0 - 18 years and their families.
   a. Create and implement an early childhood survey to periodically determine the social and emotional development, and mental health needs of young children.
   b. Coordinate existing youth surveys (e.g., IL Youth Risk Survey, Youth Risk Behavior) for middle and high school students and communicate the results in a timely fashion.
   c. Integrate an examination of protective factors, in addition to risks, for children’s mental health into existing youth surveys.
   d. Promote the use of common or comparable child indicators and benchmarks by early childhood programs, schools, community-based providers and others.
   e. Establish a statewide system for monitoring the status of children’s mental health.
   f. Define Kids Count indicators related to mental health.

2. Promote the use of common or comparable indicators and benchmarks by early childhood programs, schools, community-based providers, and others.

3. Require government-administered early childhood programs and schools to review program requirements and policies, and track outcomes related to the statewide benchmarks.

4. Improve accountability, data tracking and reporting for children’s mental health in relevant programs and services.
   a. Identify critical data sets that are necessary in order to document need, utilization of services, and outcomes.
   b. Develop a statewide data tracking and reporting system to collect summary information on key indicators of children’s social and emotional development, and mental health status, while protecting confidentiality and tracking no personal information.
   c. Develop policies and protocols for the sharing of databases among relevant state and local agencies.
   d. Explore the development of uniform reporting forms and test in select programs for the tracking, reporting and planning of services.
   e. Institute contract and monitoring changes to increase the accountability of current children’s mental health providers.

5. Continue to implement the plan for obtaining the core indicator and benchmark data, and regularly reporting findings to policymakers, the general public, and other key groups.

GOAL VI. INVEST IN RESEARCH

1. Provide funding for culturally competent and clinically relevant research, including longitudinal studies that: address evidence-based practices in prevention, early intervention, and treatment; are translated into practice standards and policy implications for key groups; and are used to improve programs and services.
### APPENDIX B: Illinois Children’s Mental Health Partnership Committee Members

#### Cultural Competence Committee

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
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<tbody>
<tr>
<td>Anna Abdelrahman</td>
<td>Illinois Federation of Families</td>
</tr>
<tr>
<td>Baheia Ahmad</td>
<td>Metropolitan Family Services</td>
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<tr>
<td>Graciela Andersen</td>
<td>Private Practice</td>
</tr>
<tr>
<td>Abdul Basit</td>
<td>Feinberg School of Medicine, Northwestern University</td>
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<tr>
<td>Rodney Bullock</td>
<td>Illinois Association of Multicultural Counseling</td>
</tr>
<tr>
<td>Juana Burchell</td>
<td>Illinois State Board of Education</td>
</tr>
<tr>
<td>Sandra Burke</td>
<td>Peoria Citizens Committee for Economic Opportunity Inc.</td>
</tr>
<tr>
<td>Elizabeth Colon</td>
<td>Heartland Alliance</td>
</tr>
<tr>
<td>Caryn Curry</td>
<td>Coalition for Education on Sexual Orientation &amp; Mental Health Association in Illinois</td>
</tr>
<tr>
<td>Claudia L. Fabian, Co-Chair</td>
<td>Latino Coalition for Prevention</td>
</tr>
<tr>
<td>Tatyana Fertelmeyster</td>
<td>Jewish Family and Community Service</td>
</tr>
<tr>
<td>Mary Jane Forney</td>
<td>Bureau of Childcare and Development, Illinois Department of Human Services</td>
</tr>
<tr>
<td>Patricia Gomez</td>
<td>La Voz Latina</td>
</tr>
<tr>
<td>Lorena Johnson</td>
<td>Ounce of Prevention Fund</td>
</tr>
<tr>
<td>Susan Kim</td>
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<td>Mill Street Elementary School</td>
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<tr>
<td>Luz Maria B. Solis</td>
<td>Chicago Public Schools Office of Early Childhood Education</td>
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#### Early Childhood Committee

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<tr>
<td>Sarah Baur</td>
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<td>Deborah Fears</td>
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<td>Jeanette McCollum</td>
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<td>Munisha Mehra-Bhatia</td>
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<td>Molly Dunn-Steinke</td>
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<td>Maribeth Swanson</td>
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<td>John Tschoe</td>
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<tr>
<td>Mark Valentine</td>
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<tr>
<td>Dennis Vickers</td>
<td>Infant Welfare Society of Chicago</td>
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</table>
Marlita White  Chicago Safe Start Initiative, Office of Violence Prevention, Chicago Department of Public Health  
Norma Wilson  Abraham Lincoln Centre  
Samantha Wulfsohn  Erikson Institute  
Martha Stouffer Zych  DuPage County Health Department  
Marcia Zumbahlen  Southern Illinois University, Carbondale

**Family Involvement Committee**

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<tr>
<td>Kim Adams</td>
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<td>Nena Bell</td>
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<td>Katharine Bensinger</td>
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<tr>
<td>Michelle Benson</td>
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<td>Beth Berndt</td>
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<tr>
<td>Todd Carmichael</td>
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<tr>
<td>Marie Cassidy</td>
<td>National Alliance for the Mentally Ill Illinois, Visions for Tomorrow Instructor</td>
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<td>Colleen Charaska</td>
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<td>Dale Schaefer</td>
<td>Lyons Township, Families and Schools Together</td>
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**Public Awareness Committee**

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<td>Karen Berg</td>
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Mary Forney  Illinois Department of Human Services, Bureau of Child Care and Development  
Carole Franke  Iroquois-Kankakee Regional Office of Education Teen REACH  
Judy Fried  Northern Illinois Council on Alcohol & Substance Abuse  
Gaylord Gieseke  Voices for Illinois Children  
Kathryn Goetz Wolf  Strengthening Families Illinois  
Angie Hampton  Egyptian Health Department  
Jan Holcomb  Mental Health Association in Illinois  
Roxanne Hooper  Pledge for Life Partnership  
Joe Hylak-Reinholtz  Illinois Department of Public Aid  
Andrea Ingram  Illinois Department of Children & Family Services  
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Daniel Martinez  Pilsen-Little Village Community Mental Health Center  
Diane Mermigas  Parent, “Mermigas on Media”  
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Lena Parsons  Fight Crime: Invest in Kids Illinois  
Gloria Pope  Depression & Bipolar Support Alliance  
Karen Robinson  Parent  
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Kris Sandra Wheatley  Illinois Counseling Association  
Harvey Saver  Evanston Mental Health Board  
William Schwartz  Mental Health Association in Illinois  
Susan Silk  Consultant  
Georgina Tegart  Collaborative for Academic, Social, and Emotional Learning  
Florence Townsend, Co-Chair  Association of Black Psychologists  
Dessie Trohalides  Division of Mental Health, Illinois Department of Human Services  
Mary Weyer  Elmhurst College  
Paula Wolff, Co-Chair  Chicago Metropolis 2020

**School Age Committee**

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Debbie Bretag  Illinois Center for Violence Prevention  
Terry Carmichael  Community Behavioral Healthcare Association  
Betsy Clarke  Juvenile Justice Initiative  
Ray Connor  Individual Care Grant Parents Association  
Carroll Craddock  Advocate Illinois Masonic Medical Center  
Kathleen Delaney  Rush Medical Center, Rush College of Nursing  
Ed Dunkelblau  Institute for Emotionally Intelligent Learning  
Judy Faigen  Community Care Options  
Michelle Geller  Mandel Legal Aid
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<td>Juan Valbuena</td>
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<td>Brooke Whitted</td>
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<tr>
<td>Carol Wozniewski</td>
<td>Mental Health Association in Illinois</td>
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School Policies and Standards Committee

Barbara Bacon Loyola University Graduate School of Social Work
Beth Berndt Illinois Federation of Families
Marie Cassidy National Alliance for the Mentally Ill Illinois, Visions for Tomorrow Instructor
Joan Crisler Dixon Elementary School
Ruth Cross, Co-Chair Naperville School District
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Rick Velasquez Youth Outreach Services
Heather Walter Children’s Memorial Hospital
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Anna Marie Yates Elk Grove High School
Lisa York Illinois School Psychologists Association
APPENDIX C: Description of Mental Health Key Concepts and Terms for Children and Adolescents

The following is a list of key concepts and terms that are used in the Preliminary Plan and are important aspects of mental health services and programs for children and adolescents. These terms reflect the continuum of services and concepts provided in a coordinated and comprehensive system of children’s mental health that includes prevention, early intervention, and treatment. The term “child” is used to refer to children and adolescents between the ages of 0 and 21. This is not a comprehensive list but represents many of the key concepts, services, and models of care used by children and adolescents.

**Assessment**
An assessment is a professional, comprehensive and individualized review of the psychosocial needs that are identified during an initial screen, and includes the type and extent of behaviors, problems, and social and emotional factors influencing a child’s mental health. An assessment also evaluates a child’s strengths and resources, and provides recommendations for treatment intervention. Assessments are typically more extensive than screenings as they require more individualized attention and expertise of a mental health professional.

**Case management**
Case managers help coordinate the appropriate services (e.g. health, mental health, social work, educational, vocational, transportation, advocacy, respite care and recreational) needed by children and families who need services from more than one provider or system. There are many different models of case management but case managers are often involved in assessing needs, developing service plans, contacting service providers on a child or family’s behalf, and working with the child and/or family to facilitate access to needed services.

**Confidentiality, privacy rights, and reporting laws**
All mental health programs and services must be provided in compliance with state and federal laws regarding confidential services, privacy rights, and reporting. These laws assure that no protected mental health and service information can be released to or be requested from other persons, organizations, agencies or other third parties without informed written consent, except in response to a court order or as otherwise required by law, and/or to protect a child and others from injury, abuse or neglect. Laws that apply most to directly to the services and programs mentioned in the ICMHP Preliminary Plan include the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Family Educational Rights and Privacy Act (FERPA), and the Illinois Mental Health and Developmental Disabilities Confidentiality Act.
Crisis intervention services
Crisis intervention services are used in emergency situations to provide immediate intervention or care when children are or are at high risk of becoming a danger to themselves or others, are experiencing acute psychotic episodes, or other emergency events (e.g., suicide). Such services are available 24 hours a day, and provide screening, psychiatric evaluation, emergency intervention and treatment, stabilization services, and referral to community services and resources. Crisis intervention services take many forms and can be initiated through multiple settings including: telephone hotlines, group homes, walk-in services, runaway shelters, mobile teams and therapeutic foster homes for children who need short-term placements.

Cultural competence is a set of congruent practice skills, attitudes, policies and structures which come together in a system, agency or among professionals and enable that system or those professionals to work effectively in cross cultural situations. Cultural competency is the acceptance and respect for difference, continuing self assessment regarding one’s own or another culture, attention to the dynamics of difference, ongoing development of cultural knowledge and resources and flexibility within service models to work towards better meeting the needs of diverse populations. These can be along the dimensions of race, ethnicity, gender, gender identity, sexual orientation, socio-economic status, age, physical abilities, religious beliefs, political beliefs, or other ideologies.

Culturally competent services and programs
Culturally competent services and programs are sensitive and responsive to cultural differences and reduce disparities in access and service outcomes based on race or cultural differences. Culturally competent providers are aware of the impact of culture and possess skills to help provide services that respond appropriately to a person’s unique cultural background, including race and ethnicity, national origin, religion, age, gender, gender identity, sexual orientation, or physical disability. Culturally competent services and programs are adapted to fit a family’s values and customs.

DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition):
The DSM-IV is the official manual of mental health problems developed by the American Psychiatric Association. Psychiatrists, psychologists, social workers, and other health and mental health care providers use this reference book to understand and diagnose mental health problems. Insurance companies and health care providers also use the terms and explanations in this book when categorizing or describing mental health problems.

Early intervention
Early intervention is a process aimed to recognize mental, emotional, behavioral, or learning problems and to respond to factors that put individuals at risk of developing mental health problems before they become established and more difficult to treat or reverse. Early intervention, through provision of services or referral to appropriate services, can help children get better in less time and can prevent problems from developing or becoming worse. Early intervention programs use validated screening tools to identify children with or at risk for mental health problems; include consultation by trained professionals with parents, teachers and other caregivers; and work with children in their natural environments to provide needed supports and guidance.

Effective school mental health programs
The core elements of effective school mental health programs are developed through partnerships between schools and community agencies to move toward a full continuum of effective mental health promotion, early intervention, and treatment for youth in regular and special education. The school-community partnership underlying the school-based (services provided by an outside agency on site at the school) and school-linked (services offered by outside agency near the school) approach strengthens cross-agency collaboration and the sharing of knowledge and resources, and promotes the development of a system of care.
Evidence-based programs incorporate significant and relevant practices based on scientifically based research that obtains reliable and valid knowledge by: employing systematic, empirical methods that draw on observation or experiment; involving rigorous data analyses that are adequate to test the stated hypotheses and justify the general conclusions drawn; relying on measurements or observational methods that provide reliable and valid data across evaluators and observers, across multiple measurements and observations and across studies by the same or different investigators.

Evidence-based practices are those practices which research has shown to produce consistently good outcomes and applicable across varied populations.

Family-driven means families have a primary decision making role in the care and education of their own children as well as the policies and procedures governing care for all children in their community, state, tribe, territory and nation. This includes:

- choosing supports, services, and providers;
- promoting the inclusion of current, innovative treatments and therapies;
- setting goals;
- designing and implementing programs;
- supporting the youth/consumer to guide care as appropriate;
- monitoring outcomes; and
- determining the effectiveness of all efforts to promote the mental health of children and youth.

Family self-help
Self-help groups are based on the premise that people who share a condition have similar concerns, or have a family member with a condition also share common experiences and, therefore can help each other by providing information, as well as practical and emotional support. Self-help groups are peer-led and range from small informal groups to well-organized national networks. Family-run organizations may include drop-in centers, case management, employment, housing, crisis, and family support programs.

Family support is a set of relationships and supports that are unique to each family, that build on a family’s strengths and resiliency and work to connect each family to needed resources.

Inpatient hospitalization
This term refers to intensive mental health treatment provided in a hospital setting 24 hours a day. Inpatient hospitalization provides: (1) short-term treatment in cases where a child is in acute psychiatric crisis or may be a danger to self or others, and (2) diagnosis and treatment when the patient cannot be evaluated or treated appropriately in an outpatient setting.

Isolated families are families who may feel or be isolated for geographic, socio-economic, cultural, social, stigma or family reasons.

Linguistic Competence is the capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities. The organization must have policy, structures, practices, procedures and dedicated resources to support this capacity.

A local coordinated mental health system integrates and ensures access to a full range of key child-serving systems including: mental health, education, early childhood, health, child welfare, substance abuse, violence prevention, juvenile justice, and diverse community based organizations (e.g., faith-based and civic institutions).

Medication and medication monitoring
As a result of a mental health assessment or psychiatric evaluation, psychiatrists or other physicians may recommend and prescribe medication for some children. In some cases, children with serious mental illnesses may also need medication dispensing and monitoring services in which medications are directly administered by a health professional and the individual is closely monitored to identify both beneficial and undesirable effects.
Mental health
Mental health is the state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity. Mental health is indispensable to personal well-being, family and interpersonal relationships, and contribution to community or society. It is easy to overlook the value of mental health until problems surface. Yet from early childhood until death, mental health is the springboard of thinking and communication skills, learning, emotional growth, resilience, and self-esteem.

Mental Health Promotion and Prevention
Mental health promotion and prevention efforts increase public awareness of children’s mental health issues and reduce stigma associated with mental illness. Quality promotion and prevention efforts ensure a coordinated system of education, programs, and interventions that are designed to promote social, emotional, and behavioral well-being as an integral part of a child’s healthy development. Prevention and promotion can be accomplished through strategies that include voluntary, periodic developmental screening, education about social and emotional development, reduction of risk factors, and strengthening of resilience and protective factors.

Outpatient services
Outpatient services are those services provided in a clinic, private office, school or other community location. Outpatient services are provided by a licensed mental health professional. Outpatient services can include: case management; counseling and psychotherapy; medication monitoring, and day treatment services.

Partial hospitalization
Partial hospitalization, also called day treatment or intensive out-patient care, is a specialized form of treatment that is less restrictive than inpatient care, but more intensive than other forms of outpatient care. It typically combines education, counseling and family interventions, and may be provided in a variety of settings, including hospitals, schools, or clinics. Partial hospitalization is sometimes used as transitional services for those leaving inpatient or residential care; in other cases, it is used to prevent institutional placement.

Protocols are guidelines that specify in writing what should happen, when and by whom. Protocols are designed to apply to common conditions and to provide flexibility for judgment in uncommon situations. Protocols provide guidance on: how standards or goals may be achieved and how problems can be addressed. Protocols may stand alone or be part of other policies and guidelines.

Residential treatment centers
Residential treatment centers provide services 24 hours a day for children with serious emotional disturbances who require constant supervision and care. Treatment may include individual, group, and family therapy; behavior therapy; special education; recreation therapy; and medical services. Residential treatment is usually more long-term than inpatient hospitalization. Residential treatment centers may also be known as therapeutic group homes.

Residential treatment facility means an institution, other than a hospital or nursing home, where a child lives which is operated for the primary purpose of providing a care to individuals with serious emotional disturbance and co-occurring disorders. This level of care offers room, board, psychiatric and other specialized treatments, and access to education. The primary purpose of residential treatment is improve overall functioning, including social and behavioral skills, so the individual can function adequately in the community, either at home or independently.
**Respite care**

Respite care is a service that provides a break for families/caregivers who have a child with a serious emotional disturbance. Trained parents or counselors take care of the child for a brief period of time to give families relief from the strain of caring for the child. This type of care can be provided in the home or in another location. These services may be offered to families on a periodic or routine basis.

**Screening**

Screening is a commonly used method to inform parents and professionals about the physical, cognitive and emotional strengths and needs of a child. Voluntary screening is conducted with parental consent and in accordance with existing Illinois and federal confidentiality, consent, reporting, and privacy laws and policies. Screening is designed to determine whether children have or may be at-risk of having behavioral or emotional conditions that warrant further review and/or intervention. Mental health screening identifies social and emotional development needs in children and adolescents as early as possible, and prevents potential mental health problems from developing or worsening.

Screening is conducted by an adequately trained professional (e.g., health care provider, social worker, psychologist, counselor) and uses objective, accurate, reliable and validated instruments and methods. All mental health screening is conducted in accordance with Illinois and federal confidentiality, reporting, and privacy laws and policies. Screening does not result in definitive statements about a child’s problem nor does it draw a conclusion about a mental disorder or diagnosis.

**Serious emotional disturbances**

Serious emotional disturbances are diagnosable disorders in children and adolescents that severely disrupt their daily functioning in the home, school, or community. These disorders may include depression, attention-deficit/hyperactivity, anxiety disorders, bi-polar disorders, conduct disorder, and eating disorders. Children with serious emotional disturbance may be but are not always eligible for special education and related services under the Individuals with Disabilities Education Act (IDEA); however, although mental health researchers estimate that up to 19 percent of the student population exhibit symptoms of serious emotional disturbance, only one percent of students are identified and referred for the necessary support services.

**Social and Emotional Learning (SEL)**

SEL is the process of acquiring the skills to recognize and manage emotions, develop caring and concern for others, make responsible decisions, establish positive relationships, and handle challenging situations effectively. Research has shown that SEL is fundamental to children’s social and emotional development—their health, ethical development, citizenship, academic learning, and motivation to achieve. Social and emotional education is a unifying concept for organizing and coordinating school-based programming that focuses on positive youth development, health promotion, prevention of problem behaviors, and student engagement in learning.

**System of Care**

A System of Care is a comprehensive method of addressing children’s mental health needs organized around defined principles of care, and based on the premise that the mental health needs of children, adolescents, and their families can be met within their home, school, and community environments. These systems are also child-centered, family-driven, strength-based, and culturally competent, and involve interagency coordination and collaboration.
Treatment
Treatment is a type of service, support or clinical intervention designed to address identified emotional, psychological, and social needs of a child and/or family. The term often refers to therapy and counseling that is repeated over a course of time, as determined by the child and/or family (depending on the age of the child) together with and service provider. Treatment involves a plan especially designed for each child and/or family, based on individual strengths and needs and establishes goals and details that build on strengths and address special needs. Treatment includes, but is not limited to, hospitalization, partial hospitalization, outpatient services, evaluation, various psychotherapies, and medication monitoring.

Wrap-around services
Wrap-around services refer to a package of unique, community services and natural supports that are flexible and tailored to meet the unique needs of children/adolescents with serious emotional disturbances. Wrap-around services are based on a definable planning process and are designed for a child and family to achieve a positive set of outcomes in the home setting. Services are provided by multi-disciplinary teams that may include: case managers, psychiatrists, nurses, social workers, vocational specialists, substance abuse specialists, community workers and family members or caregivers. Wrap-around services are also referred to as family or home-based, family preservation services, intensive family services or family-centered services.

Sources:
10. U.S. Substance Abuse and Mental Health Service Administration, National Mental Health Information Center. Glossary of Terms: Child and Adolescent Mental Health.
# APPENDIX D: Glossary of Key Terms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ABCD</td>
<td>Assuring Better Child Health and Development Initiative</td>
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<tr>
<td>CEU</td>
<td>Continuing Education Units</td>
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<tr>
<td>CMH</td>
<td>Children’s Mental Health</td>
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<tr>
<td>DASA</td>
<td>Division of Alcoholism and Substance Abuse</td>
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<tr>
<td>DC:0-3</td>
<td>Diagnostic Code for Children ages 0 to three.</td>
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<tr>
<td>DCFS</td>
<td>Department of Children and Family Services</td>
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<tr>
<td>DHS</td>
<td>Department of Human Services</td>
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<tr>
<td>DOC</td>
<td>Department of Corrections</td>
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<tr>
<td>DPA</td>
<td>Department of Public Aid</td>
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<tr>
<td>DMH</td>
<td>Division of Mental Health</td>
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<tr>
<td>DSM-IV</td>
<td>Diagnostic and Statistical Manual of Mental Disorders – 4th edition</td>
</tr>
<tr>
<td>DSM-PC</td>
<td>Diagnostic and Statistical Manual of Mental Disorders – Primary Care</td>
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<tr>
<td>EI</td>
<td>Early Intervention</td>
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<tr>
<td>EPSDT</td>
<td>Early and Periodic Screening Diagnostic and Treatment Program (of Medicaid)</td>
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<tr>
<td>FFP</td>
<td>Federal Financial Participation</td>
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<tr>
<td>FQHC</td>
<td>Federally qualified health center</td>
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<tr>
<td>GLBT</td>
<td>Gay, lesbian, bisexual, and transgender</td>
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<tr>
<td>IASB</td>
<td>Illinois Association of School Boards</td>
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<tr>
<td>ICD – 9 CM</td>
<td>International Classification of Diseases, 9th Revision, Clinical Modification</td>
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<tr>
<td>ICG</td>
<td>Individual Care Grant</td>
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<tr>
<td>ICMHP</td>
<td>Illinois Children’s Mental Health Partnership</td>
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<tr>
<td>IDEA</td>
<td>Individuals with Disabilities Education Act (Part C refers to services for children 0-3 and Part B refers to services for children 3-18)</td>
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<tr>
<td>IEP</td>
<td>Individualized Education Plan</td>
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<tr>
<td>IFSP</td>
<td>Individualized Family Service Plan</td>
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<tr>
<td>ISBE</td>
<td>Illinois State Board of Education</td>
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<tr>
<td>LAN</td>
<td>Local Area Network</td>
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<tr>
<td>RFP</td>
<td>Request for Proposal</td>
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<tr>
<td>SAMHSA</td>
<td>Substance Abuse and Mental Health Services Administration</td>
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<tr>
<td>SASS</td>
<td>Screening Assessment and Support Services</td>
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<tr>
<td>SED</td>
<td>Social and emotional development</td>
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<td>SEL</td>
<td>Social and emotional learning</td>
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<tr>
<td>Title V MCH</td>
<td>Title V Maternal and Child Health Services Block Grant</td>
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<tr>
<td>WIC</td>
<td>Supplemental Food and Nutrition Program for Women, Infants and Children</td>
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