Illinois Children's Mental Health Partnership

FY2019 ANNUAL REPORT TO THE GOVERNOR

ICMHP FY 2019 Annual Report

Dear Governor Pritzker, September 30, 2019

On behalf of the members and partners of the Illinois Children's Mental Health Partnership (ICMHP or the Partnership), I am pleased to present you with our fourteenth Annual Report. ICMHP has grown this year, with several new legislators appointed to serve on the Partnership. We have also recommended a new group of clinical experts for appointment by your office.

As has been true in the past, everyone is in favor of children's mental health, but it is not the primary responsibility of any state agency. Thus, there is not a comprehensive approach to children's mental health issues in Illinois. This ICMHP report brings together some of the essential pieces. In this report we summarize national, state, and local activities that have affected children's mental health in Illinois in the past year.

It is important to recognize that many children's mental health services in Illinois are improving (despite our decline in the national ranking this year). Your administration is funding more children's mental health services. The Department of Healthcare and Family Services is implementing a plan regarding Early and Periodic Screening, Diagnosis, and Treatment for children covered by Medicaid. This has the potential to significantly improve the public sector portion of Illinois' child mental health service delivery system. Private foundations are supporting important work in child development. Multiple organizations are working together to address child trauma. All this activity represents a significant gain for children's mental health. Nonetheless, important work remains to be done.

This report identifies multiple children's mental health needs and makes recommendations on three issues. First, monitoring is needed as the state determines which children will have access to mental health care through the public sector and what services they will be allowed. Next, even for children who are given access there is general consensus that the state does not currently have a sufficient clinical workforce to provide the necessary services. Finally, there is a current crisis regarding youth vaping that may assist in understanding risks in the cannabis legalization process.

ICMHP looks forward to working with your administration on all these issues. We particularly appreciate your leadership in advancing the new funding for mental health and children's issues. Please let us know how we can be of assistance in improving children's mental health in Illinois.

Gene Griffin

Gene Griffin, J.D., Ph.D.
Chair, ICMHP

NOTE: The Illinois Children's Mental Health Partnership represents multiple parties and interests. Positions expressed by the Partnership as a whole do not necessarily reflect the opinions of all its members. Partnership members, such as those representing state agencies or legislators, may choose to recuse themselves from taking a position on a policy issue.

Illinois Children's Mental Health Partnership Members

as of September 2019

Appointed Members

Jeff Aranowski
Illinois State Board of Education
Lisa Betz
Illinois Department of Human Services, Division of Mental Health
Christina Bruhn
Aurora University School of Social Work
Terry Carmichael
Community Behavioral Healthcare Association
Colleen Cicchetti
Ann & Robert H. Lurie Children's Hospital of Chicago
Betsy Clarke
Juvenile Justice Initiative
Wendy Cohen
Illinois Office of the Attorney General
Ray Connor
Mental Health America of Illinois
Representative William Q. Davis
State Representative
Reshma Desai
Illinois Criminal Justice Information Authority
Senator Donald DeWitte
State Senator
Andrea Durbin
Illinois Collaboration on Youth
Karen Freel
Illinois Association for Infant Mental Health
Carol Gall
Sarah's Inn
Gaylord Gieseke
Illinois Childhood Trauma Coalition
Debbie Humphrey
Association of Community Mental Health Authorities of Illinois
Jennifer Jaworski
Illinois Department of Juvenile Justice
Shannon Lightner
Illinois Department of Public Health
Kimberly Mann
Department of Child and Family Services
Senator Iris Y. Martinez
State Senator
Rosario Pesce
Loyola University School of Education
Jennie Pinkwater
Illinois Chapter, American Academy of Pediatrics
Joel Rubin
National Association of Social Workers, Illinois Chapter
Mary Satchwell
Illinois School Psychologists Association
Senator Dave Syverson
State Senator
Representative Karina Villa
State Representative
Senator Ram Villivalam
State Senator
Representative David Welter
State Representative
Marlita White
Chicago Department of Public Health
Representative Patrick Windhorst
State Representative
Paula Wolff
Illinois Justice Project

Executive Committee

Lisa Betz
Illinois Department of Human Services, Division of Mental Health
Jeff Aranowski
Illinois State Board of Education
Colleen Cicchetti
Ann & Robert H. Lurie Children's Hospital of Chicago
Ray Connor
Mental Health America of Illinois
Karen Freel
Illinois Association for Infant Mental Health
Carol Gall
Sarah's Inn
Gaylord Gieseke
Illinois Childhood Trauma Coalition
Jennifer Jaworski
Illinois Department of Juvenile Justice
Michael Kelly
Loyola University School of Social Work
Shannon Lightner
Illinois Department of Public Health
Kimberly Mann
Department of Child and Family Services
Nell McKitrick
Ann & Robert H. Lurie Children's Hospital of Chicago
Heather O'Donnell
Thresholds
Barbara Shaw
Independent Consultant
Cynthia Tate
Illinois Governor's Office of Early Childhood Development
Paula Wolff
Illinois Justice Project

Advocacy Committee Co-Chairs

Carol Gall
Sarah's Inn
Heather O'Donnell
Thresholds

School-Age Policies and Practices Committee Co-Chairs

Colleen Cicchetti
Ann & Robert H. Lurie Children's Hospital of Chicago
Michael Kelly
Loyola University School of Social Work

Early Childhood Committee Co-Chairs

Karen Freel
Illinois Association for Infant Mental Health
Gaylord Gieseke
Illinois Childhood Trauma Coalition

Partnership Chair

Gene Griffin

Staff

Amanda Walsh
Director
Katelyn Kanwischer
Program Director, Early Childhood Initiatives
Julianna McHale
Program Coordinator
Ieshia Johnson
Administrative Assistant

Management Team

Colleen Cicchetti
Gene Griffin
Nell McKitrick
Amanda Walsh

Governor's Office Liaison

TBD

Demonstration Project Consultants

Theresa Atchley
MIECHV
Colleen Berman
MIECHV
Tanya Blackshear
MIECHV
Dena Jade Bumgarner
MIECHV
Teresa Burrows
MIECHV, MHCI
Courtney Clark
MIECHV
Linda Delimata
IDPH, Director;, MHCI, Pilot Director
Margaret Jablonski
MIECHV
Bryan E. Jacob
MIECHV
Michelle Lee
MHCI
Lynn Liston
IDPH
Tamara Livingston
MIECHV
Colette Lueck
MHCI, Director
Rebecca Molitor
IDPH
Tajuana Rice
After School SEL, MIECHV, MHCI
Maria Elena Roman
MIECHV
Delreen Schmidt-Lenz
MIECHV, Project Lead; MHCI
Carly Schneider
MIECHV
Nancy Segall
MIECHV
Zully Vock
MIECHV

Table of Contents

I. Introduction

This Illinois Children's Mental Health Partnership's (ICMHP) 2019 Report to the Governor offers a snapshot of the current state of children's mental health in Illinois. Its intent is to focus on current resources and activities and to offer recommendations for the future.

While multiple publications address some aspects of children's mental health, none primarily focus on the mental health of Illinois children and families. Hence, there is a continued need for this consolidation. Where available, this report will compare Illinois' current status with the data we shared in our 2017 report. For this report, ICMHP surveyed its members and used national and state summaries of children's needs and services. Some state data do not exist and some could not be accessed. Given the information available, the picture is incomplete.

Children who experience mental health issues, with proper care, can lead healthy and productive lives. Therefore, it is critical that Illinois identify and support those children and families who have mental health needs. Though ICMHP's name refers to "mental health" it is more appropriate to discuss children's behavioral health, which would include mental health, substance use disorders, and trauma. Recent advances in science and medicine argue for adopting an even more integrated, comprehensive public health approach to wellness, looking at the impact of a child's behavioral health on his or her overall health. Additionally, such a holistic approach is strengths-based and family-centered. Further, child development now incorporates findings regarding brain development, genetics, and epigenetics. Therefore, a more holistic, developmental view of the child will be incorporated into ICMHP's "mental health" recommendations.

As with many terms, the definition of “child” can vary, depending on the source. For example, the U.S. Census counts "persons under 18 years"[1] while the Illinois Department of Healthcare and Family Services (HFS) lists "under 19 years" for medical coverage,[2] but "under 21 years" for federal Early and Periodic, Screening, Diagnosis, and Treatment (EPSDT) coverage.[3] Although some systems, such as child welfare, education, or juvenile justice, do not allow children to enter the system after age 18, some services may continue through age 21 if they were already in the system before age 18. Under federal law, a child may remain on a parent's health insurance until age 26. Thus, different sources, even when reporting on the same health issue, may be focusing on different groups of “children.” When referring to children’s mental health in this report, unless otherwise noted, we use the Partnership’s statutory definition of "children from birth through age 18."[4]

This report has three main sections: Children's Mental Health Needs, Illinois Children's Mental Health System, and ICMHP's Issues and Recommendations for Children’s Mental

Health. The Needs section will describe some of the national data summarizing children's issues in mental health, substance use, and trauma. The Children's Mental Health System section will focus on the state, local, and private changes over the last year. It will also highlight some current children's mental health programs. The final section will discuss pressing gaps and offer the Partnership's recommendations for moving the system forward.

II. Children's Mental Health Needs

For a baseline, this report relies upon U.S. Census data as of July 1, 2018,[5] which state that the overall population of Illinois is 12,741,080 (a decrease of 60,000 from its 2016 estimates). Of these residents, 12.6% live in poverty. Regarding race, 61.0% are White (not Hispanic or Latino); 17.4% Hispanic (or Latino); 14.6% Black (or African American); and 5.9% Asian. Regarding age, 22.4% (over 2,850,000) are *under* 18 years old and 6% (over 760,000) are under age 5.[6]

A. Mental Health

When ICMHP was created in 2003, the statute noted that **one in 10 children in Illinois currently suffered from a mental illness severe enough to cause some level of impairment**. That number was based on a national estimate, which remains the best estimate to date.[7] This report will continue to assume the 10% rate. Therefore, given the current census data, **over 285,000 Illinois children are in need of mental health services.**[8]

Mental Health America (MHA) publishes an annual report on the state of mental health in America and it includes some child-specific and state-specific data. ICMHP previously cited MHA's 2015 report.[9] Comparing that data with MHA's current 2020 report (see Table 1),[10] Illinois children are not doing very well. In MHA's national rankings, Illinois' state rank for youth mental health has dropped and more children are showing signs of major depression. Additionally, most of these children are not receiving treatment. Fewer children are being identified by schools even though more children are experiencing mental health issues. On a positive note, significantly more children have insurance coverage for mental health issues and there is a decline in substance use disorders. Nonetheless, there remains reason for overall concerns about children's depression and some related risk behaviors.

Table 1: MHA's Children's Mental Health Data for IL 2015 v 2020

MHA- Illinois	2020	2015
Overall State Rank For Youth Mental Health	27	19
Youth With At Least One Major Depressive Episode In The Past Year	14.00% 141,000	8.86% 94,000
Youth With Major Depressive Episodes In The Past Year Who Did *Not* Receive Treatment	56.1% 80,000	(Not Reported)
Youth with *Severe* Major Depressive Episode	10.1% 98,000	(Not Reported)
Youth With *Severe* Major Depressive Episodes Who Received Some Consistent Treatment	27.40% 26,000	(Not Reported)
Students Identified With Emotional Disturbance for an IEP	10.17% 18,373	10.87% 20,192
Youth With Private Insurance That Did Not Cover Mental Or Emotional Problems	5.8% 28,000	36.4% 82,513
Youth With Substance Use Disorder In The Past Year	4.67% 47,000	5.83% 62,000

Issue: Suicide

An increase in depression raises concerns about suicide. In our 2017 report, ICMHP noted that multiple sources, including MHA and the Illinois Department of Public Health (IDPH) were concerned about suicide rates for Illinois adolescents. At that time, both organizations were relying upon data from the Centers for Disease Control and Prevention (CDC)'s Youth Risk Behavior Survey (YRBS)[11] from 2015. Since our report, the CDC conducted another round of surveys in 2017.[12] Unfortunately, this new data show that adolescent rates of suicidal thoughts, plans, and attempts are trending upward. The suicide attempt rate and need for treatment rate for Illinois youth is significantly higher than the national rate (see Table 2). In Illinois, suicide remains the third leading cause of death for youth ages 1 – 17.[13]

Table 2: IL High School Youth Risk Behavior Survey for Suicide 2015 v 2017[14]

CDC High School Youth Risk Behavior Survey (YRBS)	Illinois 2015 % (# of respondents)	Illinois 2017 % (# of respondents)
Felt sad or hopeless (almost every day for 2 weeks or more in a row so that they stopped doing some usual activities, during the 12 months before the survey)	29.3% (26.1–32.7) 3,190	32.3 (30.3–34.3) 4,910
Seriously considered attempting suicide (during the 12 months before the survey)	15.9% (13.9–18.2) 3,222	17.2% (15.4–19.3) 4,911
Made a plan about how they would attempt suicide (during the 12 months before the survey)	14.5% (12.9–16.4) 3,215	14.8% (12.6–17.3) 4,891
*Attempted suicide (one or more times during the 12 months before the survey)	9.8% (8.1–11.7) 2,739	10.0%* (8.1–12.2) 4,248
*Suicide attempt resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse (during the 12 months before the survey)	4.3% (3.2–5.8) 2,721	4.0%* (3.0–5.3) 4,206
Death by Suicide for ages 1 - 17 (IDPH data)[15]	60	73

** Denotes results that are higher than the national average. In 2017, 10% of respondents in Illinois reported attempting suicide, compared to the national average of 7.4%. Additionally, 4% of Illinois respondents, and only 2.4% of respondents national wide, reported attempting suicide that resulting in injury, poisoning, or overdose requiring medical attention.*

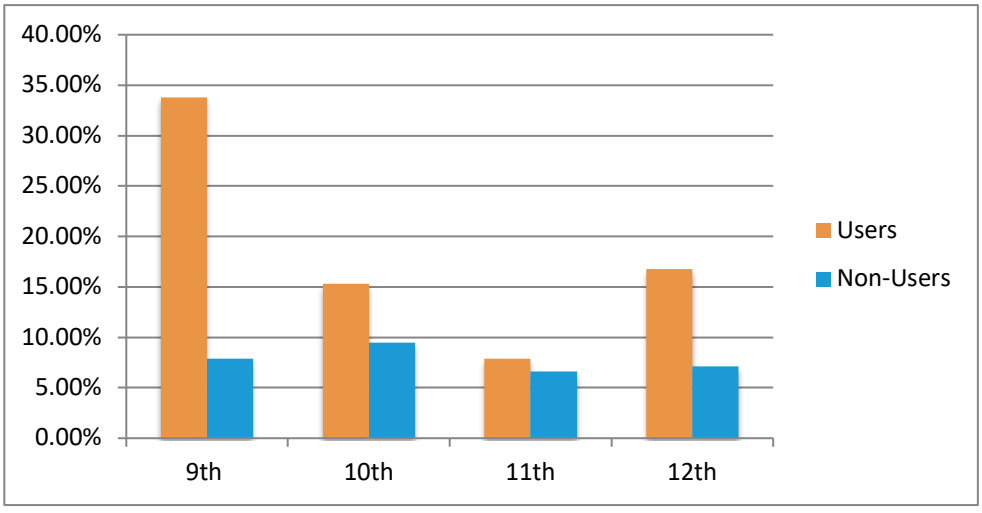
Suicide is still an issue that crosses all demographics. In 2017, high school females were more likely to have suicidal thought, plans, and attempts, though males and females had a similar rate of treatment. Racially, the results were mixed, with Asian and White suicide attempt rates (traditionally lower) both increasing while Black and Hispanic suicide attempt rates (traditionally higher) both decreasing. Black and Hispanic suicide attempt rates are still higher than Asian or White rates, but the gap has narrowed (See Table 3).

Table 3: IL High School Students Self-Reports of Suicidal Thoughts and Actions 2015 v 2017

Illinois YRBS		% Seriously Considered Attempting Suicide	% Made A Suicide Plan	% Attempted Suicide	% Attempted Suicide and Received Treatment
All	2017	17.2	14.8	10.0	4.0
	2015	15.9	14.5	9.8	4.3
Asian	2017	16.9	17.6	9.3	4.2
	2015	15.1	14.1	6.7	4.8
Black	2017	15.7	16.2	13.7	5.5
	2015	16.3	15.9	15.2	7.0
Hispanic	2017	17.3	14.7	10.3	4.2
	2015	16.7	15.5	12.6	5.3
White	2017	17.3	13.8	8.3	3.1
	2015	14.4	13.2	7.0	3.0
Multiple Races	2017	17.0	11.7	9.1	7.2
	2015	12.2	13.1	8.9	2.8

As IDPH notes in its report "An Epidemiological Profile of Prescription Drug and Opioid Use in Illinois,"[16] there is co-morbidity between mental health and substance abuse issues. Specifically, IDPH has looked at the relationship between depression, suicide, and youth who have misused prescription drugs (See Figure 1). In fact, the relationship is stronger for young adults (18 -25). But this is because prescription drug use increases with age. In fact, the YRBS data show that, in Illinois, the misuse of prescription painkillers by high school students is decreasing but the misuse of other prescriptions (Ritalin, Adderall, Xanax, etc.) is increasing.[17] Regardless of the drug, it is clear that working with youth on issues of depression and suicide need to include awareness of substance use disorders.

Figure 1: Percent (%) of Prescription Drug Users that Have Actually Attempted Suicide[18]



B. Substance Use

As shown in Table 1 above, the MHA 2020 report indicates a slight decrease in youth diagnosed "with substance abuse disorder in the past year" compared with its 2015 report.[19] Similarly, in looking at the Illinois YRBS data from 2015 and 2017, there appears to be slight improvements in overall adolescent drug use (see Table 4). The exceptions to the improvements include an increase in the use of inhalants by youth, with both inhalants and heroin being used at a significantly higher rate in Illinois than nationally.

Though not part of traditional mental health research, it is worth noting that more high school students report vaping than either smoking cigarettes or using marijuana. This is consistent with the national trend.[20] The concerns with this increase in addictive substances have resulted in the federal government beginning a campaign to prevent youth e-cigarette use.[21] Most recently, it appears that vaping may cause serious health issues,[22] such as respiratory illness, and may be caused by youth vaping marijuana products.[23] In response, IDPH has begun tracking cases of vaping-related respiratory illnesses.[24]

Table 4: IL Youth Risk Behavior Survey on Substance Use 2015 v 2017

Illinois YRBS	IL 2015 %	IL 2017 %
Ever Used Alcohol	60.9 (55.9–65.7)	57.4 (52.9–61.7)
Ever Tried Cigarette Smoking	33.8 (29.6–38.3)	27.3 (24.2–30.7)
Ever used an electronic vapor product[25]	47.0 (43.1–51.0)	41.4 (36.6–46.3)
Ever Used Marijuana	36.3 (31.4–41.6)	34.2 (30.0–38.5)
Ever Used Cocaine	5.4 (4.4–6.7)	6.4 (4.8–8.3)
*Ever Used Inhalants[26]	6.9 (5.9–8.1)	*8.4 (7.1–9.8)
*Ever Used Heroin	3.4 (2.4–4.7)	*3.4 (2.5–4.6)
Ever Used Methamphetamines	3.5 (2.6–4.6)	3.7 (2.7–5.0)
Ever Used Ecstasy	6.1 (5.0–7.5)	5.3 (4.1–6.9)
Ever Injected Any Illegal Drug	3.3 (2.3–4.6)	3.2 (2.2–4.8)
Ever Used Prescription Pain Medicine w/out Doctor's Order	Not Available	14.1 (12.0–16.6)

** Denotes results that are higher than the national average. In 2017, 8.4% of respondents in Illinois reported ever using inhalants, compared to the national average of 6.2%. Additionally, 3.4% of Illinois respondents, and only 1.7% of respondents national wide, reported ever using heroin.*

Issue: Opioids

Illinois, like many other states, is still experiencing an opioid use crisis. In January 2018,

IDPH's semi-annual report to the Governor concluded that "[t]he number of opioid overdoses – both fatal and nonfatal – continues to rise in Illinois. However, the increase in overdose fatalities, emergency department visits, and hospitalizations is occurring at a slower rate. As activities in the State Opioid Action Plan progress, the rate of increase should continue to slow and more lives will be saved."[27]

The limited positive news in the data is that, while Table 3 shows that over 14% of Illinois high school students are inappropriately using prescription pain medications (such as codeine, Vicodin, Oxycontin, Hydrocodone, and Percocet, one or more times during their life) and heroin, the fatality rate for youth is low (see Table 5), compared to adults in Illinois.

2,710 adults (18 or older) died of Any Drug Overdose in 2018 (compared to 12 youth). Nonetheless, while children may not be dying of drug overdoses, children and families would still be affected, not only by many of these deaths, by also by the thousands of (nonfatal) emergency department visits and hospital stays as well as the pain involved in living with adults with opioid dependence.

Table 5: IDPH, Number of Drug Overdose Deaths by Year for Youth (Under 18 Years Old)[28]

IDPH	2013	2014	2015	2016	2017	2018
Any Drug	**15**	**12**	**14**	**9**	**13**	**12**
(Any Opioid)	8	9	10	7	6	6
(Heroin)	4	3	3	3	1	0
(Opioid - Analgesics)	2	5	6	6	6	6

C. Child Trauma

Trauma is a major issue for Illinois youth, cutting across all Illinois child-serving agencies. Children who experience multiple adverse events (also referred to as adverse childhood experiences, or ACEs, such as child abuse or neglect, domestic violence, or living with a parent dependent on substances) are more likely to have mental health issues, abuse substances, do poorly in school, engage in high-risk behaviors, attempt suicide, and have medical health problems. Children who have experienced six ACEs are likely to die 20 years sooner than children who have not experienced any ACEs. In Illinois, more than 42% of children age 0 to 17 have had one or more adverse family experiences.[29] A study done in Cook County Juvenile Detention Center found that 84% of the youth reported multiple exposures to trauma, with a majority exposed to six or more events.

In connection to domestic violence, the Illinois Criminal Justice Information Authority (ICJIA) notes that in 2017, domestic violence agencies served over 42,000 adult victims, who had more than 68,000 minor children. Also, Illinois rape crisis centers served over 2,300 youth victims aged 12 to 17 years.[30]This is all in addition to those children who are exposed to

violence in their communities, including murder, gun violence, sexual violence, robbery, and aggravated or simple assault.[31]

Issue: Violence

Homicide by assault is the second leading cause of death for Illinois youth (ages 1-17) with 77 youth murdered in 2018.[32] This number is higher than the 57 suicides and 12 drug deaths for Illinois youth that same year.[33] With such high violence rates, it is not surprising that some youth carry weapons. As the 2017 Illinois YRBS data demonstrate (see Table 6), a small but significant percentage of youth carry weapons and an increasing number of youth have been threatened with a weapon.

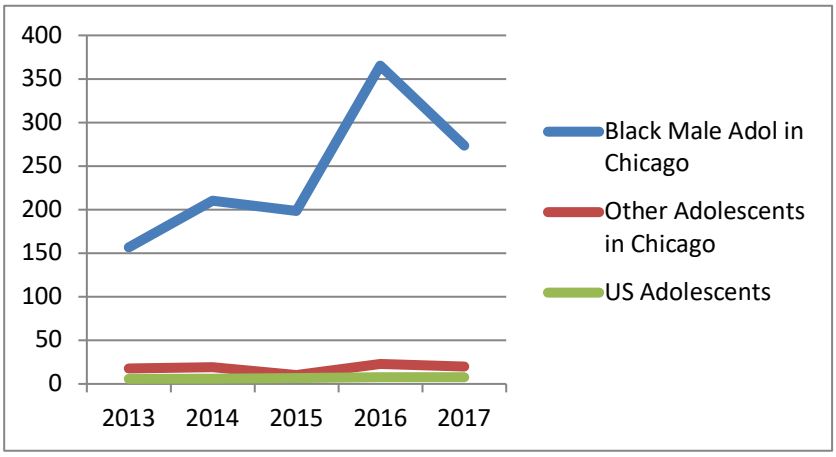
Table 6: Illinois YRBS Data on Weapons and Safety, 2017 v 2015

Illinois YRBS	IL 2015 %	IL 2017 %
Carried a Weapon in the Last 30 Days	15.4 (12.8–18.5)	14.0 (12.1–16.2)
*Carried a Gun in the Last Year	Not Available	*6.2 (5.2–7.3)
Carried a Weapon on School Property	4.3 (3.4–5.5)	3.7 (2.5–5.3)
*Was Threatened or Injured with a Weapon on School Property	6.6 (5.2–8.5)	*7.5 (6.6–8.6)
Did not go to school because they felt unsafe at school or on their way to or from school	6.0 (4.6–7.8)	9.0 (7.1–11.4)

** Denotes results that are higher than the national average. In 2017, 6.2% of respondents in Illinois reported carrying a gun in the last year,, compared to the national average of 4.8%. Additionally, 7.5% of Illinois respondents, and only 6% of respondents national wide, reported being threatened or injured with a weapon on school property.*

Nationally, the Giffords Law Center to Prevent Gun Violence[34] reports that three million U.S. children are directly exposed to gun violence each year. Young children are disproportionately victims of domestic violence–related shootings, while teens are at increased risk of gun suicide and community-based gun homicide. It also disproportionately impacts minority youth: gun violence is the first-leading cause of death among Black children and Black children are 10 times more likely to be killed in a gun homicide than White children. These findings are consistent with data from Chicago (see Figure 2).[35]

Figure 2: Adolescent Firearm Homicide Rates per 100,000 for Black Males in Chicago, all others in Chicago, and the U.S. (2013 - 2017)



Given that exposure to violence can cause trauma in youth and can then lead to a lifetime of suffering and high-risk behaviors, the three issues of mental illness, substance use, and trauma remain intertwined.

III. Illinois Children's Mental Health System

Illinois does not have an integrated, comprehensive system in place to address the mental health, substance use, and trauma issues of children. The discussion regarding the mental health needs of Illinois children is significantly different depending on whether one focuses on the clinical issues children are facing or on the system that is in place to address these needs. The national research data reviewed in the previous sections concentrate on the needs of the child, including diagnostic issues and risk behaviors. The system, particularly at the Illinois state level, has a slightly different focus, concentrating on the service providers working with the children and families.

This section will review recent executive, legislative, judicial, and private activities that have affected the state's children's mental health service system.[36] The discussion will include information about each child-serving state agency represented on ICMHP, including significant changes to children's mental health services within each agency. The most significant change that will be discussed involves the Department of Healthcare and Family Services (HFS) implementation plan for children's mental health.

A. Executive Level Activities

i. Federal Executive

Three actions at the federal executive level in the past year are having a negative impact on children's mental health in Illinois.

a. Immigration - Family Separation

In 2018, the federal government announced a "zero-tolerance" policy under which the U.S. Department of Homeland Security (USDHS) referred all migrants who enter the U.S. without authorization to the Department of Justice (DOJ) for criminal prosecution. Since children cannot be held in criminal detention, the children are designated as "unaccompanied alien children" and placed in the custody of the U.S. Department of Health and Human Services' (USHHS) Office of Refugee Resettlement (ORR). ORR places the children in shelters until they are released to a family member, guardian, or foster family. As a result of the zero-tolerance policy, the government separated more than 2000 children from their parents at the border. The government later halted the separation of families. However, there was no procedure in place to reunite the thousands of families already separated. Currently, there are multiple federal lawsuits challenging the practice of forcibly separating asylum-seeking parents and their children. On June 26, 2018, a federal judge issued a nationwide injunction temporarily stopping the separation of children from their parents at the border and ordered that all families already separated be reunited within thirty days.[37]

Many of the separated children were sent to ORR shelters in Illinois.[38] As a result of their separation from their families, there are major concerns about trauma for these sheltered children.[39] In September 2019, the USHHS Office of Inspector General (OIG) issued a report on the mental health needs of immigrant children in HHS custody.[40] In the report, the OIG visited and surveyed forty-five Care Provider Facilities housing immigrant children; four of the included facilities are located in Illinois. The major findings of the report include:[41]

- Intense trauma common among children who entered care facilities;
- Care provider facilities reported that separation from parents and a hectic reunification process added to the trauma that children had already experienced and put tremendous pressure on facility staff;
- Care provider facilities described challenges providing age appropriate mental health services, especially when faced with an unexpected increase in children age twelve and younger;
- Care provider facilities reported that longer lengths of stay resulted in deteriorating mental health for some children and increased demands on staff;
- Care provider facilities reported high caseloads due to challenges recruiting and retaining mental health clinicians;
- Care provider facilities faced challenges accessing external specialists; and
- Care provider facilities reported challenges transferring and caring for children who needed specialized treatment.

b. Immigration - Public Charge

In addition to the family separation policy impacting migrants entering the U.S., the federal government has also finalized policies harmful to immigrant families who are already living in the country. On August 14, 2019, the USDHS published the Inadmissibility on Public Charge Grounds final rule,[42] which will make it more difficult for immigrants to obtain a green card if they use a wide range of public benefits, including the Supplemental Nutrition Assistance Program (SNAP, also known as food stamps), public housing subsidies, and Medicaid.

Although the final rule does not go into effect until October 15, 2019, it has already had a "chilling" effect on immigrant families, leading to many immigrants to avoid or drop out of public aid programs out of fear of eventual deportation. Since the first public announcement of changes to the rule in 2018, studies have already shown a significant decrease in use of public benefits: one study found the use of SNAP benefits for immigrant families who have been in the U.S. for 5 years or more has decreased significantly, increasing the rates of food insecurity for immigrant and U.S.-born children;[43] another study found that this chilling effect was higher for households with children than those without.[44]

Increased food and economic insecurity and overall instability harms children's development and mental health. Pediatricians in Illinois have reported that parents are worried seeking medical services for their children could lead to deportation and children are unable to sleep, eat, or pay attention in school because they are afraid their parents will be taken away.[45] It is anticipated that the chilling effect could impact as many as 379,000 children in Illinois.[46] This could lead to an increase in prevalence for mental health needs within this population. In an effort to block this policy from going in to effect, Illinois joined twelve others states to challenge the federal rule in court. Even if successful, however, the negative impact of the chilling effect on children and families should be anticipated by public aid and service systems for several years to come.

c. Gun Violence and Mental Illness

Some federal officials have blamed mental illness for the increase in mass shooting in the U.S. and federal agencies have been limited in their ability to respond.[47] As noted by the American Psychological Association, "Routinely blaming mass shootings on mental illness is unfounded and stigmatizing."[48] The emphasis should be on how gun violence increases the likelihood of trauma and mental health issues, not the other way around.[49]

ii. State Executive

The Governor's Office and ICMHP member agencies have engage in activities that have improved children's mental health care this year.

a. Governor's Office

Working with the legislature, the Governor signed the Illinois FY2020 budget, which

included several increases for mental health services, programs, and supports for children and families, including:

- $150,000 appropriation to continue funding the Youth Budget Commission and fiscal scan created by Public Act 100-0818;
- $2 million (12%) increase for Comprehensive Community Based Youth Services (CCBYS);
- $50 million increase to the Early Childhood Block Grant, representing a 10.1% increase;
- $12 million increase to Early Intervention funds, representing a 12.4% increase;
- An additional $40 million for mental health and substance use services delivered through Medicaid;
- $28.8 million increase in funds for the Child Care Assistance Program, representing a 7.2% increase that should allow more families to access the program;
- An added $100 million for the Department of Children and Family Services; and
- An additional $100 million for early childhood construction grants, for construction or renovation of early childhood facilities, with priority given to projects located in those communities in this State with the underserved population of young children.

b. Illinois Department of Healthcare and Family Services (HFS)

The HFS is responsible for providing healthcare coverage for adults and children who qualify for Medicaid through managed care organizations (MCOs). This included 1,432,135 children covered in FY18,[50] which would represent about half the children in Illinois, based on the U.S. Census of over 2,850,000 children.[51]

For FY19, HFS reports that over 210,000 children utilized some behavioral health service (see table 7). Currently, behavioral health services covered by HFS include psychiatric hospitalization, residential treatment, crisis response, and community-based behavioral services (such as assessment, therapy/counseling, medication monitoring, and case management).[52] HFS also administers the Family Support Program (FSP) and Specialized Family Support Program (SFSP),[53] formerly known as the Individual Care Grant (ICG) program and formerly administered by the Illinois Department of Human Services' Division of Mental Health (DMH).[54] Under HFS, the number of children served in FSP[55] has

increased modestly to 200 in 2019. Additionally, approximately 80% of those youth were placed in residential treatment programs. SFSP,[56] which provides immediate services for youth and families in crisis, served 42 youth during 2019.

Table 7: HFS FY19 Total Costs and Count of Children Utilizing Behavioral Health Services[57]

Service Type	Unique Client Count By Service	Total $ Paid
Psych Hospital	15,541	$123,251,706
CMHC	62,956	$72,373,784
Pharmacy	86,308	$53,311,483
Hospitals[58]	24,064	$24,185,579
LEA[59]	67,510	$23,936,486
Other	21,888	$19,921,238
Physicians	74,386	$14,539,678
Clinics	41,444	$10,793,304
Transportation	7,736	$2,820,755
EI	2,860	$2,716,854
State Op	2	$122,291
Nursing Facilities	5	$50,100
Waiver	3	$1,386
Total $	N/A	$348,024,642.97
Total Unique Client Count	210,650	N/A

I. N.B. v Eagleson

The most significant activity regarding children's mental health care in Illinois from this past year is the release of the HFS draft implementation plan for *N.B. v Eagleson*. Its implementation will drive the children's public mental health system for years to come. Significant improvements include the use of a standardized assessment tool for all children and the use of system of care principles that emphasize community-based care with family involvement.

Originally filed in 2011, *N.B.* is a federal class action originally filed in 2011 alleging that Illinois failed to provide Early and Periodic Screening, Diagnostic, and Treatment ("EPSDT") services for children with mental and behavioral health diagnoses as required under the federal Medicaid Act. In January 2018, the federal court approved a consent decree, which required Illinois to develop a continuum of behavioral health services, including home and community-based services.

After drafting an initial implementation plan in 2018, HFS released a revised draft implementation plan in July 2019 after a change in the state executive administration. This draft plan proposes using a standardized assessment tool on all children receiving

behavioral health services (the Illinois Medicaid Comprehensive Assessment of Needs and Strengths, or IM+CANS) and using MCOs to oversee the Integrated Health Homes (IHH) care-coordination system, developed by HFS to create the full continuum of behavioral health services using system of care principles.[60] Once the implementation plan is approved, HFS has seven years to reach substantial compliance. This consent decree will be discussed in more detail in the ICMHP Issues and Recommendation for Children's Mental Health section, below.

c. Illinois Department of Children and Family Services (DCFS)

The mission of DCFS is to promote prevention, child safety, permanency and well-being.[61] In FY19, the number of (unduplicated) children in substitute care and institutional care settings through DCFS was:

Table 8: DCFS FY2019 Expenditures by Youth Served

Service Type	Distinct Youth Served	Expenditures[62]
Paid Substitute Care	22,092	$434,903,239
Institutions & Group Homes	1,449	$121,279,210
Early Childhood Services	4,253	$2,700,000

Regarding mental health needs of the children in DCFS care, the 2017 Illinois Study of Child Wellbeing[63] indicates that about 42% of children and youth in care, aged 6-18, demonstrate clinical or borderline clinical mental health disorder on the Child Behavior Checklist. Among younger children aged 3-5, about 18% showed emotional or behavioral problems in the clinical or borderline clinical range. Based on caregivers' assessment, the most prevalent emotional and behavioral health problems among children and youth in DCFS care were: 1) extreme stress from abuse and neglect (31%), 2) attention deficit disorder (29%), oppositional or defiant behavior (29%), conduct or behavior problems (29%), and attachment problems (21%).

Regarding mental health services, the Illinois Study of Child Wellbeing found that the majority (60%) of children and youth aged 2-17 years old (n=320) received some mental health service, and that 86% of the children with an identified mental health need received mental health services (n=126). The dominant services received among children and youth with mental health needs were: 1) counseling 70%, 2) in-school therapeutic services (40%), and 3) outpatient psychiatry (38%).[64]

DCFS is also in the process of preparing to implement federally-legislated provisions of the Family First Prevention Services Act (FFPSA). One of the major goals of this legislation is to prevent children and youth from coming into DCFS care. DCFS is coordinating planning with other Illinois agencies to offer prevention services to families including mental health services, substance use treatment, and in-home parenting skill training.[65] The goal is to reduce gaps and inequities in delivery of prevention services.[66] Illinois' target population includes children and youth with mental health needs and disorders, as well as family

members with mental health needs and disorders. Illinois will also offer prevention services to pregnant and parenting youth.[67]

Other ongoing DCFS programs that assist youth with mental health, substance use, and trauma issues include the department's Alcohol and other Drug Abuse (AODA) Title IV-E waiver project;[68] the Intensive Placement Stabilization Services (IPS) program_and Specialized Family Support Program;[69] the Illinois Birth Thru Three (IB3) and Early Childhood Projects;[70] and the Demonstration Programs for Dually Involved Youth in Juvenile Justice and Child Welfare Systems.[71]

Finally, DCFS is working with HFS to switch to a Medicaid managed care model of treatment and once completed, DCFS youth will be enrolled in the IlliniCare Health Plan. Details are still pending on this process.[72]

d. Illinois Department of Juvenile Justice (DJJ)

The mission of DJJ is to build youth skills and strengthen families in order to promote community safety and positive youth outcomes. DJJ envisions an agency that is restorative, focuses on learning and treatment, and takes into account the developmental needs of the young people committed to its care.[73]

At the end of 2018, the DJJ census county was 266 youth, a significant decline from an average daily census count of 725 youth in 2015.[74] In addition, improvements in services and aftercare supervision resulted in a decrease in youth returning to custody for aftercare violations (from 51% in 2015 to 17.9% in October 2018), as well as a decrease in the three-year recidivism rate (from 59% in FY2015 to 52.1% in FY2018). To further reduce recidivism rates, a new statute signed into law in August 2019 requires DJJ to develop policies and procedures to promote family engagement. DJJ has already started this process by engaging youth and their families in family therapy and using WebEx to allow youth to better interact with their families.

Table 9: DJJ by Age (2018)

AGE	Facilities	Aftercare
Average Age	17.2 years	18.3 years
16 & Under	35.9% (N=136)	19.2% (N=94)
17 to 20	64.1% (N=243)	76.9% (N=377)
20.5 & Over	0	3.9% (N=19)

Table 10: DJJ by Sex (2018)

SEX	Facilities	Aftercare
Male	92.3% (N=350)	95.0% (N=471)
Female	7.7% (N=29)	5.0% (N=25)

Table 11: DJJ by Race (2018)

RACE /ETHNICITY	Facilities	Aftercare
White	20.6% (N=78)	20.8% (N=103)
Black	65.2% (N=247)	63.7% (N=316)
Hispanic	8.7% (N=33)	13.7% (N=68)
American Indian	0.3% (N=1)	0
Asian	0.3% (N=1)	0.2% (N=1)
Multiracial	5.1% (N=19)	1.6% (N=8)

While the decline in the number of youth in DJJ care has decreased dramatically, the rates of youth in DJJ's care with a mental health diagnosis remain high. Nationally, it is estimated that as high as 70% of youth in the juvenile justice system have a mental health diagnosis.[75] The figures in Illinois are much higher: in 2018, 94.55% of youth in DJJ's care had one or more mental health diagnoses. Although the number of youth with a mental health diagnosis has declined slightly since 2015, the percent of youth on psychotropic drugs during that same time period has significantly increased (see figure 3 and table 12).

Figure 3: DJJ Average Distribution of DSM-5 Diagnoses

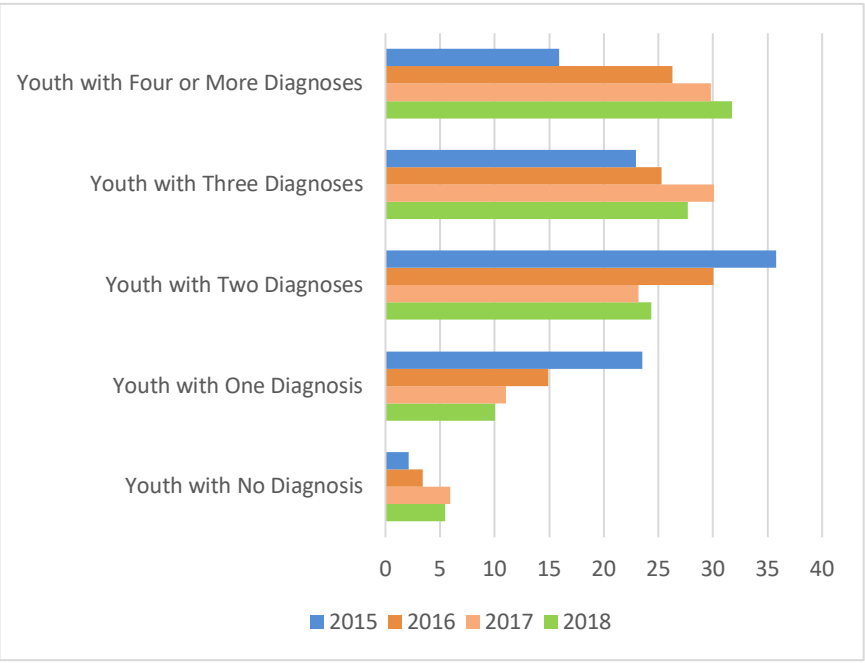


Table 12: Youth on Psychotropic Drugs

Average	Youth on Psychotropic Drugs
2015[76]	28.89%
2016[77]	36.46%
2017[78]	44.20%
2018[79]	45.90%

In order to serve these youth, DJJ provides a range of mental health services, including individual, family, and group counseling. Groups include a focus on anger management, trauma, and skill building. Additionally, DJJ has specialized treatment units for youth with serious mental health issues and for juvenile sex offenders. The Department is also starting to implement trauma-informed screening and assessments in order to better serve the needs of youth in DJJ's care who have experienced trauma. A particular success from the past

year is that DJJ has been successful in getting youth who need more intensive psychiatric care into psychiatric hospitals.[80]

e. Illinois Department of Human Services, (DHS)

The vision of DHS is for healthy, independent people of Illinois to live in safe, strong communities.[81] DHS has multiple divisions including mental health, substance use prevention and recovery, developmental disabilities, rehabilitation services, and family and community services.

In its 2018 Community Mental Health Services Block Grant Implementation Report, the Division of Mental Health (DMH) reports that its goal for children and adolescents is to "integrate a state of the art behavioral health system in Illinois that ensures service delivery based on systems of care values and principles, family driven, and emphasizes services that are evidence-based."[82] For child and adolescent mental health programs, DMH currently funds the following:

- The Screening, Assessment and Support Services (SASS) crisis intervention program for unfunded, Medicaid fee-for-service, and children in DCFS care;
- A first-episode psychosis program called First.IL for individuals ages 14 to 40 who have had a psychotic illness for no more than 18 months. The program promotes early identification and aims to provide best treatment practices as soon as possible;
- Forensic mental health services for adults and children referred by the court system who are found "not guilty by reason of insanity" or are found "unfit to stand trial;" these services include one secure juvenile inpatient facility.

Table 13 provides a breakdown of the DMH services, consumer count, and sum of dollars for fiscal year 2019:

Table 13: FY19 Child and Adolescent Consumers by Service Type[83]

Service Category	Unduplicated Consumer Count	Sum of Dollars
Assessment and Treatment Planning	7,161	$ 1,654,223.30
Assessment, treatment planning, intensive outpatient, and oral	10	$ 51,721.48
Case Management - Client Centered Consultation	2,241	$ 206,939.04
Case management	3,132	$ 403,587.30
Case management - LOCUS	3	$ 127.05
Community support	2	$ 95.84
Community support, group	434	$ 108,962.03
Community support, individual	2,898	$ 1 ,702,762.52
Community support, team	1	$ 244.56
Crisis intervention	806	$ 182,054.90
Medication Administration	19	$ 527.00
Psychological Evaluation & Mental Health Assessment	570	$ 64,898.70
Psychotropic medication administration	1	$ 21.08
Psychotropic medication monitoring	1,481	$ 130,843.99
Psychotropic medication training	250	$ 12,887.00
Targeted Case Management Services	124	$ 10,255.28
Therapy/counseling	6,895	$ 4 ,365,547.98
Treatment plan development, review, modification	612	$ 38,921.02
(Total Unduplicated Consumer Count)[84]	(10,843)	N/A
Total Dollars	N/A	**$ 8,934,620.07**

Notably, in 2018, DHS revised its rules on mental health services to allow for the use of the DC: 0-5 Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood when making a diagnosis for children age 6 or younger, further benefiting this younger population.[85]

In addition to DMH, there are several programs within DHS' Division of Family and Community Services that also directly intersect with children's mental health, such as the Bureau of Early Intervention and the Bureau of Youth Intervention Services. Through the Bureau of Early Intervention, DHS serves as the lead agency in the state to provide leadership in establishing and implementing the coordinated, comprehensive, interagency, and interdisciplinary system of Early Intervention (EI) services as required under Part C of the federal Individuals with Disabilities Education Act.[86] EI services are available to children ages 0-3 who experience a 30% developmental delay, experience a medically diagnosed physical or mental condition that typically results in developmental delay, or is at risk of

substantial developmental delay.[87] EI services include, but are not limited to, family training, counseling, and home visits, occupational therapy, psychological services, developmental therapy, social work services, and transportation.[88] DHS most recently reported that 17,030 Illinois children received EI services in FY19.[89]

The Bureau of Youth Intervention Services administers several programs, including Comprehensive Community-Based Youth Services (CCBYS). CCBYS is a statewide 24/7 crisis intervention system for youth ages 11-17 who are at risk of involvement with the child welfare or juvenile justice systems.[90] The system is mandated to serve youth in crisis (homeless, runaway, locked-out, or youth beyond the control of a parent/caregiver and constitute an immediate or substantial danger to the youth's physical safety) or who are at-risk of crisis. CCBYS services include crisis intervention, emergency shelter, case management, and mental health, substance use, and trauma assessments. The most recent data available on the DHS website for the CCBYS program states that in 2015:

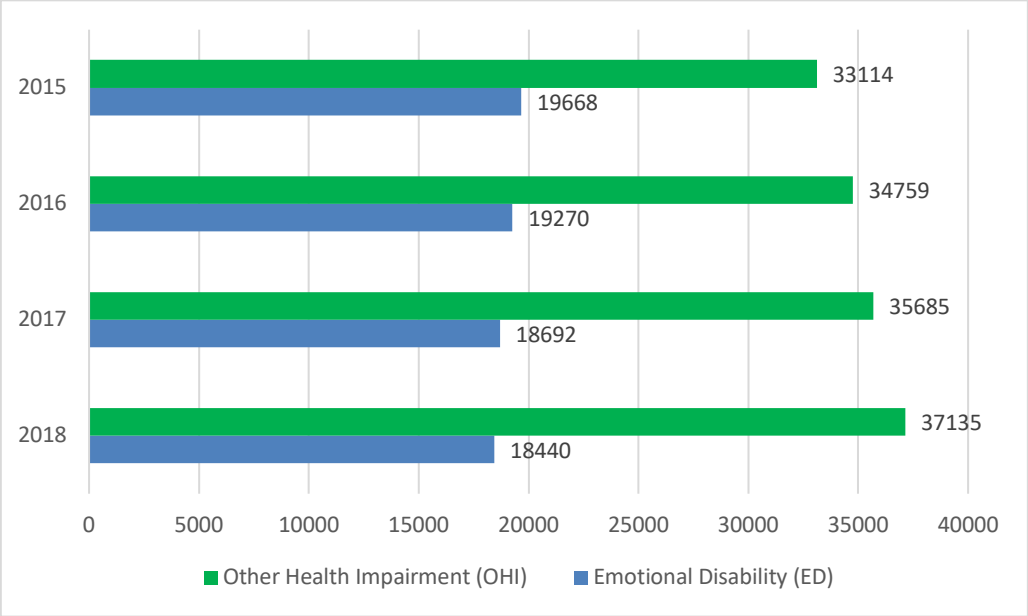
- 7,020 youth were served in the CCBYS program,
- the primary referral sources came from law enforcement (47%) and schools or afterschool programs (24%), and
- 93.09% of youth with identified mental health needs, 79.99% with identified substance use needs, and 95% with identified trauma needs received services related to those needs.[91]

f. Illinois State Board of Education (ISBE)

The mission of the Illinois State Board of Education is to provide leadership and resources to achieve excellence across all Illinois districts by engaging legislators, school administrators, teachers, students, parents, families, and other stakeholders in formulating and advocating for policies that enhance education, empower districts, and ensure equitable outcomes for all students.[92] Two of ISBE's functions around children's mental health include 1) developing and providing technical assistance on the social emotional learning standards, including resources on Positive Behavior Interventions and Supports (PBIS); and 2) ensuring public school districts are in compliance with state and federal special education laws, including providing technical assistance to districts.

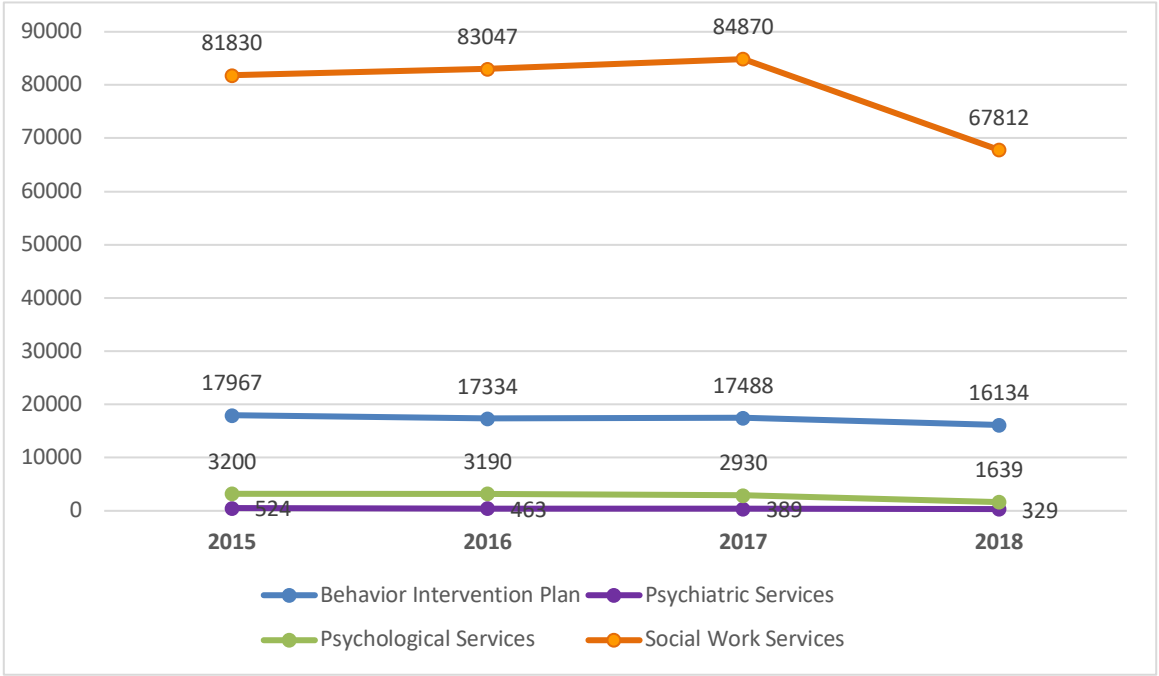
Under special education law, children with mental health needs who attend public schools would qualify for special education services under the "emotional disability (ED)" category. Consistent with national trends noted in the MHA 2020 report, Illinois' rate of students qualifying for special education under emotional disability has gone down over the past several years, despite concerns over the increasing prevalence of mental health needs among youth. Anecdotally, special education advocates in Illinois note that school districts will often choose to classify a student with mental health needs under the broader "other health impairment (OHI)" category, citing reasons such as wanting to avoid the stigmatizing classification of ED. This experience correlates with the decrease of ED classifications and increase of OHI classifications shown in ISBE's 2018 Annual Report (see Figures 4 and 5):[93]

Figure 4: ISBE Unduplicated Count of Public School Students Receiving Special Education Services 2015 - 2018, ED vs OHI categories



ISBE's Annual Report also provides data on the number of students receiving mental health-related services and supports (such as behavior intervention plans, psychiatric services, psychological services, or social work services) in their special education plans (similar data is not available for students receiving mental health supports in school outside of special education plans). Since 2015, there has also been a decline in the numbers of students receiving mental health-related supports and services (figure 5):

Figure 5: Special Education Mental Health Utilization Rates, 2015-2018



There are many possible reasons for the drop in services and classifications, including mis-classification of OHI vs ED or failure to identify all students eligible for special education services due to mental health needs.[94]

g. Illinois Department of Public Health (IDPH)

The mission of the IDPH is to protect the health and wellness of the people of Illinois through the prevention, health promotion, regulation, and the control of disease and injury.[95] It views mental health as a critical part of health care.[96] This commitment is reflected in its lists of projects, which include every one of the issues raised by that national research on children's mental health.

IDPH has a Suicide Prevention Strategic Plan with goals and objectives through 2021. These include educating the professional workforce regarding youth suicide being the third leading cause of death and focusing on college campuses and higher risk groups of juvenile justice and gay, lesbian, bisexual, and transgender youth.[97] Related to substance use disorders, the department has an Opioid Data Report and is tracking overdose deaths. It is also tracking the vaping-related illnesses.[98] Finally, IDPH also acknowledges the impact of adverse childhood experiences and how exposure to community violence can lead to trauma and a higher risk for substance use and suicide, bringing the three issues back together.[99]

IDPH is also involved in implementing Illinois' new law requiring social emotional and developmental screenings. In 2017, Illinois enacted Public Act 99-0927, which requires that social emotional screenings and developmental screenings be conducted as part of the Child Health Examination required for school-age children. IDPH was tasked with implementing this new law. After convening a stakeholder group in 2018, IDPH released draft rules for comments from the stakeholder group in January 2019. The State Board of Health is now reviewing revised draft rules. Questions that remain include how these screening requirements will work with HFS new EPSDT screening requirements. Also, this does not ensure that the medical providers who may be completing these forms are familiar with these types of screenings or know where to connect a child and family if a screening indicates further follow-up is needed. In addition, although state law requires that the Child Health Examination form used by schools must include information on whether or not a social emotional and developmental screening has been completed, it does not require that the school be informed about actual results, nor does the school have to follow-up to assist the child or family. Thus, the social emotional and developmental screenings are limited in how much help they may offer regarding children's mental health issues.

Finally, in FY18, the IDPH awarded ICMHP a 3-year grant[100] to pilot the use of mental health consultation in public health settings. The project seeks to determine whether this can build the capacity of public health staff and programs to prevent, identify, and reduce the impact of mental health concerns on infants, young children, and their families.[101] The four sites for the implementation phase are Stephenson County, the East Side Health Department in East St. Louis, the Southern Seven Health Department, and Winnebago County Health Department. The mental health consultation will focus on staff in two public health

programs: Special Supplemental Nutrition Assistance Program for Women Infants and Children (WIC) and Family Case Management programs.[102]

h. The Illinois Criminal Justice Information Authority (ICJIA)

ICJIA brings together key leaders to identify critical issues facing Illinois' criminal justice system and to propose policies, programs, and legislation that address those issues.[103] ICJIA's responsibilities include administering grants, research and analysis, policy and planning, and information systems and technology.

Several of ICJIA's grants intersect with the mental health system. For example, ICJIA is the State Administering Agency (SAA) for the Federal Victim of Crime Act (VOCA) Funds. Beginning in federal fiscal year 2015, the federal VOCA allocations to SAAs increased dramatically. To address this influx of funding, ICJIA completed a thorough needs assessment with a resulting plan[104] that included funding victim services that address long-term victim needs, such as counseling and mental health services, and funding trauma-informed and trauma-focused services. From October 1, 2017 through September 30, 2018, ICJIA's VOCA grant recipients reported serving over 24,000 children:

Table 14: ICJIA VOCA Services by Age

Age	# Served
0 - 12	15,760
13 - 17	8,243

In July 2019, ICJIA published a survey of Illinois behavioral health and public health providers on their perspectives on violence prevention as part of ICJIA's Targeted Violence Prevention Program (TVPP).[105] Of the 152 respondents, 56% reported serving youth ages 11-17 and 51% reported serving youth ages 10 and below. Overall, ICJIA found that providers reported feeling comfortable assessing clients for suicide risk but were less comfortable intervening to prevent individuals from committing future violence. Additionally, providers infrequently identified violence risk assessments as part of regular practice. Most providers had no experience working with an individual who discussed or engaged in targeted violence, and the providers felt unprepared to assess, prevent, or intervene with someone who ascribed to beliefs or ideologies that justify violence.[106] These findings suggest that behavioral and public health professionals, both those that serve adults and youth, may need additional education and training on how to work with populations at risk for violence against themselves or others, targeted or otherwise.

iii. Local Executive

a. 708 Board Mental Health Plans

The Illinois Community Mental Health Act allows communities to levy a local tax on property services to be spent in assisting people (children and adults) with mental illness, developmental disabilities or substance abuse issues. That Act also mandates the

appointment of a local mental health board to plan, fund, and monitor these services. These "708 boards,"[107] named for the original bill, available in many Illinois communities,[108] conduct their own local planning.

The Association of Community Mental Health Authorities of Illinois (ACMHAI)[109] is a partnership of organizations committed to the concept of community behavioral health. It helps organize not only the 708 Boards (mental health) but also other local government bodies, including 377 Boards (developmental disabilities) and 553 Boards (public health). These all play a role in providing local resources to support health services for Illinois children. They demonstrate how local assessments can be more specific in identifying children's mental health needs. Examples of some 708 Board plans that ACMHAI shared with ICMHP which focus on children's mental health issues include:

I. McHenry County

The McHenry County 708 Board's 2017 Report on Child and Adolescent Psychiatric Services[110] relies on the YRBS reports and the Illinois Comparative Health Care and Hospital Data Report (COMPdata), generating a snapshot of local children's mental health issues (See Table 7).

Table 15: McHenry Child Mental Health Data FY16

Child Population (under 18) 75,216	SASS Crisis assessments - 51.86 per month	Hospitalizations- 358 (110 multiple admissions)	Primary Inpatient Diagnosis- Psychosis (50%)	Length of Stay 8.13 Days
Child Diagnoses (Community)	ADHD- 25% (14,500)	Panic / Anxiety- 10.3% (6000)	Eating Disorder- 3.2% (1800)	Bipolar- 3% (1800)
	Obsessive-Compulsive- 2% (12100)	Schizophrenia- < 1% (<580)		
YRBS Survey for McHenry, 2016	Felt sad or hopeless- 35% of 8th Graders	Suicidal Thoughts- 18% of 10th Graders	Alcohol In Last 30 Days- 43% of 12th Graders	Brought Weapon To School- 4-8%

Regarding needs, McHenry notes that it has no inpatient beds for children and adolescents requiring crisis-level behavioral health inpatient stays.[111] Nor are there any day programs for children.[112] Regarding workforce, there are not enough child and adolescent psychiatrists. Of the three private psychiatrists in McHenry, none take Medicaid.[113] In addition, the county struggles to keep psychiatric nurse positions filled and lack Spanish-speaking mental health workers.[114] Finally, McHenry notes that, "the only transportation options for families to transport their children to child psychiatric services require an hour or more by car or multiple hours using multiple train and bus transfers.[115]

Interestingly, McHenry's plans rely on strengthening their wraparound services, rather than directly filling their 'clear gap' of inpatient beds. The Report recommends focusing its local funding on day programs, school-based programs, and transportation issues.[116]

II. Vermillion County

The Vermillion County 708 Board 2016 report produces a slightly different snapshot of local children's mental health issues (see Table 16).[117]

Table 16: Vermillion County Estimate of Youth Mental Health Needs and Services

Child Population (under 18) 19,028	% Need	# Needing Service	# Actually Served	% of Need That Was Met
Emotionally Disturbed	21	3996	1353	34
Substance Abuse Disorder	10	1903	119	06

Vermillion's Complex Service Planning program coordinates care when traditionally siloed services are not meeting the needs of families with children with intensive emotional or behavioral issues.[118] Therefore, local providers identified that "the top issue, by a large margin, was substance abuse." However, when asked to identify the top service priorities, providers indicated, "far and away the need for psychiatric services was number one. Job training, placement and support was number two."[119] The Board's eight objectives for the next year included working with schools on a mental health initiative, with community mental health agencies on more assessment and treatment services in juvenile court, and with local mental health and substance abuse agencies on developing programs for dually involved clients.

III. Kankakee County

Kankakee County's 708 Board 2017 report on local children's mental health system[120] gives a detailed report of providers and services available by age groups. It lists both gaps in the system and proposals to address them.

Funding is always an issue. But some gaps are due to geography, given that Kankakee County is rural. The report notes that "[p]oor public transportation leaves these rural communities with a struggle to get services. This barrier forces the majority of mental health care to be placed on struggling rural school districts who may be lacking in funds or families who may lack transportation to reach services in the city."[121] The County also lacks a sufficient number of qualified professionals who specialize in working with children's mental health issues. There are also a limited number of training programs to improve staff qualifications.

The Report proposes a number of solutions, ranging from holding an annual fundraiser to developing a new training system in Evidence-Based Practices (EBP) by combining in-person interactive education with ongoing case consultations and relying on support from local

academic institutions.[122]

Such reports reflect the importance of understanding the general mental health issues at the local level. They demonstrate the commitment of local providers, the common barriers being encountered, and the attempts at creative solutions. Some support for the children's mental health providers may be coming from new legislation.

B. Legislative Level Activities

i. Federal Legislature

In June 2019, U.S. Senator Richard Durbin and U.S. Representative Danny Davis introduced the RISE From Trauma Act. SB 1770 was subsequently referred to the Committee on Health, Education, Labor, and Pensions. The RISE (Resilience Investment, Support, and Expansion) From Trauma Act would help build a trauma informed workforce and increase resources for communities to support children who have experienced trauma.[123]

ii. State Legislature

a. New Statutes

During the 2019 legislative session, the Illinois General Assembly passed several major pieces of legislation relevant to children's mental health. Three pieces directly related to the issues raised in this report are:

- Public Act 101-0461 / HB2154 – the Children and Young Adult Mental Health Crisis Act, an initiative of the Healthy Minds Healthy Lives Coalition, passed with bipartisan support. The Act is intended to fill in significant gaps in Illinois' mental health treatment system for children and young adults by shifting the focus from crisis and late stage services to support when symptoms first begin by:
    - Restructuring the Family Support Program to prevent crisis by making a more robust set of services available sooner rather than later and strengthening family engagement
    - Improving access to preventative services under Medicaid and bringing together decision makers to coordinate investments and align systems
    - Expanding private insurance coverage to include team-based early treatment models proven to curtail the debilitating effects of serious mental health conditions

- Public Act 101-0331 / SB1425 – created the Office of Suicide Prevention within IDPH to coordinate statewide suicide prevention, intervention, and postvention programs, services, and efforts; the office will work with the Illinois Suicide Prevention Alliance to prepare the Illinois Suicide Prevention Strategic Plan and

provide an annual report to the Governor and General Assembly on the recommendations and activities of the strategic plan.

- Public Act 101-0027 / HB 1438 - creates the Cannabis Regulation and Tax Act and provides that it is lawful for persons 21 years of age or older to possess, use, and purchase limited amounts of cannabis for personal use in accordance with the Act.

Other relevant children's mental health legislation includes:

- Public Act 101-0002 / HB345 - prohibits the sale or furnishing of tobacco products, electronic cigarettes, or alternative nicotine products to a person under 21 years of age. Prohibits the purchase of tobacco products, electronic cigarettes, or alternative nicotine products by a person under 21 years of age.

- Public Act 101-0010 / SB155 SA 1 – adds "exposure to a toxic substance" (such as lead) to the list of medical conditions that typically result in developmental delay and requires automatic eligibility for Early Intervention services; research has shown that even low level of exposure to lead can cause decreased cognitive, physical, and social-emotional capacities.

- Public Act 101-0085 / HB355 – amends the school code to require that no less than 15 of the 120 required hours of professional development for a Professional Educator License must include training on inclusive practices in the classroom that examines instructional and behavioral strategies that improve academic and social-emotional outcomes for all students in the general education setting.

- Public Act 101-0045 / HB907 – requires that DHS create and maintain an online database and resource page of mental health resources specifically geared towards school counselors, parents, and teachers.

- Public Act 101-0251 / HB2152 – the Mental Health Early Action on Campus Act is intended to improve mental health awareness among students, staff, and faculty; enhance access to services on and off campus; and establish statewide technical assistance center to support postsecondary institutions develop and implement policies and best practices

- Public Act 101-0219 / HB3704 – requires that the Department of Corrections to develop policies and procedures promoting family engagement and visitation appropriate for youth.

- Public Act 101-0471 / HB2444 – requires that at an initial bail hearing or subsequent hearing, a defendant shall be released on recognizance if a judge finds that the defendant's pre-trial detention will harm any infant or child in the defendant's custody at the time of arrest, unless the harm is outweighed by a clear and serious risk of harm to a victim or the community.

- Public Act 101-0438 / SB1941 – establishes the Safe Schools and Healthy Learning Environments Grant Program. The program promotes school safety and healthy learning environments by providing schools with additional resources to implement restorative interventions and resolution strategies as alternatives to exclusionary discipline, and to address the full range of students' intellectual, social, emotional, physical, psychological, and moral developmental needs.

b. New Resolutions

Also supportive of ICMHP issues, the General Assembly passed resolutions in the Senate and House, (SR0099 and HR248), and the Governor signed a proclamation declaring May 15, 2019 as Trauma-Informed Awareness Day in Illinois. SR0099 encourages all officers, agencies, and employees of the State of Illinois whose responsibilities impact children and adults to become informed regarding the impacts of adverse childhood experiences, toxic stress and structural violence on children, adults and communities and to become aware of care practices, tools and interventions that promote healing and resiliency in children, adults and communities so that people, systems and community, family and interpersonal relationships can maximize their well-being. HR248 urges policy decisions enacted by the Illinois General Assembly to acknowledge and take into account the principles of early childhood brain development.

C. Judicial Level Activities

There were no Illinois Court decisions this year that had a major impact on children's mental health issues. There were, however, several federal court actions that are relevant.

i. Federal

a. Federal Class Actions

Several Illinois child-serving agencies are under federal consent decrees. The decrees all include children's mental health services and are currently being monitored by the federal courts. The cases and departments are:

- *N.B. v Eagleson* / HFS[124] (discussed above)
- *B.H. v Smith* / DCFS[125] - originally filed by the ACLU of Illinois in 1988, *B.H.* continues to push for systemic reforms, including reforms in provisions of mental health care for DCFS youth.
- *R.J/ v Mueller* / DJJ[126] - also filed by the ACLU of Illinois, alleging inadequate education and mental health services and excessive use of solitary confinement.

b. *Wit v United Behavioral Health*[127]

Wit v UBH "is a landmark case that reinforces the need for equity in how health plans cover physical and mental health conditions," notes Patrick J. Kennedy, founder of The Kennedy Forum.[128] In a class action, plaintiffs claimed that an insurance company violated the

Employee Retirement Income Security Act (ERISA) of 1974, which regulates employer health care plans, "by developing and applying flawed and overly-restrictive guidelines to evaluate "medical necessity." The U.S. District Court in the Northern District of Illinois held "that under generally accepted standards of care, chronic and co-existing conditions should be effectively treated; ... that UBH's guidelines improperly required reducing the level of care; ... [and] that UBH failed to follow specific guidelines mandated by certain states [including Illinois] for evaluating the medical necessity of behavioral health services." Though *Wit* is only binding on the one federal district (from California) and it is limited to people covered by employer-sponsored insurance plans, this ruling will impact the way many health insurers make coverage determinations. For example, it will affect the behavioral health care that insured families receive and it reinforces the need for health insurers to respect mental health parity laws.[129]

D. Private Sector Activities

Not all children's mental health services and supports are provided by government entities. In fact, the initial Illinois census of Illinois children (over 2.8 million) and the number of children covered by HFS (over 1.4 million) suggests that only half the children are covered by government health care. The remaining Illinois children (another 1.4 million), if they receive services, would get them through the private sector.

i. Private Data

Some very useful data are available through the Illinois Comparative Health Care and Hospital Data Report (COMPdata), which keeps track of both children's inpatient psychiatric hospitalizations:

Table 17: COMPdata On Inpatient Psychiatric Care for 0- 18yo

	Public Funding	Private Insurance	Uninsured	Total
2018	14,074	11,686	616	26,376
2017	12,852	14,040	529	27,421
2016	11,115	12,701	616	24,432
2015	12,081	11,980	715	24,776

Given Illinois does not have state inpatient psychiatric facilities for children, all these hospitalization occur in private facilities, though Medicaid pays for the stays of children it covers. Most of the remaining stays are paid for through private insurance. Unfortunately, Illinois does not require private payers to publish service data, therefore we have no information about community mental health services paid through the private sector. Thus, there is a major gap in this ICMHP Report.

ii. Foundation Funding

Besides private insurance, there are multiple foundations and not-for-profit organizations

that support children's mental health services. In addition to state funding and programs, there have been significant investments in the children's mental health system from the private sector. Some examples of multi-year, multi-million dollar funding of children's mental health programs include:

a. ICMHP: Early Childhood, Home Visiting, and After School Initiatives

For years, ICMHP has worked with multiple foundations to focus on early childhood, home visiting, and after school initiatives.[130] Millions of dollars in funding for these projects continues to be provided by private foundations, including anonymous support, the Bright Promises Foundation, Crown Family Philanthropies, Illinois Children's Healthcare Foundation, the Irving Harris Foundation, J.B. and M.K. Pritzker Family Foundation, Robert R. McCormick Foundation, Telligen Community Initiative, and the W. Clement and Jessie V. Stone Foundation.

Regarding early childhood, ICMHP leads the Mental Health Consultation Initiative to implement, evaluate, and build a sustainable Infant/Early Childhood Mental Health Consultation system in Illinois.[131] Entering its third and final year of the pilot, preliminary evaluation findings indicate several promising trends, including decreased provider burnout, increased awareness of classroom environment and help-seeking behavior, increased knowledge and understanding of child development, and increased use of proactive and positive behavior management strategies.[132]

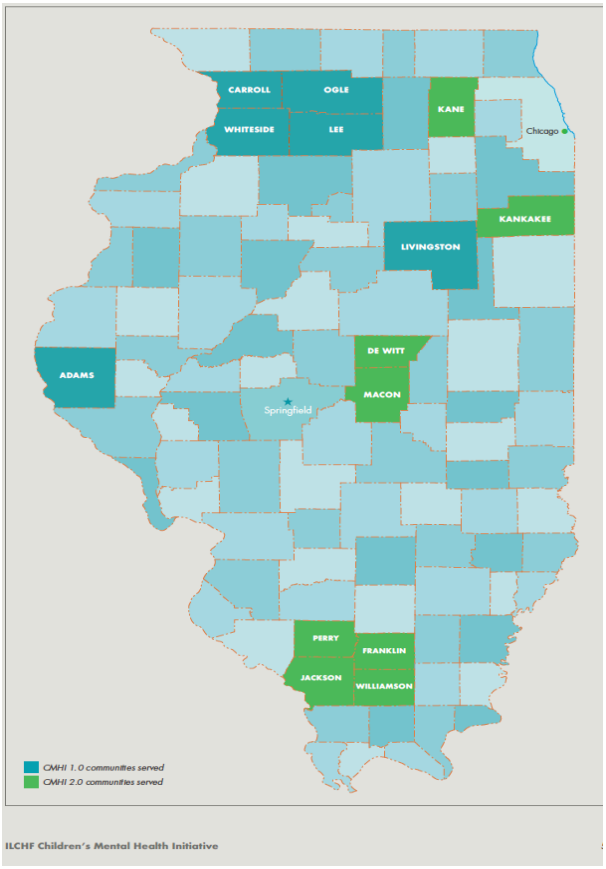
With after-school programs, ICMHP partnered with the Illinois AfterSchool Network (IAN) to complete its second year of a pilot that provided mental health consultation to staff across seven after school programs in the Chicago area in order to increase the understanding of social and emotional learning when the staff engage with parents. The Bright Promises Foundation is funding a third and final year to create a resource manual for after school programs and do a national presentation based on this model.

b. Illinois Children's Healthcare Foundation (ILCHF) Children's Mental Health Initiative[133]

In addition to supporting and participating in ICMHP projects, ILCHF is dramatically increasing its own investment in creating systems of care throughout Illinois. Since 2010, the ILCHF has invested over $12 million in four communities throughout the state to create a comprehensive, coordinated, and integrated community-based system of care to prevent,

treat, and promote children's mental health (CMHI 1.0).[134] Using the lessons learned, ILCHF is continuing its investment in the Illinois children's mental health system through CMHI 2.0, with a second $12 million, seven-year system of care development grant process for four additional communities (see Figure 6).[135]

Figure 6: ILCHF Funded System of Care Sites



Across seven years, the four CMH1.0 communities developed robust systems of care, showing a significant improvement in the level of systems integration in each community and demonstrating the immense positive impact of community-level investment. Notably, these systems integration efforts have been sustained in each community past the completion of the grant support from ILCHF in 2018. [136] These particular accomplishments provide roadmaps for other communities and the state to address three very common issues within the children's mental health system – universal screening, decrease in involvement with the juvenile justice system, and a universal release of information consent form.

E. Highlighting Children's Mental Health Programs

In addition to the philanthropically funded initatives, there are several other current children's mental health programs, both privately and publicly funded, that are worth noting:

i. Addressing Social Determinants of Health: Medical-Legal Partnerships

In developing a full system of care to address children's mental health, it is critical that the system also address the social determinants of health outside of the healthcare treatment system.[137] Within the context of children's mental health, social determinants include, but are not limited to, education, income, housing, immigration, insurance, and justice involvement, which have a profound impact on the overall outcomes for children and their families. A unique model that seeks to address these social determinants is the medical-legal partnership (MLP) model, which partners lawyers and legal advocates with healthcare professionals in order to resolve the social problems negatively impacting a patient or

client's health.[138]

While several MLPs exist throughout Illinois, one program partners lawyers with a children's behavioral health clinic. The Legal Council for Health Justice (LCHJ) and Sinai Health System's Under the Rainbow (UTR) child and adolescent mental health clinic in Chicago embeds lawyers and legal advocates on-site at the clinic, mainly serving Chicago children and families living on the south and west sides of Chicago. By integrating legal services into the mental health treatment process, advocates are able to address and resolve the client and their family's social needs early. This includes providing legal advocacy to ensure school services are provided to the child, prevent a child with severe behavioral health needs from being expelled illegally, ensure a caregiver is able to keep their job through family medical leave protections, or obtain necessary income supports such as social security disability benefits. Addressing these social barriers allows the mental health treatment team to focus their resources on treatment, ultimately improving the child's overall treatment outcomes. The same is true for MLPs that partner with primary care doctors, healthcare clinics, or hospitals, many of which frequently refer clients with mental health needs.

In late 2018, the Sinai Urban Health Institute (SUHI), in collaboration with LCHJ, was one of eight programs throughout the U.S. chosen to receive a two-year grant from the National Institute of Justice (NIJ) to evaluate innovative programs serving victims of crime. The grant assesses the evaluation needs of the MLP with UTR, which seeks to 1) legally remove any threat to the child, 2) ensure the child and family continue to access mental health services, and 3) break the cycle of violence where oftentimes a victim becomes the perpetrator.[139]

ii. Trauma-Informed Programs

Multiple organizations are working together to address different aspects of child trauma:

- *The Trauma-Informed Chicago Summit.*[140] As part of an ongoing effort to make Chicago a trauma-informed city, the Chicago Department of Public Health's Office of Violence Prevention[141] and the Illinois ACEs Response Collaborative[142] co-hosted a summit to highlight current trauma-informed activities in Chicago and create a vision moving forward. Other partners in the project included the Mayor's Office, the Center for Childhood Resilience,[143] Communities United,[144] Illinois Collaboration on Youth,[145] National Louis University,[146] Strengthening Chicago's Youth,[147] VOYCE,[148] Illinois Childhood Trauma Coalition,[149] and Wisdom Exchange.[150]

- *ICJIA: Illinois Helping Everyone Access Linked Systems (Illinois HEALS).*[151] This is a six-year initiative that brings together experts, service providers, community groups, young victims and their families, and other stakeholders to build local systems of care. Illinois HEALS is implementing policies, practices, and programs that strengthen the capacity of Illinois' communities to recognize when victimization has occurred and connect and engage young victims and families in needed services.[152]

- *The Illinois Childhood Trauma Coalition [ICTC] Refugee and Immigrant Children Committee.* ICTC joins over 80 organizations to address child trauma issues in Illinois. It has a committee focusing on traumatized "Refugee and Immigrant Children"[153] that is addressing some the issues noted in the federal executive activities section above.

IV. ICMHP Issues & Recommendations for Children's Mental Health

Sections II and III of this report has reviewed the data on children's mental health needs and the current status of the Illinois children's mental health system. This report will now identify what ICMHP considers the most pressing issues in order of perceived need and urgency. These are not the only mental health issues facing children but we believe that addressing these issues will provide some immediate relief and benefit to the children's mental health system.

First, it is important to acknowledge that many children's mental health services in Illinois are improving (despite the lower national ranking). The current administration is funding more children's mental health services. The Illinois Department of Healthcare and Family Services (HFS) has the potential to significantly redesign the public sector portion of Illinois' child mental health service delivery system with its new implementation of federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements. These procedures coupled with the new social, emotional, and developmental screening requirements being issued by the Illinois Department of Public Health (IDPH) could result in more children who need mental health services being identified sooner. For example, the increasing number of youth with depression could benefit from the increased services in the new children's mental health service delivery system. Private foundations are supporting important work in child development. Multiple organizations are working together to address child trauma. All this activity represents a significant gain for children's mental health. Nonetheless, important work remains to be done.

A. Identification and Access to Services

ISSUE: How many Illinois children in need of mental health care are being properly identified and have access to the appropriate services in sufficient amounts?

a. Service Estimates

Since the state's primary focus through *N.B.* is on developing the service system, we will first look at service accessibility issues.This report estimates that 10% (over 285,000) of Illinois children are in need of mental health services. It also estimates that about half of Illinois children qualify for Medicaid. That coverage includes funding for mental health services. The remaining half would need to be funded by the private sector. Table 1 notes that the vast majority of children with private insurance do have coverage for mental health issues. Thus, while some children have neither Medicaid nor private insurance, it appears most Illinois children have some coverage for mental health services.

We do have some rough estimates regarding the total number of Illinois children receiving mental health services. HFS is the major funding source for half of Illinois children, and reports that 15% (over 210,000) of children received some behavioral health services during FY19.[154] Private insurance companies are not required to report how many children are funded for mental health services. From the COMPdata discussed above, we know that over 26,000 children were psychiatrically hospitalized during calendar year 2018, with over 11,000 paid for through private insurance.[155] An unknown number of children also received privately funded community-based services.[156] Given our initial estimate of need, it is likely that more than 285,000 Illinois children are receiving some mental health services in Illinois.

b. Appropriate Services in Sufficient Amounts

The remaining issue is whether the identified children are receiving the appropriate services in sufficient amounts. We cannot give a comprehensive answer to that question. We do know that many service gaps exist. Recall that Table 1 indicates over half the Illinois youth with depression did not receive services and that nearly three-quarters of the youth with severe depression did not receive consistent treatment. There are unmet trauma and substance abuse needs. Further, the local 708 board assessments identified large gaps in services such as inpatient, day programs, and psychiatric care.

The *N.B.* Consent Decree and draft Implementation Plan, which is redesigning the children's mental health system for those children covered by Medicaid, may address many of these gaps. In particular, the use of the IM-CANS as functional assessment being used on all *N.B.* children could allow the discussion to move from how many children are being served to whether children are receiving the appropriate treatment in sufficient amounts. It should also allow for a focus on the most important question of whether the children receiving care are improving and demonstrating healthy development.

c. Access Through *N.B.*

As noted above, the *N.B.* implementation plan will drive the children's public mental health system for years to come. Significant improvements include the use of a standardized assessment tool for all children and the use of system of care principles that emphasize community-based care with family involvement.

However, it is unclear how many children will be eligible to access these new services. In February of 2014, the Federal Court defined the EPSDT Class as: "All Medicaid-eligible children under the age of 21 in the State of Illinois: 1. Who have been diagnosed with a mental or behavioral disorder; and 2.For whom a licensed practitioner of the healing arts [LPHA] has recommended intensive home- and community-based services to correct or ameliorate their disorders." This is a broad class definition.

By contrast, in the proposed HFS Implementation Plan, this Class is *operationalized* as "all Medicaid-eligible children… for whom: 1) an LPHA has completed the standardized, HFS approved Integrated Assessment and Treatment Planning (IATP) instrument (e.g., IM-CANS); and 2) supporting information, including but not limited to, claims or other utilization data indicates that the child meets eligibility criteria for intensive home and community-based services coordinated by a Integrated Health Home (IHH). These identified Class Members and their families will receive medically necessary services through the Model."

The operational range could be very wide or very narrow depending on how HFS applies its eligibility algorithm in "indicating" that a child meets eligibility criteria and how narrowly/broadly HFS defines "medically necessary services."

Further, a Benchmark at the end of the seven-year Implementation Plan requires HFS to certify "that the Model is at a capacity to substantially serve the Class needs for intensive home- and community-based services on a systemic level statewide." This certification is possible only if there is an initial agreed-upon estimate of needed capacity. If in the end, the parties simply rely on the number of children that HFS actually serves, then the Benchmark loses its meaning.

Thus, many *N.B.* questions remain to be answered. How many children is the system being designed to serve? What are the eligibility requirements to enter the system? Once a child is eligible how do managed care organizations (MCOs) determine what dosage of what services to provide? How does the system determine whether a child has improved or needs more services? Administrators are making these decisions now.

d. Other Access Issues: Identification and Entryway

The implementation of *N.B.* is the most significant activity impacting the children's public mental health services system this year. However, the state's primary focus on developing the services system is missing a critical and necessary opportunity to address the moments

before a child will enter that system. There are several unanswered questions and gaps related to early identification and intervention.

The first of these questions is how to screen and successfully follow-up on the screening results to connect children and their families to services. The draft *N.B.* implementation plan states that there will be multiple entry pathways for children to be identified and referred for assessment, listing parents/caregivers accessing community mental health providers, MCOs, primary care physicians, and systems referrals from schools, child welfare, or juvenile justice. However, there is no plan in place to train and ensure readiness for those potential entry-way points.

Further, how will the entryway points for connecting children to the *N.B.* system interact with the social emotional and developmental screening requirements being developed through IDPH as part of Child Health Exams required for school? Similarly to the lack of an entryway development plan for *N.B.*, there is no plan to ensure primary care physicians, who will likely be the main source for conducting these screenings, are ready to conduct these screenings or have adequate and available avenues for follow-up.

Theoretically, the screening requirements through Child Health Exams could allow schools to identify students; however, the screening results are not required to be shared with schools. Further, as noted previously, students are not being identified or improperly classified when their mental health needs require special education services. We do not have data for those students with mental health needs that do not rise to the point where special education services are required, although we anecdotally know that these students are likely not being served or served with sufficient supports.

There are additional gaps in knowledge around how the crisis intervention system is used and to what extent it acts as an entryway point for children and families. Although crisis intervention services are not the point at which children should first be identified for services, this is exactly what happens for many children. However, the children's crisis intervention system has become more divided and complex in the past year. Through the development of the Medicaid managed-care system, HFS developed a parallel crisis system to the SASS program, called Mobile Crisis Response (MCRs), that would be operated by each MCO. For children in MCOs, they are referred to the MCRs while children who are uninsured or still in Medicaid fee-for-service plans are still served through SASS. In 2018, HFS also expanded the responsibilities of the existing children's crisis response providers to cover both children and adults, adding additional strain on these services.[157]

Perhaps the biggest gap around the crisis intervention system is what happens to children with private insurance since SASS and MCRs are only available to individuals with Medicaid. What crisis intervention services are provided to children with private insurance? How are those children connected to follow-up services? Does crisis intervention serve as an entryway point for these children and if so, how often? How do these plans define medical necessity for these services and does the *Wit v. UBH* decision impact those definitions?

Although the need to reform and invest in the treatment system is clear, these questions demonstrate a simultaneous need to continue to build early identification, intervention, and supports into the community system that precedes the treatment system. Some of the legislation reviewed above may assist with some of these gaps.[158]

RECOMMENDATIONS

1. Ongoing public monitoring of *N.B.* is essential. Besides the plaintiffs attorneys, there is a court appointed expert with a team that is reporting back to the court regarding benchmarks. In addition, HFS has formed a subcommittee to review progress.[159] Some states that have entered consent decrees regarding federal EPSDT requirements have created an interagency review group.[160] ICMHP could serve that function in Illinois. Specifically, *N.B.* eligibility and service criteria need to be developed and reviewed.
2. The monitoring of *N.B.* needs to include access to the IM-CANS data. The standardized functional assessment being used on all *N.B* children will allow the discussion to move from how many children are being served to whether children are receiving the are receiving the appropriate treatment in sufficient amounts, leading to improved outcomes and healthy development.
3. Private insurers should be required to report similar, non-identifiable, group information to the state regarding children's mental health services.
4. Definitions of "Medical Necessity" should be tied to clinical guidelines published by the relevant expert organizations. Both HFS and the private insurers should use these definitions.
5. The state needs to develop a robust identification and entryway system, both for public and private systems. This includes proactive coordination between the EPSDT requirements through *N.B.* and the new screening requirements for child health exams. To begin, Illinois, in collaboration with public and private stakeholders, should identify best practices for screenings, such as the successful models developed through the ICHF grants, follow-up assessments, and connection to appropriate services.

B. Workforce Development

ISSUE: Once we are able to identify children who are eligible for medically necessary mental health services, do we have an adequate supply of services and providers?

Illinois can put a strong system in place to fund children's mental health services. This system's success will be dependent upon local clinicians actually delivering the services. While this report found that many children are receiving some mental health services, there does not appear to be the correct level of care or a sufficient number of adequately trained providers in many parts of the state. To remedy this gap, Illinois needs to develop its children's mental health workforce.

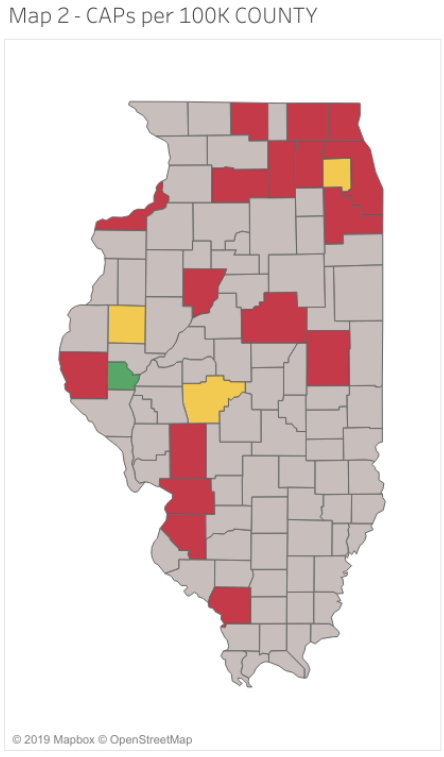
Similar to the struggle to have a precise estimate of the mental health needs for children and

adolescents, it is difficult to determine the full extent of child and adolescent mental health workforce needs.[161] However, provider requests to immediately begin more workforce development are referenced throughout this report.[162]

Illinois' workforce need is identified at a national level as well. The MHA 2020 Report ranks Illinois 29th regarding Mental Health Workforce Availability.[163] While it does not focus specifically on children's service providers, it estimates a ratio of 480 people to every 1 mental health provider (including psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists and advanced practice nurses specializing in mental health care). While our workforce has been slowly increasing nationally, MHA notes "projections from the Health Resources and Services Administration (HRSA) still indicate an immense shortage of mental health and substance use treatment providers to meet the demand in 2030. Mental health provider shortages result in little access to care, high burnout rates among providers, and long waits for necessary treatment."

The most frequently cited need by Illinois providers is for child and adolescent psychiatrists. The American Academy of Child and Adolescent Psychiatrists (AACAP) estimates that on average, there is only one child psychiatrist for every 15,000 youths under age 18. According to AACAP, 81 of the 102 Illinois counties, representing 540,000 children, do not have a single child and adolescent psychiatrist; in the 21 counties that do have one, there are only 310 child and adolescent psychiatrists 2.45 million children (see figures 7 and 8).[164]

Figures 7 & 8: Child and Adolescent Psychiatrists Per County



County	Pop. < 18	Number of CAPs
Cook County	1,186,398	181
DuPage County	218,771	41
Lake County	179,177	27
Sangamon County	45,563	14
Will County	182,916	7
Champaign County	39,273	6
Winnebago County	69,159	6
Kane County	142,953	4
McHenry County	76,907	4
Peoria County	44,665	4
McLean County	38,166	3
St. Clair County	64,054	3
Rock Island County	32,821	2
Adams County	15,184	1
Brown County	1,045	1
DeKalb County	22,872	1
Jackson County	10,703	1
Lee County	7,006	1
Macoupin County	10,072	1
Madison County	59,303	1
McDonough County	5,274	1

Psychiatry, however, is not the only need; another significant workforce gap is with mental health supports in schools. A report by the

American Civil Liberties Union (ACLU) found that 90 percent of youth are in public schools that fail to meet the minimum recommended ratios (as determined by each profession's national association) for counselors, social workers, psychologists, or nurses, but most of those same schools have 2-3 times the number of police officers than these other supports.[165] Illinois' ratios for each of these school supports are far behind the recommended minimums:

Table 18: Illinois Ratio of School-Based Mental Health Provider-to-Student[166]

School-Based Mental Health Provider	Recommended Minimum Ratio to Students	Illinois Ratio
Counselors	250:1	555:1
Social Workers	250:1	741:1
Psychologists	700:1	1,261:1
Nurses	750:1	871:1

There are some movements already underway to develop a stronger workforce. As noted above, ICMHP is working with multiple private foundations on early childhood projects. These have included a workforce development committee that focuses on developing and strengthening mental health consultants to support and build the capacity of professionals work with infants, young children, and their families. Other efforts include training and an infant/early childhood mental health (I/ECMH) credentialing process developed by the Illinois Association for Infant Mental Health. Although both of these efforts have been supported by the private sector, the state should also be investing and supporting these efforts to better serve young children and their families, especially as the need for I/ECMH professionals grows in response to state legislation significantly curtailing the use of expulsion from early childhood programs.[167]

Additionally, there are new opportunities for increased resources and funding for school-based services and supports. For examples, Safe Schools and Healthy Learning Environments Grant Program discussed above provides schools with additional resources to implement restorative interventions and resolution strategies as alternatives to exclusionary discipline, and to address the full range of students' intellectual, social, emotional, physical, psychological, and moral developmental needs. Another opportunity for additional resources for school-based services is through the reversal of the federal Free Care Rule, which only allowed schools to receive Medicaid reimbursement for services provided to students through special education Individualized Education Plans (IEPs) and other limited circumstances. The reversal of this rule provides Illinois schools with the opportunity to bill for Medicaid eligible services such as screening and diagnostic services; mental health and substance use disorder services; occupational, physical and speech therapy; physician services; dental, vision and hearing services; respiratory therapy; and nutritional services.[168]

Other workforce development efforts include the Illinois Childhood Trauma Coalition (ICTC)

workforce development committee, which developed core competencies on childhood trauma for professional development and updated these competencies in 2019 with a new tool identifying seven core content areas.[169] This work might tie into ICJIA's call for therapists to receive additional training in working with high-risk, violent youth.

The above examples demonstrate that the provider community is taking steps to better develop its workforce, but there is a clear need for significant additional development. For these efforts to succeed, it will require a long-term commitment from the state.

RECOMMENDATIONS

1. Similar to the state's endorsing professional guidelines in defining "medical necessity" the child-serving state agencies can endorse best practice guidelines for the children it serves, identify credentials it wants providers to have, and specify provider-to-client ratios.
2. Child-serving state agencies can provide direct training or grants for professionals to become proficient or credentialed in these best practices.
3. Child-serving state agencies can provide incentives for providers to achieve proper ratios, use the best practices or obtain the preferred credentials.
4. Offset some of the gaps in psychiatric coverage with telepsychiatry, consultation, integration with primary care, and alternative providers, such as nurse practitioners and psychologists with prescription privileges.
5. Explore additional revenue options to increase support services for schools through the reversal of the Medicaid Free Care Rule.

C. Cannabis and Vaping

ISSUE: What can we learn from the public health vaping crisis to prepare for the upcoming legalization of cannabis?

Illinois has legalized the recreational use of cannabis by adults. This will increase youth access as well. Though cannabis / marijuana has been illegal for all, the survey of Illinois high school students (Table 4) indicates that over a third of the students have used marijuana. Once it becomes legalized, it is reasonable to assume that those numbers will rise.

That same survey indicates that vaping is even more popular, with over 40% of students vaping various products, including THC, the psychoactive ingredient in marijuana. Nationally, we are now experiencing a public health crisis with vaping causing severe lung injuries.[170] Illnesses and deaths are being reported, including in Illinois.[171] The federal CDC is working with experts from IDPH[172] to understand the problem. It appears that the lung injuries are frequently tied to the vaping of THC. Part of the challenge of solving this crisis is that "patients, particularly younger ones, are often reluctant to share information about their use of illicit substances, such as marijuana."

Illinois has begun to address some of the vaping issues through new legislation prohibiting the purchase, sale, or furnishing of vaping products to a person under 21 years of age.[173] However, just as marijuana has never been legal for high school age students to use but a third of them do, it is unlikely that this law will stop these high-risk taking youth from vaping. Some states, such as Washington,[174] are responding to the crisis by banning all flavored vaping products, requiring the disclosure of all ingredients in these products, increasing the regulatory oversight, and expanding an educational campaign about the health risks.

Illinois, at the same time it is tightening vaping access, is increasing marijuana access. Besides vaping, cannabis / CBD / THC is also used in many edible products, such as chocolates, brownies and gummy bears.[175] These food products are largely unregulated and, with edibles, there tend to be more emergency room visits related to psychiatric and cardiovascular complaints.[176]

Now that cannabis is legalized in Illinois, the issues around potential physical and psychological harm to children needs to be openly and rigorously addressed.

RECOMMENDATIONS

1. Illinois needs to take lessons learned from IDPH involvement with the vaping crisis and apply them to new cannabis regulations.
2. Just as states are now limiting the targeting of youth in the marketing of vaping products, Illinois needs to limit the targeting of youth with cannabis / CBD/ THC products, particularly through edibles.
3. Illinois child serving agencies need to be trained on how to educate youth regarding the potential risks of both vaping and cannabis / CBD / THC.
4. Illinois needs to work with law enforcement regarding how to enforce the ongoing prohibition of vaping and cannabis products by youth.

V. Conclusion

By statute, ICMHP is required to report on Illinois' children mental health system.[177] Everyone is in favor of children's mental health, but it is not the primary responsibility of any state agency. Thus, there is not a comprehensive approach to children's mental health issues in Illinois. This ICMHP report brings together some of the essential pieces.

In this report we summarized national, state, and local activities that have affected children's mental health in Illinois in the past year. The administration is funding more children's mental health services. Many of these services are improving. Nonetheless, important work remains to be done. This report identifies multiple needs regarding children's mental health and makes recommendations on three issues.

ICMHP looks forward to working with your administration on all these issues. Please let us know how we can be of assistance in improving children's mental health in Illinois.

Acknowledgments

This report is based on the work and input of many child mental health experts. We would like to particularly thank the following Partnership members and partners for their assistance in providing information for this report, and/or for their editorial contributions:

David Albert, *Clinical Operations, Division of Mental Health*;
Heather Alderman, *Illinois Children's Healthcare Foundation;*
Laura Altman, *Illinois ACEs Response Collaborative;*
Stephanie Altman, *Shriver Center on Poverty Law;*
Jeff Aranowski, *Illinois State Board of Education*;
Louis Bedford, *Illinois Collaboration on Youth*;
Lisa Betz, *Illinois Department of Human Services, Division of Mental Health;*
Christina Bruhn, *Aurora University School of Social Work;*
Terry Carmichael, *Community Behavioral Healthcare Association;*
Colleen Cicchetti, *Ann & Robert H. Lurie Children's Hospital of Chicago*;
Carrie Chapman, *Legal Council for Health Justice;*
Wendy Cohen, *Illinois Office of the Attorney General;*
Nora Collins-Mansfield, *ACLU of Illinois;*
Ray Connor, *Mental Health America of Illinois;*
Katie Danko, *Ann & Robert H. Lurie Children's Hospital of Chicago;*
Amy D'Arco, *Ann & Robert H. Lurie Children's Hospital of Chicago;*
Reshma Desai, *Illinois Criminal Justice Information Authority;*
Andrea Durbin, *Illinois Collaboration on Youth*;
Michelle Eckhoff, *Illinois Department of Healthcare and Family Services;*
Jill Fraggos, *Ann & Robert H. Lurie Children's Hospital of Chicago;*
Karen Freel, *Illinois Association for Infant Mental Health;*
Carol Gall, *Sarah's Inn;*
Gaylord Gieseke, *Illinois Childhood Trauma Coalition;*
Leslie Helmcamp, *Ann & Robert H. Lurie Children's Hospital of Chicago;*
Kristine Herman, *Illinois Department of Healthcare and Family* Services;
Debbie Humphrey, *Association of Community Mental Health Authorities of Illinois;*
Jennifer Jaworski, *Illinois Department of Juvenile Justice;*
Michael Kelly, *Loyola University Chicago School of Social Work*;
Amber Kirchhoff, *Thresholds;*
Becky Levin, *Strengthening Chicago's Youth;*
Shannon Lightner, *Illinois Department of Public Health;*
Allison Lowe-Fotos, *Ounce of Prevention Fund;*
Kimberley Mann, *Illinois Department of Children and Family Services;*
Deb McCarrel, *Illinois Collaboration on Youth*;
Jen McGowan-Tomke, *NAMI Chicago;*
Nell McKitrick, *Ann & Robert H. Lurie Children's Hospital of Chicago;*
Carrie Muehlbauer, *Illinois Collaboration on Youth;*
Kristin Nguyen, *EverThrive;*

Heather O'Donnell, *Thresholds*;
Dru O'Rourke, *Illinois Chapter, American Academy of Pediatrics*;
Rosario Pesce, *Loyola University;*
Jennie Pinkwater, *Illinois Chapter, American Academy of Pediatrics;*
Cheryl Potts, *The Kenney Forum*;
Stefanie Polacheck, *Children's Home and Aid*;
Joel Rubin, *Illinois Chapter, National Association of Social Workers*;
Anh-Thu Runez, *Illinois Department of Public Health;*
Mary Satchwell, *Illinois School Psychologist Association*;
Susan Scherer, *Illinois Council of Child and Adolescent Psychiatry;*
Tony Smith, *NAMI Chicago;*
Meryl Sosa, *Illinois Psychiatric Society;*
Susan Stanton, *ACT Now Coalition;*
Amy Starin, *Illinois Children's Health Care Foundation*;
Anne Studzinski, *Illinois Childhood Trauma Coalition (Retired)*;
Kaylan Szafranski, *Legal Council for Health Justice;*
Cynthia Tate, *Governor's Office of Early Childhood Education*;
Marlita White, *Chicago Department of Public Health*; and,
Paula Wolff, *Illinois Justice Project*

IN MEMORIAM

Dear ICMHP friends,

Carl Bell, MD passed away on Friday, August 2, 2019. Dr. Bell made significant contributions to the study and prevention of community violence, child trauma, and fetal alcohol exposure. He was active at many levels, from local to international programs. In particular, he had a tremendous impact on Illinois' child-serving systems. Carl was a friend of the Partnership, including supporting our work and mentoring many of us. Through it all, Dr. Bell maintained a sense of humor, a sense of spirituality, and a sense of style. As those of you who worked with him know, Carl had many hats and he wore them well. We will miss him. The children still need him.

Endnotes

[1] "QuickFacts Illinois" United States Census Bureau, accessed September 2019, https://www.census/gov/quickfacts/IL.
[2] "Number of Persons Enrolled in the Entire State," Illinois Department of Healthcare and Family Services, accessed September 2019, https://www.illinois.gov/hfs/info/factsfigures/Program%20Enrollment/Pages/Statewide.aspx
[3] Illinois Department of Healthcare and Family Services, "Chapter HK-200- Policy and Procedures" in *Handbook for Providers of Healthy Kids Services*" (2017), 200.1, https://www.illinois.gov/hfs/SiteCollectionDocuments/FY18CMS416ReportingofEPSDTServicesforChildren.pdf
[4] "Mental Health and Developmental Disabilities (405 ILCS 49/) Children's Mental Health Act of 2003", Illinois Compiled Statutes, Illinois General Assembly, accessed September 2019, ttp://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=2481&ChapterID=34
[5] United States Census Bureau, "QuickFacts Illinois."
[6] These percentages have not changed more than 1% from the U.S. Census 2016 data.
[7] Friedman R, Friesen B, Huang L, Mayberg S, Mrazek P, Pires S, Stroul B. "Transforming Mental Health Care for Children and Their Families." *American Psychologist* 60, no. 6. (September 2005): 615-627, which explains that "Recent studies indicate an alarmingly high prevalence rate, with approximately 1 in 5 children having a diagnosable mental disorder and 1 in 10 youths having a serious emotional or behavioral disorder that is severe enough to cause substantial impairment in functioning at home, at school, or in the community... In conjunction with this prevalence rate, there is an extremely high level of unmet need. It is estimated that about 75% of children with emotional and behavioral disorders do not receive specialty mental health services; U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, "Achieving the promise: Transforming mental health care in America", *New Freedom Commission on Mental Health*. (2003): SMA-03-3832, http://govinfo.library.unt.edu/mentalhealthcommission/reports/reports.htm.
[8] This is based on children *under* 18, so it is an underestimate, given our definition of child through age 18. Additionally, this estimate is lower that the 2017 estimate of 293,000 people that age.
[9] Mental Health America, "Parity or Disparity: The State of Mental Health in America", *The National Survey of Children's Health* (2015), https://www.mhanational.org/sites/default/files/Parity%20or%20Disparity%202015%20Report.pdf.
[10] Mental Health America, "The State of Mental Health in America 2020," last accessed September 26, 2019, https://mhanational.org/issues/state-mental-health-america.
[11] "Youth Risk Behavior Surveillance System (YRBSS)," Centers for Disease Control and Prevention (CDC), last modified August 22, 2018, https://www.cdc.gov/healthyyouth/data/yrbs/index.htm. The YRBS is a self-administered survey provided to students in grades 9-12. The 2015 and 2017 YRBS results in Illinois had a response rate of at least 60% and are therefore considered weighted, or representative of all public school students in Illinois in grades 9-12.
[12] "Youth Risk Behavior Surveillance System (YRBSS)," CDC.
[13] "Leading Causes of Death of Age Group, Illinois Residents, 2018", Illinois Department of Public Health, accessed September 2019, http://www.dph.illinois.gov/sites/default/files/Leading%20causes%20by%20age%202018.pdf.
[14] "High School YRBS", Illinois 2017 Results, Centers for Disease Control and Prevention, accessed September 2019, https://nccd.cdc.gov/youthonline/App/Results.aspx?LID=IL.
[15] "More Detailed Death Statistics", Illinois Department of Public Health, last modified on August, 19, 2019, http://www.dph.illinois.gov/data-statistics/vital-statistics/death-statistics/more-statistics.
[16] Illinois Statewide Epidemiological Outcomes Workgroup, "An Epidemiological Profile of Prescription Drug and Opioid Use in Illinois", (November 2017), https://www.dhs.state.il.us/OneNetLibrary/27896/documents/IllinoisPrescriptionDrugEpidemiologicalProfile(Final).pdf.
[17] Illinois Statewide Epidemiological Outcomes Workgroup, "An Epidemiological Profile of Prescription Drug and Opioid Use in Illinois",4.
[18] Illinois Statewide Epidemiological Outcomes Workgroup, "An Epidemiological Profile of Prescription Drug and Opioid Use in Illinois", 41. Figure 49 is based on 2015 IL YRBS data.
[19] However, it should be noted that the 2017 report used a slightly different diagnostic criteria (Youth Dependence or Abuse of Illicit Drugs or Alcohol in the Past Year).

[20] National Institute of Drug Abuse, "Teens and E-cigarettes." Last modified February 2016. https://www.drugabuse.gov/related-topics/trends-statistics/infographics/teens-e-cigarettes.
[21] Centers for Disease Control and Prevention, "Quick Facts on the Risks of E-cigarettes for Kids, Teens, and Young Adults." Last modified March 11, 2019. https://www.cdc.gov/tobacco/basic_information/e-cigarettes/Quick-Facts-on-the-Risks-of-E-cigarettes-for-Kids-Teens-and-Young-Adults.html.
[22] Sheila Kaplan, and Matt Richtel, "The Mysterious Vaping Illness That's 'Becoming an Epidemic," *The New York Times*. August 31, 2019. https://www.nytimes.com/2019/08/31/health/vaping-marijuana-ecigarettes-sickness.html.
[23] "America's outbreak of vaping illness and its most vulnerable – teens," Chicago Tribune, August 23, 2019. http://digitaledition.chicagotribune.com/infinity/article_share.aspx?guid=60aba57c-1408-4b1a-89b3-0f5e9aa6ea55
[24] Illinois Department of Public Health, "E-cigarettes and Vapes."Accessed September 2019. http://www.dph.illinois.gov/topics-services/prevention-wellness/tobacco/e-cigarettes-and-vapes.
[25] This includes e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, ehookahs, and hookah pens.
[26] Center for Disease Control and Prevention, "Illinois 2017 Results." High School YRBS. Accessed September 2019. https://nccd.cdc.gov/youthonline/app/Results.aspx?LID=IL. The question- **Ever Used Inhalants** included the explanation "(sniffed glue, breathed the contents of aerosol spray cans, or inhaled any paints or sprays to get high, one or more times during their life)".
[27] Illinois Department of Public Health." 010219 Opioid Semiannual Report". January 2019, 2. https://nccd.cdc.gov/youthonline/app/Results.aspx?LID=IL.,"Opioid overdose deaths are considered a subset of drug overdose deaths in which any opioid drug was reported as a contributing cause of death (ICD-10 codes T40.0, T40.1, T40.2, T40.3, T40.4, and T40.6). IDPH reports opioid overdose deaths in three categories: any opioid, heroin, and opioid analgesics. The opioid analgesic category includes drug overdose deaths in which any opioid analgesic was reported as a contributing cause of death (ICD-10 codes T40.2, T40.3, and T40.4). Opioid analgesics include natural (e.g. morphine and codeine) and semi-synthetic opioid analgesics (e.g. oxycodone, hydrocodone, hydromorphone, Oxymorphone), methadone, and synthetic opioid analgesics other than methadone (e.g. fentanyl and tramadol). IDPH does not collect data related to the legality of manufacturing or obtaining opioids used in any given opioid analgesic overdose death."
[28] Illinois Department of Public Health, "Drug Overdose by Sex, Age Group, Race/Ethnicity and County, Illinois Residents, 2013-2016." Last modified since September 5, 2017. http://www.dph.illinois.gov/sites/default/files/publications/Drug-Overdose-Deaths-September2017.pdf.
[29] "Seven Core Content Areas of Childhood Trauma for Professional Development," Illinois Childhood Trauma Coalition Workforce Development Committee (2019), forthcoming.
[30] Baldo, Paola and Kolnik, Jaclyn Houston, "Child and Youth Exposure to Violence in Illinois."ICJIA, March 18, 2019. http://icjia.state.il.us/articles/child-and-youth-exposure-to-violence-in-illinois. http://icjia.state.il.us/articles/child-and-youth-exposure-to-violence-in-illinois.
[31] Baldo and Kolnik, "Child and Youth Exposure to Violence in Illinois."
[32] Illinois Department of Public Health, "Leading Causes of Death of Age Group, Illinois Residents, 2018."
[33] Illinois Department of Public Health, "More Detailed Death Statistics."
[34] Giffords Law Center, "Gun Violence Statistics." Accessed September 2019. https://lawcenter.giffords.org/facts/gun-violence-statistics/.
[35] Stanley Manne Children's Research Institute, "Adolescent Firearm Homicide in Chicago 2013-2017: Young Black Males at High Risk." Accessed September 2019. https://www.luriechildrens.org/globalassets/documents/luriechildrens.org/research/research-areas/research-programs/smith-child-health-research-program/2019-ivdrs-adolescent-firearm-homocide-chicago-2013-2017.pdf
[36] Though the Federal Government plays a major role in funding services for children, that funding will not be reviewed in detail in this report.
[37] American Bar Association, "Family Separation and Detention." Accessed September 2019. https://www.americanbar.org/advocacy/governmental_legislative_work/priorities_policy/immigration/familyseparation/
[38] Bogado, Aura. "Here's a map of shelters where immigrant children have been housed," *Reveal,* June 26, 2018. https://www.revealnews.org/article/heres-a-map-of-shelters-where-immigrant-children-have-been-housed/.
[39] Cohen, Jodi S., Duaa Eldeib, and Melissa Sanchez. "Immigrant Children Sent to Chicago Shelters Are Traumatized and Sick, In Some Instances With Chicken Pox or Tuberculosis." *ProPublic Illinois*, July 11,

2019. https://www.propublica.org/article/heartland-chicago-shelters-immigrant-children-sick-traumatized.
[40] Chiedi, Joanne. "Care Provider Facilities Described Challenges Addressing Mental Health Needs of Children in HHS Custody." *U.S. Department of Health and Human Services*, *Office of Inspector General* (September 2019). https://oig.hhs.gov/oei/reports/oei-09-18-00431.pdf.
[41] Chiedi, "Care Provider Facilities Described Challenges Addressing Mental Health Needs of Children in HHS Custody," 9-14.
[42] U.S. Citizenship and Immigration Services, Department of Homeland Security; Inadmissibility on Public Charge Grounds, 84 Fed. Reg. 41,292 (Aug. 12, 2019), https://www.federalregister.gov/documents/2019/08/14/2019-17142/inadmissibility-on-public-charge-grounds.
[43] Allison Bovell-Ammon et al., "Trends in Food Insecurity and SNAP Participation Among Immigrant Families of U.S.-Born Young Children," *Children* 2019, 6, 55 (April 4, 2019), https://doi:10.3390/children6040055.
[44] Hamutal Bernstein et al., "One in Seven Adults in Immigrant Families Reported Avoiding Public Benefit Programs in 2018," *Urban Institute* (May 2019), https://www.urban.org/sites/default/files/publication/100270/one_in_seven_adults_in_immigrant_families_reported_avoiding_publi_7.pdf.
[45] Maria Ines Zamudio, "Illinois Joins Legal Fight Opposing Trump Administration's Public Charge Rule," *WBEZ Chicago* (August 16, 2019), https://www.npr.org/local/309/2019/08/16/751572773/illinois-joins-legal-fight-opposing-trump-administration-s-public-charge-rules.
[46] "The Trump Administration's Public Charge Rule Could Impact 1 Million People in the Prairie State," *Protecting Immigrant Families* (August 2019), https://www.clasp.org/sites/default/files/IL%20PIF%20State%20Fact%20Sheet_08.15.2019_0.pdf.
[47] Abutaleb, Yasmeen and William Wan. "After Trump Blames Mental Illness for Mass Shootings, health agencies ordered to hold all posts on issue." *The Washington Post*, August 2019. https://www.washingtonpost.com/health/after-trump-blames-mental-illness-for-mass-shootings-health-agencies-ordered-to-hold-all-posts-on-issue/2019/08/20/c4030e4c-c370-11e9-b5e4-54aa56d5b7ce_story.html
[48] American Psychological Association. "Statement of APA President in Response to Mass Shootings in Texas, Ohio," Last Modified August 4, 2019, https://www.apa.org/news/press/releases/2019/08/statement-shootings.
[49] Several state, local, and private organizations are attempting to address gun violence, particularly in Chicago. Groups include IDPH; The Illinois Criminal Justice Information Authority (ICJIA); the Chicago Department of Public Health Office of Violence Prevention; the Chicago HEAL Initiative; and Strengthening Chicago's Youth (SCY).
[50] Illinois Department of Healthcare and Family Services. "Number of Persons Enrolled in the Entire State." Last accessed on September 2019. https://www.illinois.gov/hfs/info/factsfigures/Program%20Enrollment/Pages/Statewide.aspx
[51] Note that there is the age discrepancy in defining "children" here, with the U.S. defining a child as "under 18," but Illinois defining a child as "under 19."
[52] Illinois Department of Healthcare and Family Services. "Community-Based Behavioral Services (CBS) Provider Handbook. Last modified October 1, 2018. https://www.illinios.gov/hfs/SiteCollectionDocuments/102218CommunityBasedBehavioralServicesHandbook.pdf.
[53] ILL. ADMIN. CODE tit 89, §139(a) and (b) (2019), http://www.ilga.gov/commission/jcar/admincode/089/08900139sections.html. See also "Family Support Program," *Illinois Department of Healthcare and Family Services*, last accessed September 26, 2019, https://www.illinois.gov/hfs/MedicalProviders/behavioral/Pages/icg.aspx.
[54] The Individual Care Grant (ICG) program was established in 1969 to provide services to children with severe mental illness and to aid them in obtaining the appropriate level of treatment services (residential or in-home/community). These are typically services not provided by usual sources such as insurance. All Illinois families are eligible for grants based on clinical needs of the child and not on income or resources. Traditionally, the program worked closely with families, schools, residential providers, and community providers to assure that a child with severe mental illness was receiving all appropriate services. The Illinois Department of Human Services, Division of Mental Health (DMH) administered the ICG program until 2016 when responsibility was transferred to the Illinois Department of Healthcare and Family Services (HFS). The number of youth served has varied over time, peaking at

570 in 2007, but then declining under DMH to 160 in 2015.
[55] Some families are concerned that the program has become too bureaucratic with frequent and complicated Reauthorization Applications required of families. Additionally, concerns include the increase in use of residential treatment: 80% of youth served are now in residential treatment, while in the past it was under 50%. Increased efforts should be made to provide the intensive community services needed to support more of these youth in their home and community.
[56] The ICG/FSP program now includes the Specialized Family Support Program (SFSP), which can provide immediate services for youth and families in crisis such as impending discharge and threatened safety in the home. The SFSP program served 42 youth in 2019.
[57] "SFY2019 Total Costs and Count of Children Utilizing Behavioral Health Services," Illinois Department of Healthcare and Family Services, data pulled as of 09/26/2019, email to ICMHP. Behavioral Health Services Include both Mental Health and SUD Primary Diagnosis and data is aggregated based on the date the service was incurred. Additionally, children are defined as less than the age of 19.
[58] HFS notes that this "Includes both Inpatient and Outpatient but Excludes any psychiatric Inpatient stays."
[59] HFS notes "LEA- Services provided through the Local Education Agencies."
[60] "Integrated Health Homes," *Illinois Department of Healthcare and Family Services*, last modified August 10, 2018, https://www.illinois.gov/hfs/SiteCollectionDocuments/FinalHHTownHallforposting.pdf., In 2018, through the HHS Transformation, HFS began the process to develop and implement a care coordination model: the Integrated Health Home (IHH) program is a new, fully-integrated form of care coordination for all members of the Illinois Medicaid population. Each member in the Medicaid population will be linked to an Integrated Health Home provider based on their level of need and the provider's ability to meet those needs. The Integrated Health Home will be responsible for care coordination for members across their physical, behavioral, and social care needs. In August 2019, HFS released their final plan to implement the IHH model statewide, including details on administration, provider requirements, and quality. The IHH will be administered and monitored by the Managed Care Organizations (MCOs), with overall oversight provided by HFS.
[61] Kimberly A. Mann, email to ICMHP, August 9, 2019. "We bring the voices of Illinois children and families to the forefront, building trusting relationships that empower those we serve. When it comes to children's mental health, DCFS Director Marc Smith reinforces our focus to provide timely and effective trauma-informed care."
[62] DCFS notes: "(1) Expenditure data is preliminary, and is subject to change. (2) Institution & Group Home Expenditures exclude Medicaid Mental Health services. CYCIS Placement Data as of: 8/5/2019. MARS Payment Data as of: 8/5/2019."
[63] Children and Family Research Center, "The 2017 Illinois Child Well-Being Study Final Report," Last modified April 2019, https://cfrc.illinois.edu/pubs/rp_20190619_2017IllinoisChildWell-BeingStudy.pdf. The study involved a representative, statewide sample of 700 children and youth in DCFS care in October 2017.
[64] Children and Family Research Center, "The 2017 Illinois Child Well-Being Study Final Report." These were the top three services utilized among the statewide sample aged 2-17 with and without specific mental health needs identified.
[65] Mann, email to ICMHP. Whether children or adults experience mental health disorders, the impact on family functioning and wellbeing can be devastating without adequate care, support, and treatment. Children and youth in child welfare systems are disproportionately more likely to have mental health disorders than the general population, and needs for mental health treatment not equitably treated. Racial and ethnic minorities, children and youth from low-income families, homeless children and youth, and individuals living in rural communities are disproportionately less likely to receive mental health and other services which may substantially mitigate risk of child welfare involvement.
[66] Mann, email to ICMHP. States must submit a Prevention Plan to the Children's Bureau delineating the services, target populations, intended outcomes, and evaluation plan.
[67] Mann, email to ICMHP. Unlike many federally-funded programs, candidates identified at "imminent risk" of coming into care do not have to meet any family income criteria. States choose evidence-based interventions tailored to the needs of its population and based on evidence ratings by the Title IV-E Clearinghouse (https://preventionservices.abtsites.com/). The Title IV-E Clearinghouse classifies programs and practices as "Well Supported", "Supported", or "Promising" based on the evidence. At least 50% of the state's funded prevention services must be classified as "Well Supported" by evidence. The federal reimbursement of prevention services will be 50% through 2025, and then at the

Federal Medial Assistance Percentage (FMAP) rate. Administration and training costs are reimbursable at 50%. Illinois is in the process of determining the evidence-based services to be offered as part of Family First prevention programming.

[68] Mann, email to ICMHP. The waiver program is designed to increase and accelerate reunifications and other family permanency and safety outcomes for foster children from alcohol and drug-involved families. The program provides assessment and referral service and utilizes Recovery Coaches to assist birth parents with obtaining treatment and negotiating drug recovery and concurrent permanency planning. Thus far, children of parents in the demonstration group receiving Recovery Coach services were more likely to be reunified with their parents and these children were reunited more quickly. This waiver demonstration has generated approximately $8,825,816 in savings for the State of Illinois.

[69] Mann, email to ICMHP. The Intensive Placement Stabilization Services (IPS) program is a community-based system of care that provides an array of critical, intensive, in-home therapeutic interventions. The clients for the IPS program are children and youth with trauma reactions, emotional and behavioral problems, and who are at risk of losing their current placement/living situations and their families. FY19 Placement Stability Outcomes include that 65% of clients did not move during services and 69.2% did not move within 6 months of services ending; and for youth "stepping down" from residential, group homes, or psychiatric hospitalization, 57.1% did not move during services and 59.7% did not move within 6 months of services ending.

[70] Mann, email to ICMHP. The Illinois Birth Thru Three (IB3) project supports the adaptation of evidence-based, trauma-informed parenting programs to assist birth parents and substitute caregivers in addressing the adverse effects of maltreatment on child well-being and in promoting secure attachment relationships that can improve safety and permanency outcomes. Children within the intervention group are 7.3% more likely to achieve family unification and over five years, it is estimated that the cumulative costs savings is $1,645,681. The DCFS Early Childhood Project is a collaboration with the Erikson Institute and operates statewide. The program identifies the needs of at-risk young children though developmental screenings, referrals, and consultation provided to youth in care ages birth to five, and children involved with DCFS Intact families ages birth to three. In FY19, the program served 4,253 children.

[71] Mann, email to ICMHP. Dually involved youth are individuals that are simultaneously involved in the child welfare system and the criminal justice system. The State of Illinois' dually-involved population is one of the most difficult populations in which to achieve permanency, with these youth more likely to sequentially become stuck in state care, ultimately age out, and eventually end up in or dependent on another state system. As of July 2019 for the calendar year, there were 155 youth incarcerated or in detention and 945 having contact with law enforcement. Two programs intended to address this population are Conscience Community Network (CCN)- a network of five social services providers, that pilot wraparound care coordination and other evidence-based services with the dually involved youth. More than half (61%) of the CCN program participants avoided placement in highly restrictive settings, compared to a baseline average of 35%. Regenerations Program- Since 2015, DCFS has implemented a pilot program that provides wraparound and youth advocacy services to dually-involved youth detained at the Cook County Juvenile Temporary Detention Center (JTDC) who are on the Release upon Request (RUR) list for DCFS care. The goal is to shorten the release from detention; increase placements and placement length of stay in family or family-like settings; strengthen youth wellbeing outcomes; and reduce recidivism. An evaluation found that Regenerations youth were held in JTDC for fewer days, were more likely to be released to family or family-like settings (and less likely to be released to residential care or shelter care), and had shorter stays in residential care. Unfortunately, these youth also remained in family or family-based settings for a shorter number of days and did not show lower rates of recidivism. Thus, the dually involved youth remain a major challenge for the child system.

[72] "Medicaid/Health Plan for Youth in Care," Illinois Department of Children and Family Services, last accessed September 26, 2019, https://www2.illinois.gov/dcfs/brighterfutures/healthy/Medicaid/Pages/HealthPlan.aspx.

[73] "Annual Report 2018," *Illinois Department of Juvenile Justice*, last accessed September 26, 2019, https://www2.illinois.gov/idjj/SiteAssests/Pages/Data-and-Reports/IDJJ%20Annual%20Report%202018.pdf.

[74] "2015 Annual Report," *Illinois Department of Juvenile Justice,* January 2016. https://www2.illinois.gov/idjj/Documents/IDJJ%20Annual%20Report%2001-04-16%20FINAL.pdf.

[75] Office of Juvenile Justice and Delinquency Prevention, "Intersection between Mental Health and the

Juvenile Justice System," July 2017, https://www.ojjdp.gov/mpg/litreviews/Intersection-Mental-Health-Juvenile-Justice.pdf.
[76] "Monthly Report December 2015," *Illinois Department of Juvenile Justice*, December 2015, https://www2.illinois.gov/idjj/Documents/Public%20Monthly%20Report%20December%202015.pdf.
[77] "Monthly Report December 2016," *Illinois Department of Juvenile Justice*, December 2016, https://www2.illinois.gov/idjj/SiteAssets/Pages/Data-and-Reports/December%202016.pdf.
[78] "Monthly Report December 2017," *Illinois Department of Juvenile Justice,* December 2017, https://www2.illinois.gov/idjj/SiteAssets/Pages/Data-and-Reports/Public%20Monthly%Report%20-20%December%202017.pdf.
[79]. "Monthly Report 2018," *Illinois Department of Juvenile Justice*, December 2018. https://www2.illinois.gov/idjj/SiteAssets/Pages/Data-and-Reports/Public%20Monthly%20Report%20-%20December%202018.pdf.
[80] Jennifer Jaworski, email to ICMHP, September 5, 2019.
[81] "About IDHS," *Illinois Department of Human Services*, last accessed September 26, 2019, https://www.dhs.state.il.us/page.aspx?item=27897
[82] Illinois Department of Human Services Division of Mental Health. "FY 2018 Community Mental Health Services Block Grant Implementation Report," September 1, 2017, 28, https://www.dhs.state.il.us/OneNetLibrary/27897/documents/Mental%20Health/BlockGrant/01042019-FY2018-GrantBlockImplementationReport.pdf.
[83] "FY19 Child and Adolescent Consumers by Service Type," Illinois Department of Human Services Division of Mental Health Business Analytics Unit, data pulled as of 09/15/2019, Lisa Betz, email to ICMHP, September 23, 2019. DMH notes "This is only for Community Mental Health Center Fee-for-Service claims that have been adjudicated by the Department of Healthcare and Family Services. Counts only reflect the claims processed through September 15, 2019. Community Mental Health Centers have 180 days from the data of service to submit claims."
[84] Betz, email to ICMHP. DMH notes "The counts can't be summarized because they are unduplicated by service type."
[85] ILL. ADMIN. CODE tit 59, §132.25 (2019).
[86] "Illinois Interagency Council on Early Intervention (IICCEI) Overview & How to Apply," *Illinois Department of Human Services*, last accessed September 26, 2019, https://www.dhs.state.il.us/page.aspx?item=117789.
[87] "Chapter 9 – Early Intervention Eligibility Criteria, Evaluation and Assessment," *Illinois Department of Human Services*, last accessed September 26, 2019. https://www.dhs.state.il.us/page.aspx?item=96963. To be eligible for services, children either are: 1) experiencing a 30% delay in one or more of the following areas: cognitive, physical, social-emotional, communication, or adaptive; or 2) experiencing a medically diagnosed physical or mental condition that typically results in developmental delay, like Down syndrome, cerebral palsy, or Rett syndrome; or 3) at risk of substantial developmental delay because the child is experiencing: (a) a parent who has been medically diagnosed as having a mental illness or serious emotional disorder or developmental disability; or (b) three or more of the following: (i) current alcohol or substance abuse by the primary caregiver, (ii) primary caregiver who is currently less than 15 years of age, (iii) current homelessness of the child, (iv) chronic illness of the primary caregiver, (v) alcohol or substance abuse by the mother during pregnancy with the child, (vi) primary caregiver with a level of education less to or less than the 10th grade, unless that level is appropriate to the primary caregiver's age; or (c) an indicated case of abuse or neglect regarding the child, and the child has not been removed from the abusive or neglectful situation.
[88] "Early Intervention Program Services," *Illinois Early Intervention Clearinghouse*, last accessed September 2019, https://eiclearninghouse.org/getting-started/ei-program-services/.
[89] "Child Count (FFY18/SFY19)," *Illinois Department of Human Services*, aast accessed September 26, 2019, https://www.dhs.state.il.us/page.aspx?item=117492.
[90] "Comprehensive Community-Based Youth Services (CCBYS)," *Illinois Department of Human Services*, last accessed September 26, 2019, https://www.dhs.state.il.us/page.aspx?item=31868.
[91] *Illinois Department of Human Services*, "Comprehensive Community-Based Youth Services (CCBYS)."
[92] "2018 Annual Report," *Illinois State Board of Education*, January 2019, https://www.isbe.net/Documents/2018-Annual-Report.pdf.
[93] *Illinois State Board of Education*, "2018 Annual Report," 48.
[94] Illinois State Board of Education, Public Inquiry Team, "Final Report of Public Inquiry," April 18, 2018, https://www.isbe.net/Documents/Public_Inquiry_Final_Report.pdf. These numbers are also likely caused, in part, by widespread concerns around the failure to provide special education services by

Chicago Public Schools (CPS) from 2016 to 2018. In 2018, ISBE conducted a Public Inquiry into CPS special education procedures and systems and found that CPS systemically denied and delayed special education services to its students. See also Illinois State Board of Education, "Corrective Action and Recommendations Stemming from the Public Inquiry into Special Education Policies at Chicago Public Schools," May 16, 2018, 4, https://www.isbe.net/Documents/Corrective-Action-Report.pdf. As a result of this Public Inquiry, ISBE appointed a Special Monitor to oversee and ensure CPS complies with the corrective action plans determined by ISBE for a minimum of three school years starting with the 2018-2019 school year.

[95] "About IDPH," *Illinois Department of Public Health*, last accessed September 2019, https://www.dph.illinois.gov/about-idph.

[96] Illinois Department of Public Health, "Illinois Suicide Prevention Strategic Plan," January 2019, https://www.sprc.org/sites/default/files/011519ohpm-suicide-prevention-plan-2018-2021.pdf.

[97] Illinois Department of Public Health, "Illinois Suicide Prevention Strategic Plan," 7.

[98] Illinois Department of Public Health, "About IDPH."

[99] Illinois Department of Public Health, "Illinois Suicide Prevention Strategic Plan," 9.

[100] Illinois Department of Public Health, "Maternal and Child Health Services Title V Block Grant, Illinois, FY2020 Application/FY2018 Annual Report," July 15, 2019, 50-51, http://www.dph.illinois.gov/sites/default/files/publications/OWHFS%20FY20%20Application%20FY18%20Report%20Title%20V.pdf.

[101] This innovative pilot will be one of few examples of mental health consultation in public health programs, building on research that suggests WIC, one of the most successful nutrition assistance programs in the country, is an important gateway for many families to mental health services. See Susanne Klawetter, "Warm Connections: An Integrated Behavioral Health Intervention Development Study," *University of Denver Electronic Theses and Dissertations* (2017)l 1306, https://digitalcommons.du.edu/etd/1306.

[102] Chapin Hall at the University of Chicago is evaluating the pilot to look at the impact of mental health consultation on public health programs. The grant term includes one year of pilot implementation and then a final year to complete sustainability activities and complete the evaluation activities. The project will end with a final evaluation report and a model protocol to outline resources, implementation best practices, and proposed action plans to be used by other public health programs.

[103] "About the Authority," *Illinois Criminal Justice and Information Authority*, last accessed September 26, 2019, https://icjia.state.il.us/about/overview.

[104] Megan Alderden and Jaclyn Houston Kolnik, "Ad Hoc Victim Services Committee Research Report," *ICJIA*, January 31, 2017, https://www.icjia.state.il.us/articles/ad-hoc-victim-services-committee-research-report.

[105] Lily Gleicher, "Behavioral and Public Health Perspectives on Violence Prevention: A Survey of Illinois Practitioners," *Illinois Criminal Justice Information Authority Center for Justice Research and Evaluation*, January 15, 2019, http://www.icjia.state.il.us/assets/articles/Final%20Practitioner%20Survey%20Article_7-18-2019_V2.pdf., The survey has several limitations, including a small sample size that only incorporated seven community mental health centers out of more than 160 in Illinois. Additionally, the largest percentages of respondents served clients in two urban settings.

[106] Gleicher, "Behavioral and Public Health Perspectives on Violence Prevention: A Survey of Illinois Practitioners."

[107] Community Mental Health Act, 405 ILL. COMP. STAT. 20. The Illinois General Assembly approved in 1963 House Bill 708, creating the Illinois Community Mental Health Act. The act, which provided for the levy of a local tax on property pursuant to approval of a referendum, mandated the appointment of a local mental health board to plan, fund, and monitor services for people with mental illnesses and developmental disabilities and people with substance abuse issues.

[108] "Who We Are," *Association of Community Mental Health Authorities of Illinois*, last modified 2017, http://acmhai.org/who-we-are/. Out of 102 counties in Illinois, 71 counties have a 708 board.

[109] Association of Community Mental Health Authorities of Illinois, "Who We Are."

[110] McHenry County Mental Health Board, "Child and Adolescent Psychiatric Services," *Smart Policy Works*, June 2017, https://www.mchenrycountyil.gov/home/showdocument?id=75763.

[111] McHenry County Mental Health Board, "Child and Adolescent Psychiatric Services," 7.

[112] McHenry County Mental Health Board, "Child and Adolescent Psychiatric Services," 17.

[113] McHenry County Mental Health Board, "Child and Adolescent Psychiatric Services," 21.

[114] McHenry County Mental Health Board, "Child and Adolescent Psychiatric Services," 16.

[115] McHenry County Mental Health Board, "Child and Adolescent Psychiatric Services," 19.
[116] McHenry County Mental Health Board, "Child and Adolescent Psychiatric Services," 5. "Data makes clear that the development of one specific type of service cannot alone address the behavioral health and substance abuse needs of children and adolescents in McHenry County. As such, while we agree that a lack of inpatient beds demonstrates a clear gap in the service continuum, SPW believes that strengthening wrap around services, that is services on the less intensive end of the spectrum, will help prevent newly evident mental health incidents from escalating to crisis level, which obviates some of the need for a child and adolescent psychiatrist or local inpatient facilities… It is our recommendation, based on the Board's input, that the Mental Health Board focus funding and resources on three main areas: Day Programs, School-based programs, and transportation."
[117] Vermillion County Illinois, "Vermillion County Mental Health 708 Board," December 1, 2015 -November 30, 2016, 29, https://www.vercounty.org/Mental%20Health/47th%20Annual%20Report.pdf.
[118] Vermillion County Illinois, "Vermillion County Mental Health 708 Board." "The County has a process in place to help when families are struggling with children with emotional and behavioral issues. Many of the children involved in this planning process have either been referred to the juvenile justice system, the child welfare system, have been frequently hospitalized, are being considered for residential placement, or are in the process of 'stepping down' from residential treatment and need a very intensive, coordinated service plan to insure that all local and community resources are available to the child and family."
[119] Vermillion County Illinois, "Vermillion County Mental Health 708 Board," 40-41.
[120] "Report on Kankakee County Child Mental Health System: A Class Project by Students in the Fall 2017 Social Work Practice III Class", Olivet Nazarene University, Bourbonnais, Illinois, December 13, 2017.
[121] "Report on Kankakee County Child Mental Health System", 57.
[122] "Report on Kankakee County Child Mental Health System", 95.
[123] "Durbin and Davis Announce Bipartisan Legislation to Address Childhood Trauma, Reduce Violence," May 28, 2019, https://www.durbin.senate.gov/newsroom/press-releases/durbin-and-davis-announce-bipartisan-legislation-to-address-childhood-trauma-reduce-violence.
[124] "N.B. Consent Decree," *Illinois Department of Healthcare and Family Services,* last accessed September 26, 2019, https://www.illinois.gov/hfs/info/legal/Pages/NBConsentDecree.aspx.
[125] ACLU of Illinois, "B.H. v. Smith," last accessed September 26, 2019. https://www.aclu-il.org/en/cases/bh-v-sheldon.
[126] ACLU of Illinois, "ACLU Testimony on Safety in Illinois Juvenile Justice Facilities," December 5, 2017, https://www.aclu-il.org/en/news/aclu-testimony-safety-illinois-juvenile-justice-facilities.
[127] Wit v. United Behavioral Health, Case No. 14-cv-02346-JCS (N.D. Cal. Feb. 28, 2019), https://www.courtlistener.com/recap/gov.uscourts.cand.277588/gov.uscourts.cand.277588.418.0.pdf.
[128] The Kennedy Forum, "Landmark Decision: UnitedHealthcare Used Defective Criteria to Reject Coverage for Mental Health and Addiction Treatment Services, Federal Court Finds," March 5, 2019, https://www.thekennedyforum.org/landmark-decision-unitedhealthcare-used-defective-criteria-to-reject-coverage-for-mental-health-and-addiction-treatment-services-federal-court-finds/.
[129] The Kennedy Forum, "Landmark Decision: UnitedHealthcare Used Defective Criteria to Reject Coverage for Mental Health and Addiction Treatment Services, Federal Court Finds."
[130] Illinois Children's Mental Health Partnership, "FY2017 Annual Report To The Governor," http://icmhp.org/wordpress/wp-content/uploads/2018/02/ICMHP-Annual-Report-FY2017-.pdf.
[131] Historically, mental health consultation has not been consistently provided to children and families beyond crisis points. This reactive support can lead to higher costs of services and increased likelihood of residual impact and negative outcomes for the child's development and family stability. The Illinois I/ECMHC universal model is an innovative approach to prevention and early intervention through consistent and regular mental health consultation before, during, and beyond crisis points.
[132] The goal of the Illinois I/ECMHC universal model is to build the capacity of non-mental health early childhood providers across systems to be better prepared to address the mental health needs of children and families. As a result of the mental health consultation, non-mental health providers are able to provide consistent higher quality services and early intervention supports to pregnant women, young children, and families in order to avoid or reduce crises and to be better prepared to address mental health needs of children and families in crisis.
[133] Illinois Children's Healthcare Foundation, https://ilchf.org.
[134] ILCHF, "Accomplishments and Lessons Learned: Children's Mental Health Initiative, Building Systems of Care, Community by Community," December 2018, https://ilchf.org/wp-content/uploads/2018/12/CMHI1.0FinalReport.pdf.

[135] ILCHF, "Accomplishments and Lessons Learned: Children's Mental Health Initiative, Building Systems of Care, Community by Community." The four communities chosen for CMHI 1.0 were: Adams County Children's Mental Health Partnership, serving Adams county; Community That Cares, serving Carroll, Lee, Ogle, and Whiteside counties; Livingston County Children's Network, serving Livingston county; and the Children's MOSAIC Project, serving the City of Springfield. The four communities chosen for CMHI 2.0 are: Centerstone, serving Perry, Franklin, Jackson, and Williamson counties; Community Foundation of Kankakee River Valley, serving Kankakee county; Heritage Behavioral Health, serving Macon and De Witt counties; Kane County Health Department, serving Kane county; and the Primo Center, serving homeless youth and families in Chicago. These four communities have been matched to one of the four CMHI 1.0 communities to provide mentoring as they begin their system development.
[136] ILCHF, "Accomplishments and Lessons Learned: Children's Mental Health Initiative, Building Systems of Care, Community by Community." Three particularly notable accomplishments can serve as models for additional Illinois communities that wish to improve their children's mental health systems. First, the Adams County Children's Mental Health Partnership (AACMHP) was effective in incorporating universal mental health screenings into their system of care through the Quincy Public Schools District. All children and families are now offered a mental health screening during school registration. Next, in Livingston County, the development of their system of care saw the number of juvenile police reports and the caseload levels of youth on probation decrease by approximately half over the course the project. Finally, Livingston County was successful in the development and implementation of a universal consent form to release information shared among all child-serving systems.
[137] "About Social Determinants of Health," *World Health Organization*, last accessed September 26, 2019, https://www.who.int/social_determinants/sdh_definition/en/., According to the World Health Organization (WHO), "the social determinants of health are the conditions in which people are born, grow, live, work and age" and are "mostly responsible for health inequities."
[138] National Center for Medical Legal Partnership, "How Legal Services Help the Health Care System Address Social Needs," January 2015, https://medical-legalpartnership.org/response/i-help/.
[139] "Formative Evaluation of a Medical-Legal Partnership on the Westside of Chicago," National Institute of Justice, last modified September 29, 2018, https://nij.ojp.gov/funding/awards/2018-v3-gx-0002.
[140] "You're Invited: Trauma-Informed Chicago Summit," *City of Chicago Department of Public Health*, last accessed September 26, 2019, https://www.chicago.gov/city/en/depts/cdph/provdrs/healthy_living/alerts/2019/august/you-re-invited--trauma-informed-chicago-summit.html.
[141] "Violence Prevention," *City of Chicago Department of Public Health*, last accessed September 26, 2019, https://www.chicago.gov/city/en/depts/cdph/provdrs/violence_prev.html.
[142] "Illinois ACEs Response Collaborative," *Health and Medicine Policy Research Group*, last accessed September 26, 2019, http://www.hmprg.org/programs/illinois-aces-response-collaborative/.
[143] "Center for Childhood Resilience," *Ann & Robert H. Lurie Children's Hospital of Chicago*, last accessed September 26, 2019, https://www.luriechildrens.org/en/specialties-conditions/center-for-childhood-resilience/.
[144] *Communities United*, https://communitiesunited.org.
[145] *Illinois Collaboration on Youth*, https://www.icoyouth.org.
[146] *National Louis University*, https://www.nl.edu.
[147] *Strengthening Chicago's Youth*, https://www.scy-chicago.org.
[148] *Voices of Youth in Chicago Education,* http://voyceproject.org.
[149] *Illinois Childhood Trauma Coalition*, *h*ttp://lookthroughtheireyes.org/ictc-coalition/. See also See Center for Childhood Resilience, Illinois Childhood Trauma Coalition, and National Immigrant Justice Center, "You Are Not Alone: Supporting Dreamers and Families of Undocumented Status," accessed September 2019, https://www.chicago.gov/content/dam/city/depts/mayor/Office%20of%20New%20Americans/PDFs/You_Are_Not_Alone.pdf and "Supporting Immigrant and Refugee Children," Illinois Childhood Trauma Coalition Refugee and Immigrant Committee (2019), http://ilheadstart.org/wp-content/uploads/2019/04/ImmRefFamGuide_3fold_FINAL.pdf.
[150] *Wisdom Exchange,* https://wisdomexchange.wordpress.com
[151] Megan Alderden, et al., "Illinois Helping Everyone Access Linked Systems Action Plan." *ICJIA*, July 1, 2019, http://www.icjia.state.il.us/articles/illinois-helping-everyone-access-linked-systems-action-plan.
[152] Alderden, "Illinois Helping Everyone Access Linked Systems Action Plan." Across the planning activities, a common theme emerged. While identification, referral, and support are core to creating strong linkages, stakeholders and victims discussed relationships as essential for these three

components to function in a meaningful way. Victims emphasized that a meaningful response is centered in relationships founded on trust and respect. Providers discussed how relationships with systems and agencies built upon accountability and resource sharing were crucial to comprehensively serving clients whose needs often extended beyond their own capacity. Viewing these essential components through the lens of relationship, strong linkages involve recognizing victimization has occurred and assessing its impact, connecting victims to needed resources, and providing services that meaningfully engage victims and their families.

[153] "Advocacy," *Center for Childhood Resilience*, last accessed September 26, 2019, https://childhoodresilience.org/advocacy.

[154] We also know that DHS/DMH funded community mental health services for 10,843 youth. DJJ estimated that over 94% of its youth had at least one mental health diagnosis and the department offered an array of services, including over 45% of the youth receiving psychotropic medications. Assuming every DJJ youth with a diagnosis received some service, that would include over 800 children. DCFS estimates that 60% of its youth received some mental health service, which would mean approximately 13,255 children served. ISBE provided services for 18,440 children with an emotional disability. However, all these numbers cannot be added together as the same child might have been served by multiple agencies.

[155] Combined with the HFS numbers, this would mean that over 222,000 youth received some behavioral health services and some additional, unknown number received community-based mental health services through their private insurance or other private funding.

[156] There might be several ways to estimate this number. For example, within HFS, ten times the number of children received community services compared to inpatient services. Assuming a similar rate for private funding would add another 120,000 children bringing the estimated total number of Illinois children receiving mental health services to over 340,000.

[157] "Provider Notice: Update to Community Mental Health Service Array," *Illinois Department of Healthcare and Family Services*, July 11, 2018, https://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn180711a.aspx.

[158] For example, Public Act 101-0461 / HB2154: the Children and Young Adult Mental Health Crisis Act, an initiative of the Healthy Minds Healthy Lives Coalition, passed with bipartisan support. The Act is intended to fill in significant gaps in Illinois' mental health treatment system for children and young adults by shifting the focus from crisis and late stage services to support when symptoms first begin; also see Public Act 101-0045 / HB907 – requires that DHS create and maintain an online database and resource page of mental health resources specifically geared towards school counselors, parents, and teachers.

[159] It is not clear how often this committee will meet and it only serves in an advisory capacity.

[160] "MassHealth Children's Behavioral Health Initiative," *Mass.gov,* https://www.mass.gov/service-details/learn-about-cbhi

[161] "Comments on 2018 Behavioral Health Workforce Projections," *The National Alliance to Advance Adolescent Health,* last accessed September 26, 2019, https://www.thenationalalliance.org/publications/comments-on-2018-behavioral-health-workforce-projections. These comments on the Health Resources and Services Administration (HRSA) 2018 Behavioral Health Workforce Projections, signed by nearly 40 national advocacy organizations and 25 academic centers, stated that "[t]here are no credible data sources nor national consensus for estimating the supply and demand of behavioral health professionals available to care for children, adolescents, and young adults."

[162] See "Report on Kankakee County Child Mental Health System," 95. "The proposal to address the training gap is to introduce a new training system to provide training in EBPs, based on the program discussed in Starin et al.'s (2014) article on the introduction of a new program within Illinois. This training would consist of in-person, highly interactive education on the EBP and using it in work with clients. This would be followed by one year of ongoing support in the form of case consultations. Case consultations could be provided by professors from local colleges and universities and would occur twice-monthly in one-hour sessions." See Starin, A. C., Atkins, M. S., Wehrmann, K. C., Mehta, T., Hesson-McInnis, M. S., MartinezLora, A., & Mehlinger, R. (2014). Moving science into state child and adolescent mental health systems: Illinois' evidence-informed practice initiative. Journal of Clinical Child & Adolescent Psychology, 43(2), 169-178. doi: 10.1080/15374416.2013.848772

[163] Mental Health America, "The State of Mental Health in America 2020," 41.

[164] "Practicing Child and Adolescent Psychiatrists," *American Academy of Child & Adolescent Psychiatry*, last accessed September 26, 2019,

https://www.aacap.org/aacap/Advocacy/Federal_and_State_Initiatives/Workforce_Maps/Home.aspx, Also see McHenry County Mental Health Board, "Child and Adolescent Psychiatric Services," 3. "The lack of funding for psychiatric leadership grants is a key reason why 86 percent of Community Behavioral Healthcare Association's (CBHA) membership has either reduced or eliminated psychiatric services since the budget impasse. Only 2-4% of medical school graduates are entering psychiatry and the current population is aging (55% are age 55 or older). AACAP found there was, on average, only one child psychiatrist for every 15,000 youths under 18. The U.S. Bureau of Health Professions projects there will be about 8,300 child psychiatrists in 2020, only two-thirds of the estimated 12,600 needed." The McHenry County Mental Health Board further notes "Two core challenges exist to increasing the psychiatric services available for children and adolescents: 1) the extra training required for a child psychiatrist in addition to the four years of medical school and three years of general psychiatry, and 2) the reimbursement rate fails to reflect the extra time required for a psychiatrist to interview parents, teachers, and other interested persons familiar with a child's behavior."

[165] ACLU, "Cops and No Counselors: ow the Lack of School Mental Health Staff is Harming Students," February 2019, 4, https://www.aclu.org/sites/default/files/field_document/030419-acluschooldisciplinereport.pdf.

[166] ACLU, "Cops and No Counselors: ow the Lack of School Mental Health Staff is Harming Students," 12-14.

[167] Katherine M. Zinsser et al., "Evaluation Report of the Implementation of Illinois Public Act 100-0105: Early Childhood Programs Knowledge of and Responses to the 2018 Expulsion Legislation," University of Illinois at Chicago (2019).

[168] "Free Care Rule Reversal: Expanding Illinois' School Medicaid Program," Healthy School Campaign (August 2019).

[169] "Seven Core Content Areas of Childhood Trauma for Professional Development," Illinois Childhood Trauma Coalition Workforce Development Committee (2019), forthcoming.

[170] Lena H. Sun, "Vaping-related lung illnesses soar to 805 cases in 46 states," *The Washington Post*, September 26, 2019, https://www.washingtonpost.com/health/2019/09/26/vaping-related-lung-illnesses-soar-cases-states/.

[171] "E-cigarettes and Vapes," *Illinois Department of Public Health*, last accessed September 30, 2019, http://www.dph.illinois.gov/topics-services/prevention-wellness/tobacco/e-cigarettes-and-vapes.

[172] Lena H. Sun & Laurie McGinley, "Most vaping-related lung injuries linked to marijuana products, CDC says," *The Washington Post*, September 27, 2019, https://www.washingtonpost.com/health/2019/09/27/most-vaping-related-lung-injuries-linked-marijuana-products-cdc-says/.

[173] Public Act 101-0002 / HB345: Prevention of Tobacco Use by Minors and Sale and Distribution of Tobacco Products Act.

[174] Jacqueline Howard, "Washington state orders emergency ban on flavored vape products," *CNN*, September 27, 2019, https://www.cnn.com/2019/09/27/health/flavored-e-cigarette-ban-washington-state-bn/index.html.

[175] Vanessa Caceres, "Are Marijuana Edibles Safe?," *U.S. News and World Report*, September 27, 2019, https://health.usnews.com/health-care/patient-advice/articles/are-marijuana-edibles-safe.

[176] Kathleen Doheny, "Marijuana Edibles: Buyers and Users Beware," *WebMD Health News*, April 9, 2019, https://www.webmd.com/pain-management/news/20190409/marijuana-edibles-buyers-and-users-beware.

[177] Children's Mental Health Act of 2003, 405 ILL. COMP. STAT. 49.

Illinois Children's Mental Health Partnership

Funding for this report provided in whole or in part by the Illinois Department of Human Services