Illinois Children's Mental Health Partnership

FY2020 Annual Report to the Governor

Dear Governor Pritzker, September 30, 2020

On behalf of the members and partners of the Illinois Children's Mental Health Partnership (ICMHP), we are pleased to present you with our fifteenth Annual Report. The report contains input from state legislators, state agencies, clinical experts who have been appointed to the Partnership by the Governor's Office, and interested members of the public.

In this report, we focus on the major issues that have affected children's mental health in Illinois since last July. This last year was unprecedented in the health crisis that Illinois faced. The Coronavirus Disease 2019 (COVID-19) dominated all discussions and brought incredible challenges to Illinois, the country, and the world. It is a medical issue that has had a major impact on children's mental health. The full effects of COVID-19 are still unknown and this ambiguity, in and of itself, exacerbates mental health issues for everyone.

This deadly health issue then brought heightened awareness to the longstanding issues of America's systemic racism and trauma. In the meantime, previous concerns regarding children's mental health in Illinois, such as suicide, access to services, and workforce development still remain.

To move forward, this report makes nine recommendations. The state can help children deal with the COVID-19 pandemic by continuing to focus on (1) Safety, (2) Communication, and (3) Planning for Child Vaccines. In order to help children overcome systemic racism, the state should (4) Teach Children About Systemic Racism, (5) Continue to Modify the Juvenile Justice System, and (6) Review School Supports Through a Systemic Racism Lens. Finally, over the next year, the State can improve children's mental health by addressing (7) Telehealth, (8) Youth Suicide, and (9) Family First Prevention Services.

ICMHP applauds your efforts to deal with COVID-19 and protect Illinois citizens. We look forward to working with your administration on addressing this pandemic as well as systemic racism and other children's mental health issues in order to improve overall child well-being. Please let us know how we can be of assistance going forward.

Gene Griffin

Gene Griffin, JD, PhD
Chair, ICMHP

Amanda M. Walsh, JD, LLM, MSW
Director, ICMHP

NOTE: *The Partnership represents multiple parties and interests. Some Partnership members, such as those representing state agencies and legislators, may recuse themselves from taking official positions on public policy. Opinions taken by the Partnership as a whole do not necessarily reflect all members of the Partnership.*

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as of September 2020

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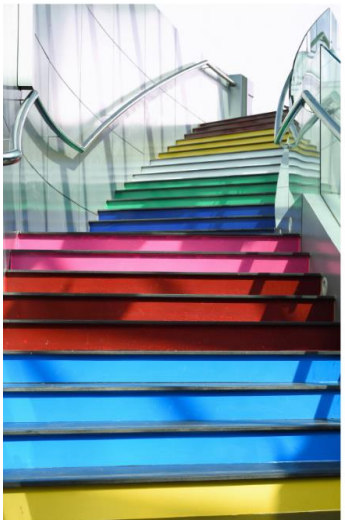

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I. INTRODUCTION

The Illinois Children's Mental Health Partnership (ICMHP) FY20 Annual Report seeks to present a summary of the current state of children's mental health in Illinois. It focuses on current issues and activities and offers recommendations to move forward. 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.

Last year, we argued that though the Partnership's name refers to "mental health," it is more appropriate to adopt an "integrated, comprehensive public health approach to wellness, looking at the impact of a child's behavioral health on his or her overall health… Therefore, a more holistic, developmental view of the child will be incorporated into ICMHP's 'mental health' recommendations."[1] That approach and its goal of wellness is even more important to take this year.

This report will address the acute impact of the Coronavirus Disease 2019 (COVID-19) on children and their families, the worsening of this impact and pre-existing disparities due to chronic systemic racism, additional ongoing children's mental health issues, and recommendations for the systems serving Illinois' children and families.

II. CORONAVIRUS DISEASE 2019 (COVID-19)

The greatest impact on children's mental health this year resulted from the COVID-19 Pandemic. COVID-19 is unique in its global presence as it crossed all political boundaries and age groups. The story of this crisis does not yet have an ending since its long-term effects are not yet known. But in the last year, it had a major negative effect on children's health, family life, and education. It also had an even greater inequitable impact on high-risk groups and marginalized communities. Although we highlight these impacts below, it is crucial to note that many of these impacts were pre-existing realities for many marginalized children and families; the pandemic has merely exacerbated those conditions.

A. Background

COVID-19 is an acute respiratory illness that is potentially fatal and can spread among people through respiratory transmission. At the time of its discovery, there was no known treatment or vaccine. In December 2019, the first outbreak of COVID-19 emerged in China. The United States Secretary of Health and Human Services declared that COVID-19 presented a national public health emergency on January 27, 2020 and the World Health Organization (WHO) declared

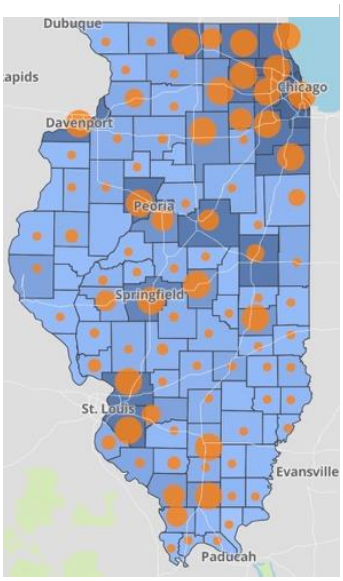
COVID-19 a Public Health Emergency of International Concern on January 30, 2020.[2] That same day the first human-to-human transmission of the COVID-19[3] in the U.S. was reported in Chicago.[4]

Governor Pritzker issued Illinois' first Disaster Proclamation on March 9, 2020, at which point there were 11 confirmed cases of COVID-19, although zero deaths, and an additional 260 persons under investigation in Illinois. The Governor restricted visitors to nursing homes on March 11, closed bars and restaurants on March 16, closed school buildings for educational purposes on March 17, and issued a Stay at Home order on March 21, at which point the number of confirmed cases had increased to 585 with five deaths. Under this order, citizens were asked to stay at home, except for essential activities. All gatherings of more than 10 people were banned and non-essential businesses were closed. By May 1, with 56,055 confirmed cases and 2,457 deaths in Illinois, that order was expanded to include wearing face masks in public.[5] Based on new safety guidelines that divided the state in to 11 regions with five phases of reopening, called Restore Illinois, the state began to safely expand operations for non-essential businesses and communities on June 26.[6] As of August 1, all 11 regions of the state were in the fourth phase of reopening; the fifth and final phase, Full Restoration, is contingent on there being "a vaccine or highly effective treatment widely available or the elimination of any new cases over a sustained period."[7] However, by early September, some regions had public health restrictions and mitigations temporarily re-introduced due to increased positivity rates in COVID-19 testing.[8]

B. Health

As of September 30, 2020, there were 293,274 known cases in Illinois with 8,672 deaths. Cases occurred throughout the state (see Figure 1), though the infections spread at different rates. The Chicago metropolitan area had a spike in cases early in the pandemic, with downstate experiencing its surge later.[9] Though regional needs vary,[10] in both cases, infection rates are tied to human behavior.[11]

Figure 1: Map of COVID-19 Cases in Illinois as of September 30, 2020

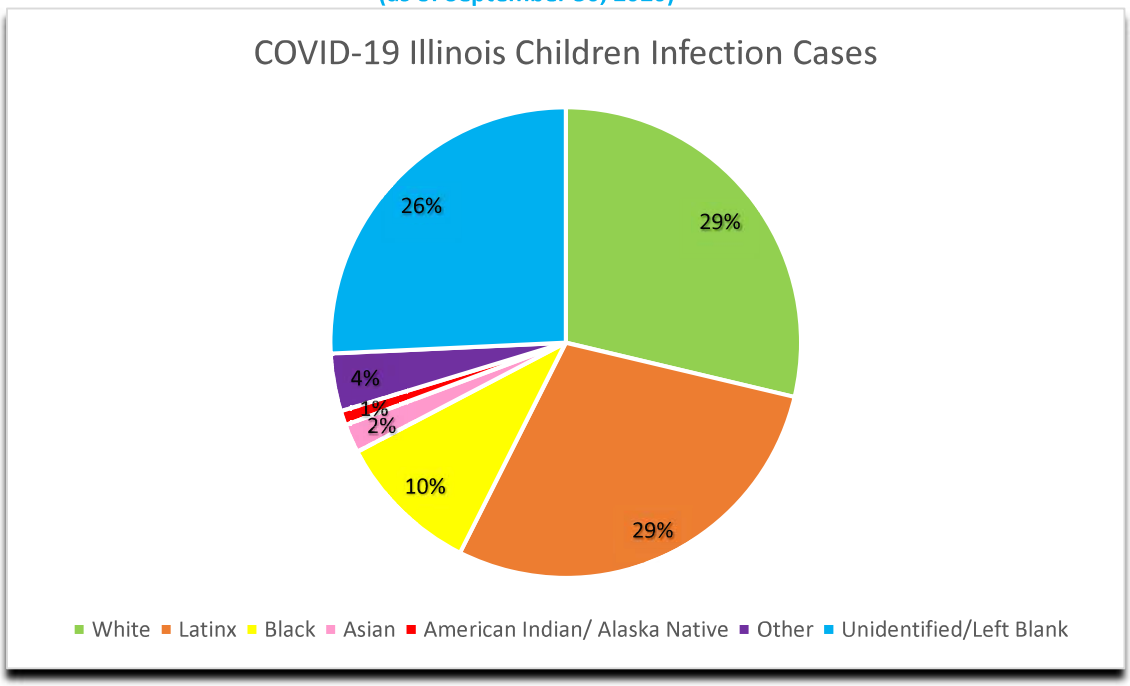


36,828 of the infected (13%) were less than twenty years old with 7 deaths.[12] As this is a new disease, there is no comparative Illinois data from previous years. However, according to a report summarizing data on COVID-19 cases in children across the U.S. as of September 10,[13] thirty-three states reported 10% or more of cases were children with 105 child deaths.

Although the numbers of children infected with COVID-19 are lower than adults, they similarly show demographic disparities (see Figure 2). Within the Illinois child group, 10,669 (29%) were White, 10,662 (29%) were Latinx, 9,578 (26%) left the item blank, 3,722 (10%) were Black, 1,520 (4%) were Other, 599 (2%) were Asian, 47 (<1%) were Native Hawaiian/Pacific Islander, and 31 (<1%) were American Indian/Alaska Native. Nationally, the Centers for Disease Control (CDC) data shows

disproportionately higher infection rates for Latinx children than for White or Black children, similar to Illinois.[14] These children of color "are infected at higher rates than white children and hospitalized at rates five to eight times that of white children. Children of color make up the overwhelming majority of those who develop a life-threatening complication called multisystem inflammatory syndrome, or MIS-C."[15]

Figure 2: Illinois Children COVID-19 Infection Rates by Race (as of September 30, 2020)



Our understanding of COVID's effect on children is evolving. At first, very few children were being diagnosed with the illness and there was some hope that children might be immune. Unfortunately, this turned out to be a false hope as it has become clear that COVID-19 does cause illness in children. Doctors do not yet understand the long term impact but a number of children are developing complications, such as MIS-C.[16] Additionally, it now appears that children can carry the virus and infect others, even if they are not experiencing symptoms.[17] Looking ahead, it also appears that children will have to wait longer for a vaccine, as scientists are currently testing vaccines for adults but have not started testing vaccines for children.[18] The limited positive news for children concerning COVID-19 is that it is not as fatal as it is to adults.

Although medical issues related to COVID-19 are limited for children, there are other medical issues that have come up as a result of the pandemic. Children with active or ongoing medical treatment, physical therapy, and health monitoring (e.g. for asthma) were less likely to attend their follow-up appointments. Wellness checks were put on hold while the Stay at Home order was in place and have been slow to resume, which could result in developmental issues going undetected. Children were falling behind on receiving their vaccinations (e.g. chicken pox, measles), which could lead to additional illnesses and medical problems going forward.[19] Even

Youth are very aware of the negative impact of COVID-19 on their access to food and outdoor space. Many identify this as a top issue that needs to be addressed.

when children did have access to medical services, they may have lived with family members who did not, increasing health risks to the children and family.

In addition to concerns about access to medical care, other social determinants of health have worsened, such issues with access to food and shelter. Some children do not have access to enough food or to nutritious food. Some children are limited in how physically active they can be, which only worsened through the closure of school buildings, cancellation of sports and recreational activities, and the stay at home order. These social conditions can lead to longer term health issues, such as obesity.

C. Family Life and Loss

The impacts on health are accompanied by significant impacts to family life. Under COVID-19, basic assumptions about life and safety are threatened. The full effects of the pandemic are still unknown and this ambiguity, in and of itself, exacerbates mental health issues for everyone. No one knows when the crisis will end or what the long-term effects will be. As noted in the Journal of the American Medical Association (JAMA):

> In addition to these direct medical risks, measuring the effects of COVID-19 on children, beyond missing memories and milestones, involves understanding that they are experiencing other adverse effects from the virus and recognizing that those effects will have lasting and yet to be appreciated consequences… Perhaps the most profound of these effects involves their psychological and educational well-being. Some newborn children are being separated briefly from their mothers at birth because of concern for vertical transmission… Many children are likely to spend crucial formative years raised by parents who are more financially and psychologically stressed because of the pandemic… Tens of thousands of children will have lost parents or grandparents at an age when they cannot appreciate (or later recall) the loss, but those loved ones' absences will influence their lives in innumerable and immeasurable ways.[20]

Many children live with caretakers and family members who are at risk of becoming ill. Some extended family, such as older grandparents, are more likely to die from the infection. In many cases, due to the COVID-19 restrictions, children were not allowed to see family members who were in the hospital or nursing home and were not allowed to attend funeral services.[21]

These risks are raised when caretakers are engaged as first responders or as "essential personnel," such as health care providers or individuals employed at grocery stores. Those caretakers may need to isolate themselves from the family given their risk of being exposed to the virus at work.[22] This absence of caretakers, presence of family illness, and the death of extended family can cause major loss and grief issues for a child, beyond the basic stresses of social distancing.

For many children and families, their daily roles also changed. Some families are spending much more time together, with mixed results. Some parents or caregivers lost their jobs, increasing financial instability for many families. Other parents' or caregivers' jobs switched to work-from-home, but some have to simultaneously care for their children. In particular, this is causing some mothers to work fewer hours, which causes additional economic loss and hurts their careers. Many other support systems, such as in-home childcare, day care, and home visiting services also stopped or declined.

It is critical to note, however, that many children were already experiencing family instability and loss prior to the pandemic. Some children have lost caregivers permanently through illness and death unrelated to COVID-19; some have lost caregivers temporarily through incarceration, institutionalization, deportation, or job-related absences (such as military families). These children were already coping with changed roles and dynamics or loss of caregivers, thus learning how to navigate through daily life with these different experiences. For these children, the pandemic just heightened these existing struggles, often worsening their impact. For instance, children with caregivers who are incarcerated or institutionalized could no longer visit them, at least in person; children who might have travelled to visit caregivers who have been deported could no longer do so as borders closed. In-person visits also stopped for children in foster care. Similar to "traditional" families, these families now face deep loss to their relationships and supports.

The increased health risks coupled with the decreased family and relational support creates toxic stress, which can lead to child trauma. Normally, having a safe place to live and having supportive relationships helps to build resilience, acting as protective factors against developing trauma in response to adverse events. During the early shelter in place, children could not go to school or go out and play with their friends. Many relationships became virtual and dependent upon technology and many non-family supportive relationships have been lost or greatly curtailed. This led to a significant increase in most children's use of screen time[23] rather than direct, in-person contact with people. For children, the loss of positive, in-person interaction can be harmful to their development.

Even when some restrictions were loosened, social distancing and face mask requirements were awkward at best. When some groups refused to follow those restrictions, the risk of infections increased for the rest of the public. This raised the general level of frustration and resulted in multiple social confrontations. Children observe all of this.

D. Education

From March through August, most children lost access to school buildings, pre-school, or day care. This was also true of after-school programs and summer camps. Now with the fall season, the diversity of school communities around the state means some schools have re-opened, some have remained virtual, and some are using a hybrid model, all of which can change as the number of local cases fluctuate. Decisions about how to provide instruction in the fall are made by local school officials in consultation with local departments of public health, often including community engagement, parent, and teacher preferences.

What is clear is that for all children, their education has been disrupted. This includes not only change to academic instruction, but also to the social and emotional learning process. Additionally, many rites of passage are being reconfigured and sometimes lost completely.

Eighth graders and high school seniors missed their traditional in-person graduation ceremonies. School children involved in sports or the arts lost most opportunities for performing. In addition, high school students missed out on attending dances and other rituals with their peers.[24] Students looking to go on to college may have had testing delayed, lost some opportunities to perform for college scholarships, and been prevented from visiting college campuses.

For children with special education needs, the disruption is even greater. They have lost essential support, such as in-person aides and individual or small group instruction. Although Individualized Education Plans (IEPs) must still be followed, including providing all services for the designated number of minutes, the modality of those services have changed; these changes are outlined in Remote Learning Plans (RLPs), which can be reviewed through IEP meetings.[25] Practically, however, this is very difficult to implement, with most services now limited to teleconferencing despite the need for in-person services to be most effective. As one parent noted, the type of supports her children need are difficult enough to ensure when school is in person; now, "[w]ith the type of support that she needs I don't know how you do that with the constraints of remote learning. It's very difficult."[26] Parents, teachers, and support staff are doing their best to work together and adapt school programs and services to the home environments, but it has added many more challenges.[27]

COVID-19 has also exacerbated the education achievement gap,[28] with low-income and marginalized families struggling to access the tools needed for online education, such as sufficient computers and reliable internet access.[29] If the internet is sporadic, or low speed, and insufficient to support streaming, that makes it impossible for children to access virtual learning programs. Additionally, if children were using libraries to access the internet, they lost that option when libraries closed. Limitations also resulted if a family only had access to one computer, with many youth trying to do schoolwork on a cellphone. All of these things can increase the education

achievement gap.[30] Feeling frustrated, alienated, and unsuccessful at school and subsequently feeling "punished" for circumstances beyond one's control (such as the COVID-19 pandemic and poverty) can then have a negative impact on a child's mental health and wellbeing. This is much more likely for high-risk populations.

E. High-Risk Populations

While issues around health, family life and loss, and education apply to all children, some groups of children and families are at even higher risk of suffering due to COVID-19.

1. Children Receiving Mental Health Services

Minimally, all children are living in a more stressful environment and all are more subject to anxiety and depression.[31] This is an even greater problem for those children already struggling with mental health issues. Many children in mental health treatment were no longer able to meet with their therapists.[32] Some children could use telehealth for therapy sessions, but lost regular contact with other supportive adults. Many treatment programs, such as inpatient and partial hospitalization programs, closed. As a result, emergency rooms began reporting more visits for children's mental health concerns.[33]

2. Domestic Violence and Child Welfare

In Illinois, from a child protection perspective, the only effect of the shelter in place that was more concerning than the significant increase in domestic violence hotline calls was the significant decrease in child abuse hotline calls.[34] No one believes that child abuse or neglect decreased or stopped occurring. The assumption is that instances of child abuse or neglect were more likely to go unnoticed.

With the pandemic, there was an increase in household stress, unemployment, substance use, and gun sales. Domestic violence shelters had less capacity due to social distancing criteria and resorted to using hotels as shelter spaces. Domestic violence perpetrators can exercise significant power and control within a household when others cannot leave. In spite of this control, adult victims of domestic violence managed to make more calls for assistance.

However, with child abuse and neglect, it is rarely the child who calls the hotline. Instead, a significant number of reports are made by concerned adults from outside the household, including school personnel, medical personnel, and other mandated reporters. Most of these adults lost access to children during shelter in place and still may have only virtual access.[35]

The Illinois Department of Children and Family Services (DCFS) still investigated the child abuse hotline calls it did receive. The department worked with schools to ask teachers with online access to children to be vigilant and, in some cases, to allow children to use certain signs or signals to quietly indicate they were in distress. DCFS also encouraged law enforcement to report any domestic violence incident they responded to where children were present.

DCFS was limited in how it could serve cases that were already open. As discussed in Section C above, during shelter in place, workers could not provide in-home services and children in foster care could not visit with their parents or siblings. All open cases in juvenile court were rescheduled or delayed, with the exception of emergency hearings and new temporary custody hearings.[36] In August, under the direction of the CDC and IDPH, in-person visits for children and families resumed whenever safely possible.[37] Children in institutional placements faced similar challenges.

3. Children in Institutional Placements

Institutionalized children, including those in juvenile justice settings (detention centers and Department of Juvenile Justice facilities), psychiatric hospitals, residential treatment centers, group homes, and shelters were at higher risk of COVID-19 infection[38] by virtue of their living with groups where social distancing is not possible: new residents are admitted regularly and staff who are active in the outside world come in every shift.

During shelter in place, these children could not have community placement or overnight visits that would lead to their discharge. This left some youth hospitalized or institutionalized when they could have functioned in a less restrictive setting. Many rehabilitation programs that were run by outside professionals were suspended.[39] Juveniles were also prohibited from having in-person family visits at facilities. These are more examples of how far-reaching the experience of family loss has extended during the pandemic.

4. Youth Experiencing Homelessness or Trafficking

Another high-risk group involves those children who do not have any stable placement. Some children and families are experiencing homelessness while some children have run away from home.[40] Some are youth who are being trafficked and exploited. During shelter in place, the struggles for these youth increased significantly. With schools, libraries, and park facilities closed, they lost access to public buildings. With restaurants and coffee shops closed, they lost access to some private facilities. Many outpatient clinics only saw clients virtually, which was not an option for some youth experiencing homelessness. Even shelters for individuals and families experiencing homelessness were not allowing clients to gather inside for meals. It became a challenge for some youth to find a place to go to the bathroom, much less to eat or sleep. They could not shelter in place and, if they became infected, they could not isolate themselves. They literally had no place to go.

Some children are forced onto the streets to beg for food and money, which increases their risk of exploitation, becoming even more of a danger due to COVID-19. Some were in danger of abuse or neglect by their exploiters.[41] They had little chance of escaping or finding help. Many children who have been trafficked are unable to return home. Those picked up by law enforcement faced delays in legal proceedings, as well as a reduction in the charitable support and protection they have relied upon in the past.

5. Immigrants/Asylum Seekers

Related to the increased health risk of living in shelters is the plight of some immigrant/asylum seeking children crossing the U.S. border. The federal government has suspended laws protecting these children.[42] Children attempting to cross the border into the U.S. can now be expelled by border agents without any medical check to see if the children are sick.[43] They often go to nearby crowded border camps.

Even those immigrant children who were already in the country and awaiting processing at shelter facilities are at increased risk.[44] In April, nineteen children at a Chicago immigrant detainee shelter tested positive for COVID-19. At the time, it was thought that the "coronavirus outbreak at an immigrant youth shelter facility on Chicago's South Side may be the largest outbreak of the virus in any shelter for immigrant youth in the country."[45]

Exacerbating the impacts of COVID-19 even more, in February 2020 the federal government modified its "public charge rule," which denies permanent residency status to individuals who have received certain public benefits. This discouraged immigrant families from seeking government aid for which they would otherwise be eligible and cause some families to stop benefits they were already receiving. Many were afraid to identify themselves to any government official for fear of deportation. This meant that many families did not seek the medical or mental health care they needed to deal with COVID-19, increasing their likelihood of suffering, illness, and death. This rule modification was blocked by a federal court in July and the issues are still being litigated.[46]

In addition, U.S. citizen children of undocumented parents were excluded from the Economic Impact Payments, also known as stimulus checks, of the federal CARES act.[47] This denied these children the economic relief that was provided to other families, increasing their risk of or exacerbating their experience of poverty.

6. Poverty

As described, families are experiencing major economic fallout and poverty. The COVID-19 pandemic caused many family members to lose their jobs or, in order to feed their families, had no choice but to continue go to work, often depending on public transportation, at essential businesses regardless of the health risks. It is simply easier for the higher-income individuals and families to shelter in place and socially distance.[48] Low-income individuals and families also have less job security, are at higher risk of layoffs and furloughs, and

often fewer or insufficient benefits like health insurance. All of these factors raise the risk of families defaulting on mortgages or being unable to pay rent. Adding more risk factors, food insecurity remains a major concern for families already experiencing poverty and is a growing concern for many families negatively impacted by the economic consequences of COVID-19.[49]

Families living in poverty cannot social distance as easily when they live in crowded, urban settings. If arrested, low-income individuals are less able to post bail and then have to stay in jails, which are high-risk infection sites.

During shelter in place, children in lower-income families lost the equalizer of being able to access resources through schools and libraries. However, federal waivers allowed Illinois schools to provide meals to all children age 18 and younger for free throughout the spring, summer, and fall.[50]

Children in lower-income families also are less likely to have internet access or appropriate computer equipment at home. The State used $80 million of its CARES Act funding for a Digital Equity Formula Grant for the highest need school districts to purchase devices and expand internet connectivity. Additionally, school districts were able to use $512 million in flexible CARES Act funding to further close the digital divide.[51] For many families, government aid is their only hope at making it through the pandemic.

F. Government Response

The response to COVID-19 by federal, state, and local governments, in addition to that of the private and philanthropic sectors, has and will continue to have a profound impact on the overall wellbeing of children in Illinois.

1. Federal

At the time of this report, over 7 million individuals in the U.S. have been diagnosed with COVID-19 and over 200,000 have died.[52] The federal government's response to COVID-19 has been inconsistent, heavily criticized, and divided along political lines. Although the White House and executive agencies have issued numerous guidelines and advisories,[53] including declaring several emergencies and initiating travel[54] and immigration[55] restrictions, there has been disagreement around testing and containment efforts.[56] Long-term planning presents its own unique challenges for federal agencies, requiring development and distribution of a vaccine.

Congress has passed several COVID-19 relief and economic stimulus packages, including the Families First Act (addressing free testing, food security, and employment regulations),[57] the Coronavirus Aid, Relief, and Economic Security Act (or CARES Act, providing $2 trillion in economic relief to individuals, health providers, and businesses),[58] and the Paycheck Protection Program (providing economic relief to small businesses).[59] Additional relief packages have passed through the House, but negotiations have failed to pass similar legislation through the Senate.

Finally, the federal courts have been active in ruling on COVID-19 issue cases,[60] including some related to immigration,[61] voting,[62] and religious requests to block state-imposed COVID-19 restrictions.[63] For many in the U.S., however, the federal government has not provided the most immediate response; those responses have mainly come from state and local governments. This included quick and comprehensive responses and aid from the Illinois state government.

2. State

Devastating as the pandemic was, and continues to be, Illinois took many positive actions to limit the harm to its citizens and assist their recovery. This swift and thorough response to the pandemic by Illinois state officials has followed the guidance and expertise of public health officials.[64]

a. Governor's Office

One of the Governor's first actions directly affecting children was to close all public and private school buildings throughout the state, shifting students and educators to remote learning, in order to help slow the spread of COVID-19.[65] Although school buildings were closed for educational purposes, the Executive Order did allow schools to remain open for the provision of food and other non-educational services.[66] Once regions of the state entered Phase 4 of the Restore Illinois plan, schools were given the option to resume in-person instruction for the fall 2020 academic session,[67] although this has varied across the state.

Additional Executive Orders impacted other parts of children's daily lives. Under the Governor's stay at home executive order,[68] essential government functions and businesses were allowed to remain open, including grocery stores, gas stations, human services, home-based care and services, and residential facilities and shelters. Non-essential businesses, including retail stores and restaurants, were closed to in-person shopping or dining. The order also allowed emergency child care programs to remain open, providing child care to children of essential employees. All other child care programs were required to close until the regions entered Phase 4.[69]

A major action by the Governor's office supporting children was the expansion of telehealth services.[70] Under this Executive Order, all health insurance issuers regulated by the Illinois Department of Insurance (DOI) are required to cover telehealth services (defined as "health care, psychiatry, mental health treatment, substance use disorder treatment, and related services") at the same rate as in-person visits.[71] This action, in conjunction with the expansion of public insurance plans discussed below, allowed for an immediate shift in healthcare delivery across the state, providing a way for services and care to continue virtually for children. This Executive Order has been extended and remains in effect as of the publication of this report.

Recognizing the deep impact of COVID-19 and its necessary response has had on the daily life of children, Governor Pritzker held a live virtual youth town hall on April 11, 2020.[72] The town hall was co-hosted by Ann and Robert H. Lurie Children's Hospital of Chicago (Lurie), the Center for Childhood Resilience, and ICMHP. Following this event, virtual youth town halls addressing

multiple aspects of COVID-19 were hosted across the state, including a youth mental health town hall hosted by Lieutenant Governor Juliana Stratton and NAMI Chicago,[73] as well as a town hall on immigrant youth wellness with Chicago Mayor Lori Lightfoot, Lurie, and the Center for Childhood Resilience.[74]

b. State Agencies

Working hand in hand with the Governor's Office, Illinois state agencies have also implemented swift and expansive responses, guidance, and relief efforts. In particular, the Illinois Department of Public Health (IDPH) was thrust into the forefront of COVID-19 policymaking. IDPH Director, Dr. Ngozi Ezike, has received national recognition for her efforts.[75] IDPH works with the Governor's Office, the White House, the CDC, and health directors from other states in its planning and efforts. The most complete information regarding COVID-19 in Illinois is kept on the IDPH website.[76] It contains up-to-date information regarding Illinois data on testing, cases and deaths, locations of testing sites, guidelines, and resources. Child-specific guidelines from IDPH include Children and Pregnant Women Guidance,[77] Guidance for Pre-K-12 Schools and Day Care Programs for Addressing COVID-19,[78] Day Care Guidance,[79] and Sports Safety Guidance.[80]

The Illinois Department of Healthcare and Family Services (HFS) has also responded quickly to address the toll of COVID-19 on children, families, individuals, and providers. In addition to expanding Medicaid coverage to include telehealth services, HFS issued guidance regarding several services to allow for virtual options, including mental health crisis intervention services for children and adults (called Screening, Assessment, and Support Services (SASS) and Mobile Crisis Response (MCR)).[81] HFS also expanded billable case management services for Community Mental Health Centers and Behavioral Health Clinics to include delivering groceries, medications, phones, and other essential products and supplies.[82]

Given the negative impact of COVID-19 on the overall stability of individuals and families, the Illinois Department of Human Services (DHS) increased funding and capacity in several areas.[83] DHS worked with the Governor's Office and Illinois legislature's Black Caucus to award funding to community providers in the areas most impacted by COVID-19 and civil unrest. One part of that funding focuses on mental health and wellness. The Division of Mental Health (DMH) within DHS developed the Community Wellness and Equity Initiative, which increases services for unfunded individuals and provides more trauma-related resources. ICMHP is working with DMH to develop training that will both assess the needs and challenges faced by the community mental health workforce and address the intersection of COVID-19, civil unrest, and trauma and adverse childhood experiences. Additionally, recognizing the emotional and mental toll of COVID-19, the DMH launched a free emotional support text line called Call4Calm.[84] Residents can text "TALK" or "HABLAR" and will be connected to a local community mental health center within 24 hours; they can also text keywords such as "unemployment," "food," or "shelter" to receive information on how to access supports and services.

For schools, the Illinois State Board of Education (ISBE), working in partnership with IDPH, is providing the most current resources and guidance to support Illinois education communities regarding the COVID-19 outbreak.[85] The pandemic upended nearly all of the regular rhythms of school, requiring ISBE to provide guidance to school districts on how to handle policies like grading, attendance, and graduation during remote learning.[86] Throughout its guidance, ISBE sought to recognize and mitigate any impact to students' mental health and to focus collective attention on students' overall wellbeing. Additionally, ISBE focused its guidance and resources on addressing equity gaps, including the existing digital divide[87] and minimizing the harmful effects of the pandemic on school-aged children.[88] As noted above, ISBE applied for and implemented federal waivers allowing schools to provide meals to all children age 18 and younger for free throughout the spring, summer, and fall.[89] For parents and caregivers, ISBE also created resources to ensure they knew how to access help during remote learning.

Additional guidance from ISBE included ensuring continued supports for at-risk student populations, such as English Learners[90] and children in temporary living situations or experiencing homelessness.[91] For other at-risk students, ISBE worked in partnership with DCFS to release guidance on what school personnel should do to ascertain a student's wellbeing if schools and districts are unable to make contact with the student for over a week.[92] ISBE worked with the Children's Advocacy Centers of Illinois and Chicago Children's Advocacy Center to create Guidance for Delivering Sexual Abuse Prevention Education During the COVID-19 Pandemic to ensure continued compliance with Erin's Law.[93]

The Illinois Department of Children and Family Services (DCFS) made urgent changes to provide a safe environment for staff and the youth and families it serves. In response to the Governor's Stay At Home Executive Order, DCFS issued guidance on specific protocols regarding the suspension of in-person visitation to keep families and staff safe, including providing the technology to assure the frequency of video and phone contacts with youth and families.[94] For its staff, DCFS secured the personal protective equipment (PPE) needed to conduct work safely.[95] DCFS also developed protocols to allow for ongoing services to be provided either safely in-person or virtually,[96] and to deal with issues around older youth who were expected to age out of DCFS during the pandemic.[97]

The Illinois Criminal Justice Information Authority (ICJIA)[98] awarded over $8 million to 11 organizations that facilitate support service and resource delivery to communities that are disproportionately impacted by the ongoing COVID-19 pandemic.[99] ICJIA also addressed COVID-19 related issues within the criminal justice field, including the pandemic's impact on law enforcement, jails and prisons, community supervision, and victim services.[100] This includes understanding the impact of mental health,[101] trauma, and homelessness within the criminal justice field.

For youth involved in the criminal justice system, the Illinois Department of Juvenile Justice (DJJ) was able to reduce the number of residents to less than 100 youth statewide,[102] which was consistent across many juvenile justice institutions throughout Illinois.[103] This significant decrease was followed by the announcement of a plan to keep this reduction in place by adopting a new model for institutionalization, which will be reviewed below. During early stages of the pandemic, DJJ developed a mitigation plan[104] that included suspending all in-person family visitation, but implementing calls and virtual visits; DJJ had already developed virtual options to increase family connection and interaction, which ensured quick implementation when the pandemic stopped in-person visits. Additionally, DJJ developed a transition plan to restore activities over time.[105]

Other efforts in the juvenile justice field emerged, including the work of Redeploy Illinois. Redeploy Illinois, which is supported through DHS, aims to reduce juvenile incarceration by granting funds to counties to establish a continuum of local, community-based sanctions, and treatment alternatives for juvenile offenders who would otherwise be incarcerated. In order to meet the immediate needs of their clients and families and adapt to a new virtual reality, Redeploy programs helped to secure technology for youth and families, such as loaner phones and WiFi and boosted hot spots in rural areas. Redeploy programs also helped obtain safety supplies and groceries for many clients and families. These efforts have allowed youth to continue most Redeploy program activities.[106]

c. Legislature

While the executive branch increased its efforts to respond to the pandemic, the operations of the legislative branch was significantly curtailed. Because of the increased risks of convening in-person, the regular Spring session of the legislature was suspended on March 16, 2020 and remained suspended until mid-May.[107] Legislators returned for a Special Legislative Session from May 20-23, 2020 with new safety precautions. The House met at a Springfield convention center to allow for social distancing and pre-session COVID-19 testing for all legislators. The Senate, with only half of the number of members as the House, was able to still meet at the State Capitol building.[108] Because of the abbreviated session, the legislature prioritized emergent issues, mostly connected to the pandemic,[109] holding all other pending bills for consideration at a later session.

d. Judiciary

Similar to the legislative branch, Illinois courts shut down during the early pandemic, hearing only emergency cases. Eventually, courts resumed with remote hearings whenever possible.[110] One set of issues heard by both federal and state courts involved the scope of the Governor's powers to issue Executive Orders related to COVID-19.[111] Those cases continue to work their way through the legal system. For children, juvenile courts held emergency hearings to release children being detained at Juvenile Temporary Detention Centers.[112] Although some courts have resumed in-

person operations, many remain virtual, following guidance issued by the Illinois Supreme Court.[113]

3. Private

Similar to public institutions, the private sector, including philanthropy, has swiftly changed course in order to respond to new needs brought on by the pandemic. In early March, the Chicago COVID-19 Response Fund was created, raising over $33 million. Building on that model, at the end of March 2020, Governor Pritzker joined the United Way of Illinois and the Alliance of Illinois Community Foundations to launch the Illinois COVID-19 Response Fund (ICRF).[114] The ICRF raised funds for nonprofit organizations serving communities most impacted by the pandemic.[115] These funds were disbursed to help provide emergency food and basic supplies, interim housing and shelter, primary health care services, utility and financial assistance, nonprofit safety and operations, and support for children and other vulnerable populations.

In addition to general supports, numerous funder collaboratives, as well as individual foundations, have been responding to the mental health needs of children and families as well as supporting the general operating costs of safety-net providers who suffered substantial financial losses as a result of the pandemic. For example, the Illinois Children's Healthcare Foundation (ILCHF) created a $2.5 million initiative to fund SASS providers and also provided $500,000 in funds for the Illinois Critical Access Hospital Network to pay for childcare for essential hospital workers.

G. Recommendations

Both the public and private sectors with Illinois have worked hard to respond to the COVID-19 pandemic. The Governor has presented a framework within which people can move forward as the pandemic continues to unfold. Public safety guidelines have helped adjust individual behavior to limit infections. However, an end to the COVID-19 pandemic is not in sight. In order to help children and families during this ongoing crisis, ICMHP recommends the state continue to focus on:

1. Safety

When everyone's life is threatened, stress levels are extremely high. Child trauma interventions start with establishing safety as a way to prevent adverse experiences from becoming traumatizing and to avoid triggering those who are already dealing with earlier traumas. To maintain safety, the state needs to continue to take appropriate cautions, administer appropriate tests that identify when children are infected with COVID-19, and provide appropriate treatments. Treatment becomes complicated, however, since many children do not show acute signs of infection but may still be contagious and subject to long-term health damage. The state cannot guarantee physical health, but the procedures the state has put in place (e.g. face masks, handwashing, contact tracing) can greatly lower children's risk of infection. The state can also

assist in setting up basic structures to a child's day (e.g. schooltime, adequate meals, bedtime) that will make a child's life more predictable and less anxious.

2. Communication

The second prerequisite to minimize child trauma is adult support. Children rely on adults for direction. In the case of COVID-19, the state can provide this support by clearly communicating with children about COVID-19 and the steps being taken to address it. This information – what we know, what we don't know, what we are expecting – should be provided in a supportive, nonpunitive, developmentally appropriate manner to children and families. As the Governor did in his virtual youth town hall, the message should remain hopeful.

3. Planning for Child Vaccines

Given that the state's plan for full restoration (Phase 5) is contingent on there being "a vaccine or highly effective treatment widely available or the elimination of any new cases over a sustained period," the state should start making distribution and contingency plans now. It appears that a vaccine for children will not be available until after an adult vaccine. Therefore, the pandemic risk likely will continue longer for children, families, and child-serving institutions. Knowing this, the state should begin making plans that will address these limitations and communicate them in ways that emphasize safety and hope.

III. SYSTEMIC RACISM

Unfortunately, the COVID-19 Pandemic is not the only major event or series of events from the past year impacting the mental health and overall wellbeing of children – so does systemic racism. In many ways, the COVID-19 crisis has led to an increased awareness of systemic racism and its impact on marginalized communities; for instance, throughout the U.S., COVID-19 has a racially disproportionate impact.[116] Racism has been linked to lack of access to healthcare, poverty, housing discrimination, law enforcement discrimination and mass incarceration, and barriers to education and employment. Each of these issues can increase the risk for infection, severe illness, and death from COVID-19.

However, these are all pre-existing conditions that have existed throughout the U.S. for generations and long before the COVID-19 pandemic. During the last year, new incidents of

systemic racism occurred for the public to witness, triggering intense responses from the political to the emotional. While COVID-19 was doing its damage, systemic racism in the police's use of their state powers once again gained international attention. The most infamous example happened in June in Minneapolis when a White policeman killed a Black man, George Floyd.[117] When the video of the killing from a bystander's cellphone went viral, it set off a chain of demonstrations that affected Illinois, the U.S., and the world. These incidents of systemic racism and the public's response also affected children.

A. Defining Systemic Racism

To understand the *impact* of systemic racism on children, we must first understand systemic racism. Systemic racism can be defined as a "system of structuring opportunity and assigning value based on the social interpretation of how one looks (which is what we call 'race') that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources."[118]

When racism seeps into the fabric of society, it negatively impacts the enforcement of laws, availability of housing, workplace fairness, and the quality of health care and life overall. In short, it amounts to systemic or structural racism, the phrase now repeated in marches, social media, and legislative hearings. Applied to this "COVID-19 era, structural racism translates to a lack of access to protective resources and care for COVID-19 in financially vulnerable and racial/ethnic minority neighborhoods."[119]

"Structural racism includes laws, policies, and practices of societies and institutions that overtly or covertly discriminate, disadvantage, neglect, or oppress across race or ethnicity... Examples of structural racism can be seen throughout housing, criminal justice, and health care systems."

Not only do we see the impact of systemic racism within our policies, institutions, and systems and throughout responses to public health crises, but we also see its deep impact on individual's mental health, including for children.

B. Systemic Racism as a Mental Health Issue

U.S. Representative Frank Pallone, Jr., Chair of the Committee on Energy and Commerce's Subcommittee on Health, held a hearing on June 30, 2020 on improving the quality and access to mental health care in the U.S. As he noted in his opening comments:

> This hearing is particularly timely as our nation is simultaneously confronting a global health crisis, a severe economic downturn, and centuries of systemic racism. All three of these crises are understandably triggering distress for millions of people... It is no wonder that nearly half of Americans are reporting that their

> mental health has been negatively impacted due to worry and stress in recent months.

Jeffrey L. Geller, MD, MPH, on behalf of the American Psychiatric Association, testified about "the unfolding communal unrest regarding systemic racism and police brutality…" while Arthur C. Evans, Jr., PhD, on behalf of the American Psychological Association, testified that:

> The U.S. is Facing a Syndemic. What we're witnessing is a confluence of forces – a rapidly spreading and dangerous disease, coupled with a racism pandemic and a preexisting crisis of mental health – that interact synergistically and have a disproportionate impact on marginalized populations… As a result, the collective mental health of the American public has endured one devastating blow after another, the long-term effects of which many people will struggle for years to come.[120]

Dr. Evans further described the mental health and trauma effects of the Racism Pandemic as well as the impact on vulnerable populations, such as children and young adults: [121]

> The public health consequences of ongoing, structural racism include both physical and mental illness. Racism is associated with a host of psychological consequences, including depression, anxiety and other serious, sometimes debilitating conditions, including post-traumatic stress disorder and substance use disorders. Moreover, the stress caused by racism can contribute to the development of cardiovascular and other physical diseases.[122]

These comments were in response to the impact of systemic racism on mental health across the U.S. In Illinois, the Mental Health Summit released its statement on Mental Health and Racism, noting that "[r]acism, in all of its forms, harms the mental health of our state and our country." The statement further comments that:

- Our health care system, specifically including the mental health care system, has systematically failed to provide adequate services to people of color. The mental health workforce does not reflect the racial and ethnic diversity of our state and is often not competent to serve the mental health needs of people of color. People of color are more apt to be misdiagnosed and receive inadequate or inappropriate treatment.

- As the result of discrimination, people of color have fewer financial resources, lower rates of employment and are less apt to have health insurance. As a result, they are less apt to be able to secure the full range of mental health services that are available in the private sector.

- The COVID-19 pandemic demonstrates what is wrong with our health care system and our criminal justice system. People of color are disproportionately

represented in prisons and jails where they are denied decent mental health care and other necessary health services. Prisons and jails have become COVID-19 hot spots. African Americans and Latinos are more apt to be diagnosed with and die from COVID-19.

- Our criminal justice system systematically mistreats people of color from arrest through imprisonment. Just as too many people with mental health conditions are arrested, convicted and imprisoned, rather than being provided with appropriate mental health services, too many people of color are denied basic human needs, including health care, and punished rather than helped. Systematic racism also results in the wrongful killing of people of color by the police.

- Mistreatment by the police causes not only physical harm but also depression, anxiety and trauma to those who are its direct victims. Importantly, it also creates anxiety, depression and trauma among others who may understandably fear that they are at greater risk of harm just because they are African American, Latino, Native American or Asian American.

- Discrimination in employment, housing, education, health care and other aspects of daily life not only denies people of color basic needs, it causes anxiety, depression and trauma among those who are its direct victims and those who understandably fear that they may become so.

- Fear, anger, mistrust and resentment too often characterize the relationships between people of different races in the United States. This harms the mental health of all of us. [123]

As this statement observes, systemic racism and it's inevitable and harmful impact on social conditions has a deeply negative effect on individual's mental and physical health. This is true for both adults and children.

C. Systemic Racism as a Children's Health Issue

According to the Policy Statement of the American Academy of Pediatrics (AAP),[124] "[r]acism is a social determinant of health that has a profound impact on the health status of children, adolescents, emerging adults, and their families… Failure to address racism will continue to undermine health equity for all children, adolescents, emerging adults, and their families."[125]

Growing up, children learn not to touch a hot stove, not to take candy from strangers, and not to cross a street without looking both ways. At some point, children also learn that humans come in different colors. That is a simple observation, and as with most things in life, it becomes more complicated as we grew older. Racism isn't always taught as directly as "don't touch that hot stove," but today's systemic racism is something all children are socialized into. Children learn society's systemic rules from parents and others around them.

Systemic racism is based on false science. Since decoding the human genome, we know that "race" is not a biological reality.[126] Race is a social construct that a system makes up. Systemic racism then takes this artificial distinction and divides the racial groups into the advantaged and the disadvantaged. These divisions are not based on any biological reality, but children still learn them. Children are not born racist. The system teaches it to them.

Racist acts against children and observed by children are profoundly detrimental to their health, including their mental health.

The primary impact, of course, is the negative effect on the disadvantaged, minority children who are the victims of racism. The data is compelling. Racist acts against children and observed by children are profoundly detrimental to their health, including their mental health. The current focus on the victims of racism is appropriate and long overdue.

An additional argument can be made that racism has an independent, negative impact on the mental health of some of advantaged children. Though the effect on mental health is rarely discussed and does not cause the advantaged to suffer in the ways disadvantaged children suffer, it nonetheless presents concerns.

Law Professor Angela Onwauchi-Willig reviews[127] "not only the detrimental effects of experiencing discrimination for Blacks but also the dehumanizing effects of perpetrating discrimination, whether voluntarily or involuntarily, for Whites."[128] She argues that, for some Whites, their advantaged identity assures them that they will not be at the bottom of the social hierarchy, which is reserved for the disadvantaged minorities. The false sense of deserved advantage for Whites leads to framing any anti-discrimination doctrine "as a zero-sum game, in which material and status gains for Blacks and other racial minorities are viewed only as losses for Whites." She reviews research that finds:

> "White respondents were more likely to see decreases in bias against Blacks as related to increases in bias against Whites—consistent with a zero-sum view of racism among Whites—whereas Blacks were less likely to see the two as linked." In fact, [these] Whites now perceive antiwhite bias to be more prevalent than anti-black bias.[129]

She argues that unless we acknowledge our systemic racism's maintenance of the structures that reinforce White advantages, society will never achieve racial equity.[130] She further argues that:

> If we intend to ever achieve true equality, we must take race into account. We must begin to reevaluate the ways in which we have defined the harms of discrimination and inequality. There is no harm in reevaluating how we view the harms of discrimination. The harm is in not doing so.[131]

Teaching children that their racial group is preferred begins a process of dehumanizing the disadvantaged group. It allows the preferred group to take advantage of the "other" racial group without acknowledging any guilt. Taken to an extreme, it encourages the advantaged children to mistreat or bully the disadvantaged group and teaches all the children that the advantaged group will get away with it.[132]

1. Learned Behavior

This learned and internalized behavior can be seen across the U.S., including two recent high-profile examples of systemic racism. The first is the killing of George Floyd by a White police officer (referenced above); the second is when a White woman walking her dog called the police to report an "African-American man" who was "threatening" her life after the man pointed out to the woman that her dog was required to be on a leash.[133] Neither the White police officer in the Floyd case nor the White woman in the dog case were creating new ways of responding to Black men. Both played out their roles and both thought they would get away with it. That is what they had been taught since childhood.

When the two people in these cases were held accountable, some Whites were embarrassed while others became angry. Still others blamed the individuals but denied this was a result of systemic racism.[134] Our teaching advantaged children to emphasize race, to dehumanize and mistreat the disadvantaged, and to deny the systemic racism at the root of these actions is harming children's mental health and society.

2. School Resource Officers

Applied to Illinois, the discussions around systemic racism have directly affected schools as they reconfigure, as demonstrated in debates regarding the appropriate use of School Resource Officers (SROs). Increasing evidence is showing that the use of SROs often has negative effects on students, with a disproportionate impact for students of color and students with disabilities.[135] This evidence creates tension between proponents of SROs and those wanted to remove SROs from schools altogether.

On the one hand, the presence of officers can help children and school staff feel safer, both during the school day and at after-school events when non-school personnel may be present. The SROs can help reduce the prevalence of bullying during lunch, in the hallways, and on the playground. With proper training, the officers could assist in de-escalating potentially violent situations and recognize signs of substance use, mental health issues, or trauma. They can also develop relationships with students, allowing the SRO to serve as an additional resource with other community or family issues.

On the other hand, when law enforcement does not have a supportive relationship with the community, the presence of SROs can serve as a trauma trigger and an increased feeling of threat, which makes the school less safe.[136] If teachers and school personnel do not have their own proper training and support, then they may over-rely on calling the officers to help deal with challenging situations. SROs can be used as disciplinarians and act punitively. This can result in the number of suspensions, expulsions, arrests and juvenile justice cases increasing, which ends up being worse for the children.

One study found that SROs understand their role as protecting the school from external threats in wealthier, white districts while SROs in poorer districts with a majority of Black or Brown students understand their role as protecting the school from internal threats.[137]

The proper use of school resource officers is a controversial issue that has a public health impact on children and communities. Some youth and groups have called for their complete elimination with some school boards adopting that position. Other schools and school boards have chosen to keep the officers.

Youth activists in Chicago advocate for police-free schools: "We need people in our schools that we can trust to talk about our situations. Arresting students is not the answer."

These conversations need to evolve into a larger system discussion that is not just about SROs. Any approach needs to be comprehensive to address the roles of everyone in the schools. Broader issues include whether poorer schools have an adequate funding base and whether teachers and other school personnel have the training and support they need to deal with conflict and difficult behaviors. There needs to be a focus on the mental health impact of the SRO presence and the need for comprehensive solutions to meet the unique needs of each community. Minimally, the entire education team needs to be part of the solution and all school staff should receive training on child development, mental health and child trauma as well as the impact of systemic racism.

3. Addressing Systemic Racism to Improve Children's Mental Health

Our system has taught White children that race is real, that they are advantaged, and that there are ways to exercise this power over the disadvantaged without consequences. To eliminate this systemic racism, we cannot concentrate solely on enacting reform laws and electing leaders devoted to the cause. We must also pay attention to how we teach our children[138] and acknowledge the trauma systemic racism creates. All parents, particularly in White families, need

to actively teach their children that people have different colors of hair, skin, and eyes, that the colors are not reasons to be advantaged or disadvantaged, that our system has been doing it wrong in regard to skin color, that it is inappropriate to mistreat or take advantage of others, and that people should be held responsible for racist behavior. Raising a less racist, mentally healthier child is just as important as raising one who doesn't touch a hot stove or walk into traffic. Both the child and our society will benefit.

D. Government Response

1. Federal

Reactions to systemic racism can be seen at all levels of government. At the federal level, the White House banned federally sponsored racial sensitivity trainings that discuss white privilege or critical race theory, labelling such trainings as "divisive, anti-American propaganda."[139] This action is deeply concerning as the U.S. works to address the systemic racism infiltrating our history, laws, and systems. Fortunately, Illinois is responding in the opposite direction.

2. State

Historically, there are numerous examples of systemic racism throughout Illinois, including police shootings of people of color. Most recently, residents are leading the response in Illinois through movements such as Black Lives Matter and peaceful demonstrations and marches. Overall, the state has yet to develop a comprehensive approach to dealing with systemic racism. However, several important discussions and programs have begun.

a. Governor's Office

Governor Pritzker has marched at large rallies calling for peace and racial harmony in response to the death of George Floyd. At one of the rallies, Pritzker acknowledged that "too many communities of color have 'seen nothing or very little over the years' in terms of investment in health care and education," that there is a need for reinvestment "to repair the damage that's been done to black communities around the state," and that "long-standing systems don't shift on their own." Further, the Governor emphasized that "my duty is to be a force for justice, a force for change."[140] He also has said that current events demonstrate how "we have systemic racism that also needs to be addressed in a state budget."[141]

Offices under the Governor are also directly addressing system racism in recent recommendations and guidance. For example, the Governor's Office of Early Childhood Development (GOED) issued "Recommendations and Guidance for Home Visiting, Doula, and

Coordinated Intake Programs" that were consistent with Phase 4 Restore Illinois Plan.[142] Relevant to the systemic racism issues, these recommendations noted that "nationally and in Illinois, communities and individuals of color have been disproportionately impacted by COVID-19" and asked providers to "assess the equity impact when making decisions about in-person contacts," including assessing "how returning to in-person services will address inequities that staff and families face, inequities that continue from historical and systemic injustices that long-preceded the pandemic."

b. Lieutenant Governor's Office

Along with the Governor, Lieutenant Governor Julianna Stratton is also working to address systemic racism. She oversees several Illinois programs that address systemic racism, inequity, and children, including the Justice, Equity, and Opportunity (JEO) Initiative.[143] The JEO Initiative is a first-of-its-kind effort in Illinois that serves as a model for the nation's efforts to reform the justice system by creating a collaborative environment among stakeholders, state agencies and the organizations they work with, ensuring a coordinated, holistic effort to transform the criminal justice system and implement those changes, advising the different branches of Illinois government proactively to create a more fair and equitable criminal justice system, and supporting research and pilot programs that test groundbreaking efforts to reform the criminal justice system.

c. State Agencies

Illinois state agencies are also pursuing ways to combat systemic racism. For example, in June 2020, ISBE adopted a resolution affirming its commitment to eliminating racial injustice.[144] The resolution affirms that ISBE is committed to ensuring public schools in Illinois provide safe and welcoming spaces where all students are able to focus on their education, secure in the knowledge that their safety and emotional well-being will be supported, regardless of race or ethnicity. As part of this commitment, ISBE is convening a workgroup to review and revise the Illinois Social Science Learning Standards through a lens of equity and social justice.[145] Additionally, ISBE's Diverse and Learner-Ready Teacher Network, composed of teachers, administrators, higher education faculty, and legislators, developed Culturally Responsive Teaching and Leading standards that will be incorporated into Illinois teacher preparation programs.[146] ISBE also staffs and supports the Black History Curriculum Task Force.[147]

Another example of state agency response is through DCFS. One way that racism manifests itself in the child welfare system is that Black children and families are disproportionately involved in the child welfare system.[148] DCFS has worked to support children, youth, and families with a keen eye to reducing disparities and addressing inequities stemming from racism and discrimination. The department addresses racial and cultural equity issues through its Office of Racial Equity Practice[149] and the Racial Equity Practice Subcommittee of the Child Welfare Advisory Committee.[150]

d. Legislature

The legislature is also actively working to address systemic racism. The Illinois Legislative Black Caucus called on the Governor to "address the systemic racism plaguing the nation and the painful looting that devastated the South and West sides."[151] State Rep. La Shawn Ford pointed out that "We know the black community has been hit the hardest by COVID-19, the black community has been hit the hardest by violence, the black community has been hit the hardest by police brutality and the black community has been hit the hardest by the recent looting and riots." The caucus called for additional funding to rebuild their communities after the devastation caused by the public health crisis and social unrest.

As noted in Section II of this report, DHS worked with the Governor's Office and the Illinois Legislative Black Caucus to award funding to community providers in the areas most impacted by COVID-19 and civil unrest through DHS' Community Wellness and Equity Initiative. One component of this overall initiative is focused on mental health and wellness; ICMHP is working with DHS to assess the needs of community mental health centers and provide trauma-informed trainings as a component of the mental health work.

E. Recommendations

Unlike COVID-19, which is a new issue, systemic racism is an issue that is as old as our nation. Unfortunately, like COVID-19, the resolution is complicated and will require years of effort to reform all levels of our society. In the more immediate term and to help children overcome systemic racism, ICMHP recommends the following:

1. Teach Children About Systemic Racism

Children learn society's rules from parents and others around them. To overcome the silence and denial around systemic racism, people must continually talk to children about it. Our system needs to actively teach children that skin color is not a reason to be advantaged or disadvantaged, that our system has been doing it wrong, that it is inappropriate to mistreat or take advantage of others on this basis, and that people will be held responsible for such racist behavior.

2. Continue to Reform the Juvenile Justice System

The state's juvenile justice system is a classic example of disproportionate impact on children of color as a result of systemic racism. The state has been reforming DJJ and the basic design of youth prisons, including the most recent announcement to restructure how youth are detained.

The Lieutenant Governor's Justice, Equity, and Opportunity (JEO) Initiative is working to reform the justice system by creating a collaborative environment among stakeholders, state agencies, and the organizations they work with. These efforts need to continue and expand, with change working its way back through arrests both inside and outside of school, all the way to funding prevention and early intervention for children in the community.

3. Review School Supports Through a Systemic Racism Lens

The current debate around School Resource Officers is just one example of people's powerful emotional reactions to how we educate our children. Schools played an essential role in our country's desegregation. Yet there are still wide discrepancies in school funding and resources that have a disproportionate impact. Given the history of economic and housing discrimination in neighborhoods with a large proportion of people of color, funding schools through local property taxes needs to be reviewed using a systemic racism lens. We then need to look at what other resources, training, and support we can offer to schools in order to help all Illinois children benefit from education.

IV. FOLLOW UP FROM 2019 ICMHP REPORT

ICMHP's 2019 Annual Report focused on children's issues related to mental health/suicide, substance use/opioids, and child trauma/violence. Our recommendations focused identification and access to services, workforce development, and cannabis/vaping. These issues are still important to children's mental health and, normally, these issues would have had a greater focus in this year's report. However, the COVID-19 pandemic and push to address systemic racism from this past year have pushed these issues more into the background.

Some updates are available based on new 2019 Census data and Center for Disease Control's 2019 Youth Risk Behavior Survey (YRBS) of Illinois high school students. This report will review these new materials and offer some additional recommendations. However, a more detailed analysis will need to wait for another year.

For a baseline, this report relies upon U.S. Census data as of July 1, 2019, which state that the overall population of Illinois is 12,671,821 (a decrease of 69,000 from its 2018 estimates). [152] Regarding race, there were no major changes from 2018; 60.8% of the Illinois population is White (not Latinx), 17.5% Hispanic (or Latinx), 14.6% Black (or African American), and 5.9% Asian. Regarding age, 22.2% (over 2,800,000) are under 18 years old and 5.9% (over 700,000) are under age 5. Based on national estimates described in earlier reports, this report will continue to assume that 10% of children are in need of some mental health services, although this is likely a conservative estimate. Therefore, given the current census data, a minimum of 280,000 Illinois children are in need of mental health services.

A. Mental Health / Suicide

An increase in depression raises concerns about suicide. In our 2017 report, ICMHP noted that multiple sources, including Mental Health America and IDPH were concerned about suicide rates for Illinois adolescents. At that time, both organizations were relying upon data from the CDC's 2015 Youth Risk Behavior Survey (YRBS).[153] Since our report, the CDC conducted additional rounds of surveys in 2017 and 2019 (see Table 1).[154] Unfortunately, this new data show that adolescent rates of suicidal thoughts and plans are trending upward, though actual reports of attempts are decreasing. In Illinois, suicide remains the third leading cause of death for youth ages 1 – 17.[155]

Table 1: IL High School Youth Risk Behavior Survey for Suicide 2015, 2017, & 2019[156]

CDC High School Youth Risk Behavior Survey (YRBS)	Illinois 2015 %	Illinois 2017 %	Illinois 2019 % [157]
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	36.3 (32.9–40.0) 3,067
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	19.0 (16.8–21.4) 3,050
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	15.6 (13.8–17.6) 3,038
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	9.0 (7.3–11.1) 2,655
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) 2 4,206	3.1 (2.2–4.1) 2,624
Death by Suicide for ages 1 - 17 (IDPH data)[158]	60	73	57 (2018)

When looked at by race, the results are also mixed (see Table 2). Consideration of suicide has increased from 2015 to 2019 by more than 4% for both Black and White youth, though not for

Latinx or Asian. The largest increase in suicidal planning was among Black youth. This is consistent with a December 2019 national report, Ring the Alarm: The Crisis of Black Youth Suicide in America.[159] Thankfully, actual suicide attempts are down among all groups from 2015. However, only roughly one-third of those children who attempt suicide reported receiving treatment.

Table 2: IL High School Students Self-Reports of Suicidal Thoughts and Actions 2015, 2017, & 2019

Illinois YRBS		% Seriously Considered Attempting Suicide	% Made A Suicide Plan	% Attempted Suicide	% Attempted Suicide and Received Treatment
All	2019	19.0	15.6	9.0	3.1
	2017	17.2	14.8	10.0	4.0
	2015	15.9	14.5	9.8	4.3
Asian	2019	15.4	15.2	6.2	2.4
	2017	16.9	17.6	9.3	4.2
	2015	15.1	14.1	6.7	4.8
Black	2019	20.8	18.8	14.0	5.6
	2017	15.7	16.2	13.7	5.5
	2015	16.3	15.9	15.2	7.0
Hispanic/ Latinx	2019	17.3	14.9	11.6	4.5
	2017	17.3	14.7	10.3	4.2
	2015	16.7	15.5	12.6	5.3
White	2019	18.9	14.4	6.7	2.1
	2017	17.3	13.8	8.3	3.1
	2015	14.4	13.2	7.0	3.0

B. Substance Use / Cannabis / Vaping

In looking at the Illinois YRBS data from 2015 and 2019, there appears to be improvements in rates of adolescent drug use for cocaine, heroin, meth, ecstasy, and injections (see Table 3). The exceptions include no decrease in the use of vaping, cannabis, inhalants, and pain killers. It may be worth noting that there has been a significant reduction in the number of high school students who report smoking cigarettes. However, this is offset by a much larger percentage of students reporting the use of cannabis and vaping.

Table 3: IL Youth Risk Behavior Survey on Substance Use 2015, 2017, & 2019

Illinois YRBS	IL 2015 %	IL 2017 %	2019 %
Ever Used Alcohol	60.9 (55.9–65.7)	57.4 (52.9–61.7)	(not asked) Current Use Reported as 27.1
Ever Tried Cigarette Smoking	33.8 (29.6–38.3)	27.3 (24.2–30.7)	19.8 (17.2–22.6) 2,905
Ever used an electronic vapor product[160]	47.0 (43.1–51.0)	41.4 (36.6–46.3)	49.2 (45.9–52.5) 3,011
Ever Used Marijuana / Cannabis	36.3 (31.4–41.6)	34.2 (30.0–38.5)	36.7 (33.4–40.1) 2,905
Ever Used Cocaine	5.4 (4.4–6.7)	6.4 (4.8–8.3)	4.7 (3.3–6.6) 3,056
Ever Used Inhalants[161]	6.9 (5.9–8.1)	8.4 (7.1–9.8)	7.1 (5.7–8.8) 3,054
Ever Used Heroin	3.4 (2.4–4.7)	3.4 (2.5–4.6)	2.8 (1.6–4.9) 3,040
Ever Used Methamphetamines	3.5 (2.6–4.6)	3.7 (2.7–5.0)	2.3 (1.4–3.6) 3,052
Ever Used Ecstasy	6.1 (5.0–7.5)	5.3 (4.1–6.9)	4.6 (3.1–6.8) 3,046
Ever Injected Any Illegal Drug	3.3 (2.3–4.6)	3.2 (2.2–4.8)	1.9 (1.2–3.0) 3,039
Ever Used Prescription Pain Medicine w/out Doctor's Order	Not Available	14.1 (12.0–16.6)	14.5 (13.0–16.2) 3,021

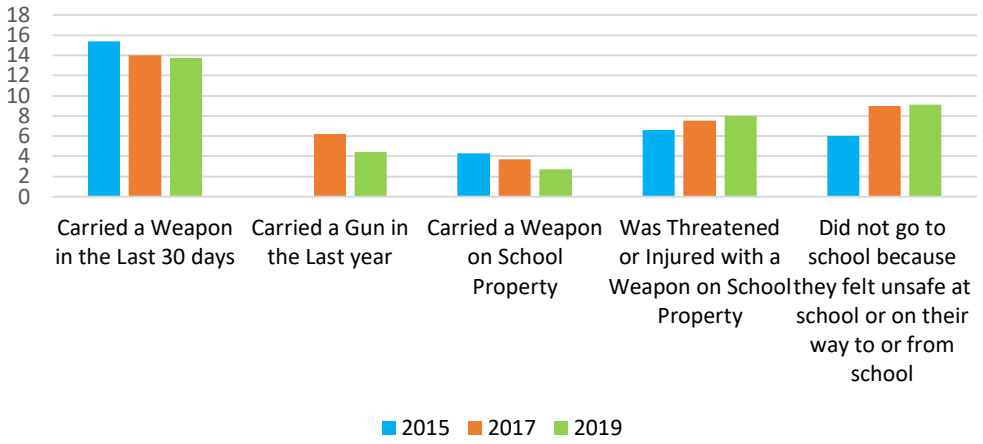
As we note in our report last year, and as the CDC notes, the use of e-cigarettes or vaping products resulted in use-associated lung injury (EVALI) in 2019.[162] The disease had its sharpest increase nationally in August 2019 and peaked in September 2019. Sample testing showed that e-cigarette, or vaping, products containing tetrahydrocannabinol (THC, the principal psychoactive ingredient found in cannabis),[163] particularly from informal sources like friends, family, or in-person or online dealers, were linked to more EVALI cases and played a major role in the outbreak. In 2019, Illinois reported over 200 people hospitalized with EVALI, including five deaths.[164] Nationally, about 15% of those hospitalized were under 18 years old. Since September 2019, emergency rooms reported a gradual, steady decline in EVALI cases.

In a new concern, however, a recent study has found that teenagers who vape face a much higher risk of COVID-19 than their peers who do not vape.[165] The study also found that Latinx or multiracial ethnicity and lower socioeconomic status were linked to the higher risk.

C. Child Trauma / Violence

Fewer youth report carrying weapons from 2015 – 2019 (see Figure 3). These positive numbers are offset by more youth reporting that they are being threatened while at school. In 2019, a larger number of youth reported that they did not go to school because they felt unsafe at school or on their way to or from school. Perhaps one of the few unintended positive effects of schools becoming virtual during the COVID-19 pandemic will be a decrease in these numbers.

Figure 3: Illinois YRBS Data on Weapons and Safety 2015, 2017, and 2019



D. Identification and Access to Services

Issues that continue to persist in regard to children's mental health, and have become even more important through the current pandemic, are properly identifying all children in need of services and ensuring they have access to holistic and appropriate services and supports.

1. Promotion, Prevention, and Early Intervention

The first challenge is defining the identification entryway points. Historically, the state's focus has been on identifying the children with more severe needs that result in diagnoses and care by mental health treatment professionals. This model can result in molding children and their needs to fit this model.[166] For example, this requires a diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for providers to be able to bill for services; in the school setting, students are required to qualify for special education plans to access many school-based mental health services (and to subsequently allow schools to be reimbursed by Medicaid for these services). For children who have experienced trauma, they may exhibit symptoms that do not correlate to a DSM diagnosis. Serving youth with diagnoses and/or those who require more intensive mental health services is still a critical investment that the state must continue to make. But it needs to be done with simultaneous investments in promotion, prevention, and early

intervention. This has only been further emphasized by the impact of the pandemic on youth. Although we will not understand the pandemic's full impact for years, we are seeing initial research and anecdotal evidence of increased rates of mental health concerns for children.[167] Increased promotion, prevention, and early intervention efforts could protect against this long-term impact.

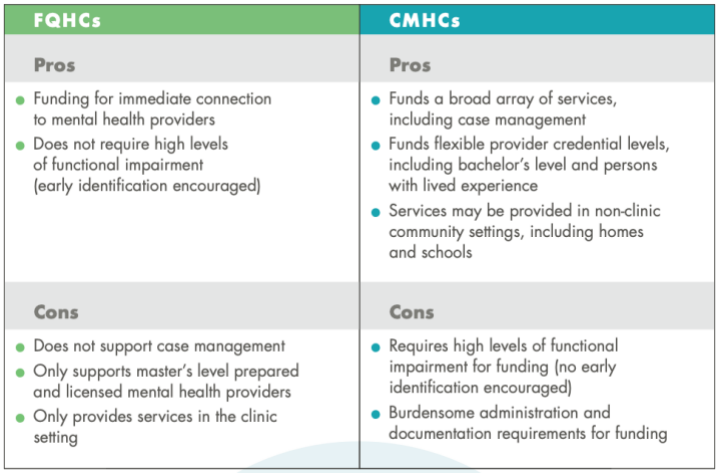
2. Integrated Care

In addition to increasing our investment in promotion, prevention, and early intervention services, the state must also work to ensure identified youth have access to holistic and appropriate services and supports in sufficient amounts. Although this requires continued investment in traditional mental health services, alternative treatment models, providers, and modalities/settings must also be included in a comprehensive response to children's mental health.

One treatment model that has grown is integrated care. Integrated care combines mental health care into another setting, such as a primary care practice or other community settings. Primary care physicians have been increasingly providing mental health care, providing approximately half of all mental health care.[168] Children are more likely to receive mental health care in this primary care setting than through a specialized mental health setting.[169] To best meet the needs of children and their providers, integrated care models can increase access to quality services, both primary and mental health.[170]

Both the public and private sectors have invested in pilots of integrated care in Illinois. In September 2019, the Illinois Children's Healthcare Foundation (ILCHF) published the results of its Healthy Minds, Healthy Children, Healthy Chicago (H3) 5-year grant project to integrate primary mental health care.[171] The H3 project studied integrated care provided in two urban federally quality health centers (FQHCs, which community based health care providers), and community mental health centers (CMHCs). Overall, the H3 project found that integrated care benefits children, families, communities, and healthcare providers. The project also discovered strengths and weaknesses of funding through both FQHCs and CMHCs:

Figure 4: ILCHF H3 Comparison of FQHCs and CMHCs



As noted by ILCHF:

> These public policy barriers make it difficult if not impossible for willing agencies to provide the full array of services as early as possible for children and families in need. If integration of behavioral health service in primary care settings is to be fully realized, there must be new administrative mechanisms that allow for the efficient and flexible provision of needed services at the time and place the need is identified.[172]

These are important lessons not only for integrated care, but when looking at early intervention services and the ability to provide services in alternative settings.[173]

E. Workforce Development

If the state is going to be successful in providing appropriate mental health services to children, it will need to significantly invest in building the children's mental health workforce and training other professionals interacting with youth. This training must also include implicit bias and anti-racism training to help address the systemic racism present in all of our systems.

1. Mental Health Care Workforce

The Behavioral Health Workforce Task Force Report notes major inequities when analyzing the workforce shortage in Illinois:

> Shortages are especially acute in rural areas and among low-income and under-insured individuals and families. 30.3% of Illinois' rural hospitals are in designated primary care shortage areas and 93.7% are in designated mental health shortage areas. Nationally, 40% of psychiatrists work in cash-only practices, limiting access for those who cannot afford high out-of-pocket costs. Community mental health centers have long argued that low Medicaid reimbursement rates limit capacity and do not allow for expanding access to services or cover the costs of recruiting and retaining teams for evidence-based behavioral health practices like Assertive Community Treatment.[174]

Broadly, Illinois lacks the resources to support a workforce beyond crisis services nor do we have a sufficient number of ongoing treatment providers. Research also shows that disparities in access to providers exist in parallel to the significant disparities around health outcomes: this has been clearly demonstrated by the disproportionate impact of COVID-19 on Black and Brown communities.

2. Other Child-Serving Professionals

Because children and adolescents interact with multiple different child-serving systems, the professionals and providers in each system, not just the mental health system, should be trained

and provided with the right tools and supports to best serve the mental health needs of children and their families. The lack of a sufficient mental health workforce has already forced other providers to address children's mental health, whether or not they have been trained to do so or have the sufficient supports.

For example, as discussed above, pediatricians provide a significant amount of mental health care. Teachers are also often required to address a student's mental health, whether or not they have received training to do so or have supports they can access in their school to assist them. When teachers do not have this training or support, they may turn to calling the police or using their SRO to help address the situation.[175]

Trainings for child-serving professionals, including pediatricians, teachers, and police stationed in schools should include child mental health, development, and trauma. They must also be trained on anti-racism and implicit bias to combat the disproportionate impact the lack of mental health resources has on Black and Latinx students.

One easy step to help Illinois support child-serving professionals providing mental health care, particularly in schools, is through the reversal of the federal Free Care Rule. This rule 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 for child-serving professionals to bill for Medicaid eligible services without an IEP, such as mental health and substance use disorder services, and dental, vision and hearing services.176 Ensuring reimbursement for these services provided in alternative settings like schools allows the state to not only ensure supports are provided where children spend the majority of their time, but it also allows for opportunity to direct other funding resources to further support and build the capacity of this workforce. Workforce development is just one tool necessary for improving children's mental health; alternative modalities are also critical.

3. Telehealth

The pandemic has highlighted a crucial tool to ensuring access to services: telehealth. Before COVID-19, advocates were already pushing telehealth as an option for providing care to more rural communities that would not otherwise have access to a particular healthcare provider. It was also promoted as a way to remove barriers for individuals and families who live in cities that have providers, but transportation and other social concerns could prevent them from getting to their appointments. Overall, telehealth has been pushed as a way to overcome these access barriers.

Although the push for telehealth began long before the pandemic, the need for remote and virtual treatment options fast tracked many policy efforts to build telehealth into healthcare

systems and payment. The federal government was the first to remove restrictions around providing telehealth by allowing this under Medicare as of March 1, 2020.[177] On March 19, just two days before Governor Pritzker issued his Stay at Home Order, Illinois followed suit in regards when Governor Pritzker issued Executive Order 2020-09: Executive Order to Expand Telehealth Services and Protect Healthcare Providers in Response to COVID-19.[178] This order required that all health insurance issuers regulated by the Department of Insurance fully cover telehealth services by in-network providers, including mental health. Then, on March 20, HFS issued a provider notice outlining that telehealth services will be reimbursed through the Medicaid program.[179]

The expansion of telehealth services for the duration of the pandemic has had a major impact on access to care. A report from CMS on the uptick in telehealth under Medicare found that pre-pandemic, only 14,000 beneficiaries received telehealth services in a given week; in the period of mid-March to early-July, over 10.1 million beneficiaries received telehealth services (more than 631,000 per week on average).[180] Anecdotally, we know that this significant uptick is mirrored in Illinois. We also know, however, that there are different barriers that arise for many low-income or rural children and families; these barriers include access to broadband internet and electronic devices or phones to allow for telehealth appointments. These present significant, although different, inequities when pushing telehealth.

The state has continued to renew these requirements for Medicaid and private insurance because of continued public health threats from COVID-19. Acknowledging the large impact on accessing services through telehealth, there was an attempt to make these telehealth provisions permanent through legislation in the Illinois General Assembly. However, this legislation was not successful when the legislature was able to come back together briefly at the end of the Spring session. In order to provide for the wellbeing of children and families in Illinois, the state will need to commit to ensure broad identification and access to services.

F. Government Response

1. State Executive

This section will briefly summarize the most relevant activities in the last year. One major development announced on July 31, 2020, the Governor and Lt. Governor announced the 21st Century Illinois Transformation Model, a four-year plan to move DJJ away from a traditional incarceration model into a system that uses small, regional residential centers.[181] This will keep youth closer to their homes and significantly upgraded available community wraparound support and interventions. The plan also increases financial support for community-based victim services.[182]

HFS continues its rollout of the *N.B.* Consent Decree, discussed in last year's ICMHP Annual Report. This includes convening a stakeholder subcommittee,[183] which is working on the training requirements for a Rehabilitative Services Associate[184] who can serve as a Children's Behavioral

Health Paraprofessional. HFS continues to develop its algorithm that will determine which children are eligible for services under *N.B.* and has begun collecting IM+CANS data[185] on all children receiving mental health services through HFS, which will prove essential in understanding children's mental health needs going forward.[186]

DCFS has several initiatives that address the mental health needs of our state's children and families.[187] The most significant is the federal Family First Prevention Services Act (FFPSA), which was passed by Congress and became law in 2018.[188] Illinois will leverage Family First legislation to mobilize and broaden the array of evidence-based parenting skills, substance use disorder prevention and treatment, and mental health services. It will strengthen and improve the ability to engage families as active partners in identifying and meeting their own needs. From intensive FFPSA planning over the past two years, DCFS will launch its implementation of FFPSA in early 2021. Illinois' target population includes children and youth with mental health needs and disorders, as well as family members with mental health needs and disorders. The overall emphasis of FFPSA is to provide supports to families to reduce risk of coming into DCFS' care and strengthen residential treatment programs in ways to provide timely trauma-informed and evidence-based services. FFPSA should result in improvements for infant and early childhood mental health,[189] home visiting,[190] residential treatment,[191] trauma-informed treatment,[192] residential placement reviews,[193] and judicial oversight.[194]

In addition to FFPSA, DCFS is working on other programs to address children's mental health, including Transition to YouthCare HealthChoice Illinois,[195] Intensive Placement Stabilization Services,[196] delivery of wraparound services,[197] and multi-system collaboration to support dually involved youth[198]

For the LGBTQ population, multiple agencies have enhanced supports for LGBTQ+ Youth. The Lieutenant Governor's Office has a program for the Illinois Council on Women and Girls (CWG) that advises the Governor and the General Assembly on policy issues impacting women and girls in this State, including protecting women who are transgender from violence and harassment, and increasing their fair and equal access to culturally competent health care, housing, employment, and other opportunities.[199] In addition to the Lt. Governor's efforts, ISBE created the Support all Students website to provide support around meeting the needs of LGBTQ youth in schools, modelled after the recommendations of the Governor's Affirming and Inclusive School's Task Force.[200] DCFS addresses LGBTQ issues through specialized services,[201] policies,[202] and its LGBTQ Specialty Program.[203]

2. Legislative

Prior to the pandemic, there were two key legislative activities impacting children's mental health. The first is the finalization of the Behavioral Health Workforce Education Center Task Force Report to the Illinois General Assembly in response to Public Act 100-0767.[204] The Behavioral Health Workforce Education Center Task Force Report provides a clear picture of the vast shortage within the behavioral workforce across the state. The report notes that it is estimated only 23.3% of Illinoisan's mental health needs can be met by the current workforce.[205]

For children, the report notes the severe lack of early childhood expertise and ability to assess and diagnose young children.[206] The report recommends, among other things, creating the Illinois Behavioral Health Workforce Education Center, and expanding programs, like telehealth and crisis intervention, that can extend the reach of the existing workforce.[207]

The second key activity is the Children and Young Adult Mental Health Crisis Act, which intends to fill 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.[208] This includes restructuring the Family Support Program (FSP, formerly known as the Individual Care Grant [ICG] 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, and expanding private insurance coverage to include team-based early treatment models proven to curtail the debilitating effects of serious mental health conditions.

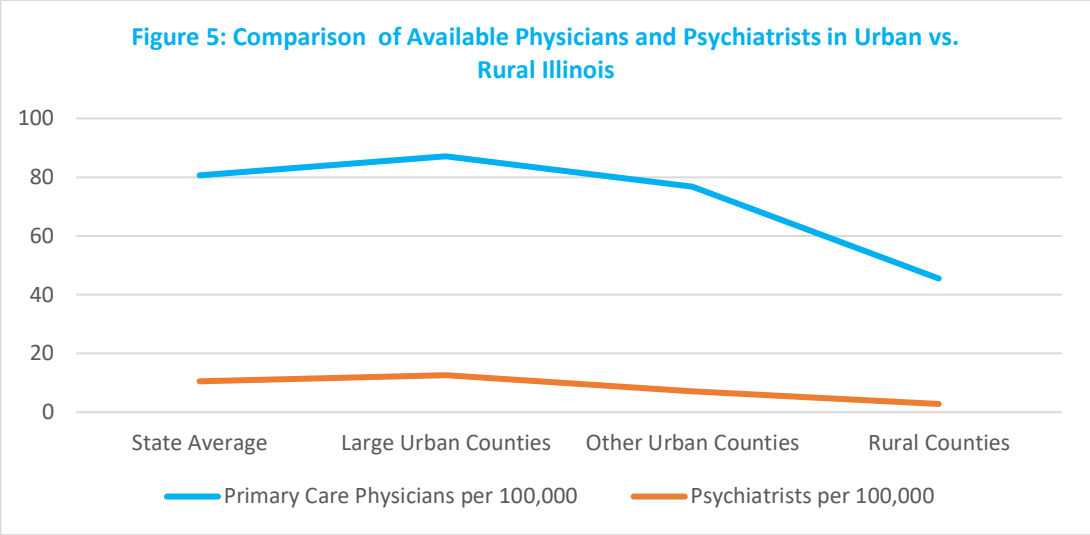
3. Judicial

Within the judicial branch, an Illinois case involving a minor and mental health forensic issues received international attention.[209] A nine year old boy was charged with five counts of murder related to arson.[210] After a forensic evaluation, the youth was found unfit to stand trial.[211] The case continues to work its way through the legal system.

ICMHP has formed a committee that is looking at juvenile fitness to stand trial issues, including the possibility of considering a child's development and child trauma in the evaluation. Similarly, the Illinois Juvenile Justice Commission,[212] Illinois Justice Project,[213] the Juvenile Justice Initiative,[214] and other juvenile justice groups are looking at reform issues related to ending youth shackling; ending the pre-trial detention of children younger than 13, limiting pre-trial detention to felony offense charges, giving lawyers to all children under age 18 during interrogation in cases that could trigger adult sentencing, providing a legal privilege for communications in restorative justice proceedings, expanding expungement, and beginning all cases of children under age 18 in juvenile court.

4. Local - Rural

Children's mental health and wellness issues exist across the state. However, the specific needs of children living outside of the Chicago metropolitan area are sometimes overlooked. For example, rural counties in Illinois have one tenth the number of psychiatrists per 100,000 people than the state average (see Figure 5).[215]



The region has begun to find its voice recently through Southern Illinois University School of Medicine's Department of Population Science and Policy,[216] in partnership with the Illinois Rural Health Summit planning committee. This group hosted a summit in 2018[217] and, in 2019, presented a Series of Policy Recommendations to Improve the Health of Illinois and America's Rural Communities to the U.S. Department of Health and Human Services.[218]

The group's recommendations for children's growth and development included increasing funding for school based health centers to allow children the opportunity to receive quality, affordable, and comprehensive health care, expanding funding to rural health clinics to better allow for integration of behavioral health care and substance use treatment into primary care, and increasing the availability of telepsychiatry as a way to connect rural individuals to behavioral health care.

G. Recommendations

Though the current crises of the COVID-19 pandemic and the resurgence of systemic racism issues have dominated the year, traditional children's mental health issues remain to be addressed. These recommendations can be addressed in more detail in future annual reports. Nonetheless, in this next year, the State can improve children's mental health by addressing:

1. Telehealth

This recommendation is the low-hanging fruit that multiple groups have called for. Telehealth is one of the major services that has improved during the pandemic. The state has temporarily extended the requirements that Medicaid and private insurance plans fund telehealth. There was an attempt to make these telehealth provisions permanent through legislation in the Illinois General Assembly. However, this legislation was not successful when the legislature came back together at the end of the Spring session. The state needs to make this temporary expansion of telehealth permanent and lobby the federal government to do the same with Medicare. At the

same time, the state needs to continue investing in broadband internet expansion and opportunities to provide electronic devices to children and families in order to ensure equitable access to telehealth.

2. Youth Suicide

The Illinois High School Youth Risk Behavior Survey (YRBS) indicates an increase in depression and suicidal thoughts from 2015 through 2019, most noticeably with Black youth. This data all preceded the COVID-19 pandemic. There is every indication that COVID-19 and increased attention on systemic racism issues has increased people's anxiety and depression, particularly for children. The state needs to track these issues among youth, particularly with youth of color, and consider using the integrated care model to assure prevention and early intervention.

3. Family First Prevention Services

As noted above, DJJ, HFS, and DCFS are all initiating programs that could significantly improve children's mental health. DCFS will launch its implementation of FFPSA in early 2021. The target population includes children and youth with mental health needs and disorders as well as family members with mental health needs and disorders. This program, if implemented effectively, would not only improve the life of families working with child welfare, it could also impact those youth receiving DJJ and HFS services. Ultimately, coordinating such care and programs would be the best approach to improving the mental health and wellness of Illinois children and families.

V. CONCLUSION

This last year was unprecedented in the health crisis that Illinois faced. COVID-19 dominated all discussions, bringing incredible challenges to Illinois, the country, and the world. It is a medical issue that has had a major impact on children's mental health. The full effects of COVID-19 are still unknown and this ambiguity, in and of itself, exacerbates mental health issues for everyone.

This deadly health issue then brought heightened awareness to the longstanding issues of America's systemic racism and trauma. In the meantime, previous concerns regarding children's mental health in Illinois, such as suicide, access to services, and workforce development still remain and, in many cases, have been heightened through this "dual pandemic."

To move forward, we make nine recommendations. We recommend that the state help children deal with the COVID-19 pandemic by continuing to focus on (1) Safety, (2) Communication, and (3) Planning for Child Vaccines. In order to help children overcome systemic racism, the state

should (4) Teach Children About Systemic Racism, (5) Continue to Modify the Juvenile Justice System, and (6) Review School Supports Through a Systemic Racism Lens. Finally, over the next year, the State can improve children's mental health generally by addressing (7) Telehealth, (8) Youth Suicide, and (9) Family First Prevention Services.

ICMHP applauds the state's efforts to deal with COVID-19 and protect Illinois citizens. We look forward to working with the administration on addressing this pandemic as well as the systemic racism and other children's mental health issues in order to improve overall child well-being. Please let us know how we can be of assistance.

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Vermilion County Mental Health 708 Board

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ACT Now Coalition

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Illinois Children's Health Care Foundation

Kaylan Szafranski
Legal Council for Health Justice

Kate Yager
Healthy Schools Campaign

Endnotes

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[82] "Case Management – Mental Health – COVID-19 Guidance." *HFS*, April 14, 2020. https://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn200414a.aspx.

[83] DHS increased FY20 funding for Emergency and Transitional Housing, Supportive Housing, and Homeless Prevention by 5% in addition to committing $6 million for emergency lodging. Hou, Grace B. "A Message to Providers from Secretary Hou: COVID-19 Budget Updates." *IDHS*, March 23, 2020. http://www.dhs.state.il.us/page.aspx?item=124002. At the start of April, the Department announced $1.2 million dedicated to support access to services for those impacted by domestic and sexual violence. Hou, Grace B."A message to Providers from Secretary Hou: Services for victims of Domestic and Sexual Violence." IDHS, April 1, 2020. http://www.dhs.state.il.us/page.aspx?item=124004. The Domestic Violence Statewide Helpline was also expanded to help connect individuals and families to emergency shelter, including support for transportation. DHS began to provide the maximum amount of Supplemental Nutrition Assistance Program (SNAP) benefits based on household size for every existing and new recipient as of April 2020. "Illinois SNAP recipients will begin receiving maximum benefit amounts this week." *IDHS*, April 6, 2020. http://www.dhs.state.il.us/page.aspx?item=123680.;
This option was available to states under the Families First Coronavirus Response Act passed by the Federal government. IDHS received federal approval to administer the Pandemic Emergency Benefit Transfer (P-EBT) program, which provides funds to help Illinois families buy food for school-aged children and young adults who would receive National School Lunch Program free or reduced-priced meals when schools are in session.
Hou, Grace B. "A message to Providers from Secretary Hou: Extended! Food Benefits for School Aged Children." IDHS, June 25, 2020. https://www.dhs.state.il.us/page.aspx?item=125343&utm_source=ICOY+Contacts&utm_campaign=13f5b789bd-Racial_Disparities_on_the_Rise_for_Youth10_6_2017_&utm_medium=email&utm_term=0_ba62da2d9f-13f5b789bd-219958981.

[84] "Governor Pritzker Announces New Statewide Telehealth Programs, Mental Health Support Hotline." Office of Governor JB Pritzker, April 11, 2020. https://files.constantcontact.com/f1e178eb701/52334ca1-10cc-4c16-99c3-3ed1099d9f5a.pdf.

[85] As noted in Section 1 of this report, school districts across the state are providing instruction in fall 2020 in-person, virtually, and through hybrid approaches. Reflecting the diversity of urban, rural, and suburban communities in Illinois and each district's unique facilities and technological capabilities, local school officials are determining how to provide instruction in the fall, in consultation with local public health departments and with engagement of educators and parents. "School Wellness: Coronavirus." *ISBE*, accessed September 2020. https://www.isbe.net/coronavirus.

[86] ISBE's Remote Learning Recommendations for spring 2020 strongly recommended that student grades be based upon the principle of no educational harm to any child, stating, "Grading should focus on the continuation of learning and prioritize the connectedness and care for students and staff. All students should have the opportunity to redo, make up, or try again to complete, show progress, or attempt to complete work assigned prior to the remote learning period in that time frame. A focus on keeping children emotionally and physically safe, fed, and engaged in learning should be our first priority during this unprecedented time… There are factors outside of the control of the school system with learning being moved off site; therefore, the aim is that student grades are not lowered as a result of remote learning. ISBE recommends that a student who is not able to be engaged, or who chooses to disengage, in remote learning should receive an incomplete or no grade." "Remote Learning Recommendations During COVID-19 Emergency." *ISBE*, March 27, 2020. https://www.isbe.net/Documents/RL-Recommendations-3-27-20.pdf#page=20. ISBE sought and received the waiver for federal accountability, exempting Illinois schools from penalties for chronic absenteeism while still collecting attendance data. ISBE established the purpose of collecting

attendance as checking in on student's overall wellbeing and defined the "preferred method of collecting attendance" during remote learning as "one-to-one daily connection between the teacher and the student." The guidance also recognized "that this method is not available or practical for all districts and student scenarios under the COVID-19 conditions" and encouraged creative ways to measure and maintain student engagement, "Student Attendance During Remote Learning." *ISBE*, May 4, 2020. https://www.isbe.net/Documents/Student-Attendance-Guidance-5-4-20.pdf. ISBE also worked with the Governor's Office on an Executive Order to adjust graduation requirements to ensure no student would be unable to graduate due to the interruption of in-person learning in spring 2020, "Executive Order in Response to COVID-19 (COVID-19 Executive Order No. 29)." ISBE, April 24, 2020. https://www.isbe.net/Documents/EO2020-31.pdf. ISBE worked with IDPH to produce guidance for schools to host virtual or socially distanced graduation ceremonies to still recognize the achievements of graduating seniors and provide closure to their secondary school experiences, while keeping them, their teachers, and their families safe, "Illinois Department of COVID-19 and subsequent school building closures for the remainder of the 2019-20 school year have created questions related to graduation ceremonies." *Released from IDPH and ISBE*, May 2, 2020. https://www.isbe.net/Documents/IDPH-ISBE-Grad-Ceremony-Guidance.pdf.

[87] Efforts already were underway by the Pritzker Administration to ensure universal broadband access across the state. The State used $80 million of its CARES Act funding for a Digital Equity Formula Grant for the highest need school districts to purchase devices and expand internet connectivity. Additionally, school districts were able to use $512 million in flexible CARES Act funding to further close the digital divide. Some school districts, such as Chicago Public Schools, also used local funds to address students' devices and connectivity needs. Further, ISBE partnered with IBHE and other state agencies on a map of freely accessible drive-up Wi-Fi hotspots at universities, libraries, and other locations, where students and families could access the internet for educational purposes. "Pritzker Administration Releases WI-FI Hotspot Map to Support Illinois Students during COVID-19 Pandemic." *ISBE,* April 17, 2020. https://www.isbe.net/Documents/IBHE-Wifi-Hotspot-Map-Release.pdf.

[88] ISBE partnered with the Illinois Emergency Management Agency (IEMA) to deliver more than 2.5 million free cloth face masks to all students and educators in Illinois schools to ensure all students would be able to access the learning and extracurricular activities provided by their district, regardless of their ability to purchase a face covering or make one at home.

[89] The federal waivers ISBE applied for and received allowed schools to deliver meals on school buses, to provide grab-and-go and drive-thru options, to provide meals for multiple days at once, and to allow parents and caregivers to pick up meals on behalf of students. ISBE also partnered with DHS to provide low-income families access to the Pandemic EBT, which distributed additional money for food for every day that children who normally were eligible for free or reduced-price meals were learning remotely.

[90] "Provisional Identification and Placement Procedures During Remote Learning Situations Grades Pre-K to 12." *ISBE*, August 12, 2020. https://www.isbe.net/Documents/EL-Provisional-Screening-August-update.pdf.

[91] "Supporting Homeless Students During the 2020-21 School Year Guidance for Schools and Districts." *ISBE*, July 23, 2020. https://www.isbe.net/Documents/Homeless-Guidance.pdf.

[92] "What Schools and Districts Should Do If They Are Unable to Make Contact with a Student for Over a Week." *Released from DCFS and ISBE*, May 6, 2020. https://www.isbe.net/Documents/DCFS-ISBE-Student-Wellness-Visit.pdf?.

[93] "Guidance for Delivering Sexual Abuse Prevention Education During the COVID-19 Pandemic." *Released from CACI, ChicagoCAC, and ISBE*, September 8, 2020. https://www.isbe.net/Documents/Guidance-sexual-abuse-prevention-education.pdf.

[94] Technology is a critical key for youth in care to maintain relationships with their families during this pandemic. To support these invaluable connections – and understanding that families' access to technology may be limited – DCFS provided approximately 200 Chromebooks to support virtual visitation and service engagement to DCFS offices and the offices of 120 private agency partners. In addition, the Department purchased and shipped 725 Chromebooks to school districts around the state for youth in care to connect with their teachers and complete remote learning. Residential facilities are required to make every effort to use available technology, including phone and video conferencing, to allow youth in care to communicate with their family members. Facilities must also make every effort to allow video conferencing available for assigned workers to communicate with youth in care.

[95] This included over one million face coverings, over 500,000 pairs of gloves, cleaning supplies, hand sanitizer and thermometers.

[96] DCFS workers collaborated with families to find solutions that allowed them to continue services whenever possible, and parents' access to services is taken into consideration as a factor in any decision making related to changes in permanency goals. Services such as parenting classes, therapy, drug treatment/counseling and family counseling have continued to occur virtually.

[97] DCFS issued an action transmittal allowing older youth who were expected to age out of DCFS care beginning in April, to choose to shelter in place and remain in their DCFS-approved placement; extending emergency cash assistance to youth who had aged out of DCFS care six months prior to the COVID-19 pandemic; and reinforcing available community resources for former youth in care through DCFS-funded family advocacy centers (FACs). FACs are performing well-being checks on these youth, working closely with youth housing programs and offering youth cash assistance from the Department.

[98] ICJIA is the State Administering Agency (SAA) for the Federal Victim of Crime Act Funds. Beginning in FFY15, the VOCA allocations to SAAs increased dramatically. To address this influx of funding, ICJIA completed a thorough needs assessment with a resulting plan, "Illinois Criminal Justice Information Authority Data and Research." *ICJIA*, accessed September 2020. http://www.icjia.state.il.us/articles/ad-hoc-victim-services-committee-research-report.
During October 1, 2017 through Sept 30, 2018 ICJIA's VOCA grant recipients reported serving 29,516 children and young adults. In one of its studies Baldo, Paola and Jaclyn Houston-Kolnik. "Child and Youth Exposure to Violence in Illinois." *ICJIA*, March 18, 2019. https://icjia.illinois.gov/researchhub/articles/child-and-youth-exposure-to-violence-in-illinois. ICJIA found that a substantial number of Illinois children "are exposed to violence in their homes, schools, and communities. Unaddressed trauma resulting from these experiences can contribute to a host of mental, physical, and developmental consequences for children and adolescents and negatively impact families and communities." But as ICJIA also notes "[a]ccessing needed services that are comprehensive and timely, however, is often difficult for families, particularly as they attempt to navigate multiple, disparate systems of care." In addressing the access issue, ICJIA has developed its Illinois Helping Everyone Access Linked Systems (Illinois HEALS) initiative. The six-year initiative seeks to improve the recognition, connection, and service engagement of children, youth, and families impacted by violence in Illinois. Illinois HEALS program staff surveyed agencies in Illinois serving children, youth, and families to better understand how they learn about client victimization and exposure to violence, services available to victims, and referral and collaboration processes. 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. More detail here:
Alderson, Megan, Paola Baldo, Reshma Desai, Jaclyn Houston-Kolnik, Sooeun Tiffany Kim, Amanda L. Vasquez, and Jason Wynkoop."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. Healthy relationships remain an essential need for all children, particularly those dealing with trauma.
[99] "The Illinois Criminal Justice Information Authority Awards Over $8 Million in Funding to Illinois Organizatons Offering COVID-19 Relief." *ICJIA*, September 14, 2020. https://www2.illinois.gov/Pages/news-item.aspx?ReleaseID=22076.
[100] Gleicher, Lily, Douglas Otto, Jessica Reichert, Amanda L. Vasquez, and William Watkins. "The Criminal Justice System and Pandemic Preparedness and Response: Operating in the Age of Coronavirus." *ICJIA*, April 16, 2020. https://icjia.illinois.gov/researchhub/articles/the-criminal-justice-system-and-pandemic-preparedness-and-response-operating-in-the-age-of-coronavirus.
[101] Green, Emilee."Mental Illness and Violence: Is there a Link?" *ICJIA*, May 4, 2020. https://icjia.illinois.gov/researchhub/apps/mental-health-disorders-and-the-criminal-justice-system.
[102] "Monthly Report: July." *IDJJ*, July 2020. https://www2.illinois.gov/idjj/Documents/July%202020%20Monthly%20Report.pdf.
[103] Concerns for the wellbeing of juveniles in detention were especially heightened; in addition to risks from COVID-19, advocates worried about increased isolation for juveniles as educational programs were cancelled and visits from families and loved ones were also halted as a precaution for the spread of the virus.
[104] "Illinois Department of Juvenile Justice Mitigation Activities." *IDJJ*, May 31, 2020. https://www2.illinois.gov/idjj/Documents/Mitigation%20Actions%20thru%205_8.pdf.
[105] By mid-August only 16 youth had tested positive and 13 of these youth were at one facility, where additional precautions were put in place. "COVID-19 Updates." *IDJJ*, accessed September 2020. https://www2.illinois.gov/idjj/Pages/COVID19.aspx.; "Reopening IDJJ: Transition Plan to Restore Operations." *IDJJ*, May 2020. https://www2.illinois.gov/idjj/Documents/Reopening%20DJJ%20%284%29.pdf.
[106] "Redeploy Illinois." IDHS, accessed September 2020. https://www.dhs.state.il.us/page.aspx?item=31991.
[107] Maxwell, Mark. "Illinois Legislature cancels second week of scheduled session." *National News*, March 18, 2020. https://www.mywabashvalley.com/news/national-news/illinois-legislature-cancels-second-week-of-scheduled-session/.; Nowicki, Jerry. "Senate, House cancel session once again." *Metropolis Planet*, March 30, 2020. https://www.metropolisplanet.com/search/?l=25&sd=desc&s=start_time&f=html&t=article%2Cvideo%2Cyoutube%2Ccollection&app=editorial&q=senate+house+cancel+session+once+again .; O'Connor, John."Illinois Lawmakers Cancel Legislative Session Over Coronavirus." *NBC Chicago*, March 12, 2020. https://www.nbcchicago.com/news/local/chicago-politics/illinois-lawmakers-cancel-legislative-session-over-coronavirus/2235608/.;
[108] "Illinois Lawmakers Return to Springfield for Legislative Session." *NBC Chicago*, May 20, 2020. https://www.nbcchicago.com/news/local/chicago-politics/illinois-lawmakers-return-to-springfield-for-legislative-session/2275097/.
[109] For a full summary of legislation passed during the May 2020 Special Legislative Session,

"Special Legislative Session 2020: Passed Legislation Overview." Office of Senator Ram Villivalam, accessed September 2020. https://docs.google.com/document/d/1NBFd8CnmdwJHc9Lh70nHAf-nn9zsf-yqW_gk8g5ng0Y/edit.; Items addressed included: an elections omnibus bill (including mailing mail-in ballots to everyone who voted in 2018-2020 and to those who have registered since March 2020 and allowing for curbside voting see SB1863, "Bill Status of SB1863: FOIA/Elections – Cybersecurity." *Illinois General Assembly*, June 16, 2020.https://ilga.gov/legislation/billstatus.asp?DocNum=1863&GAID=15&GA=101&DocTypeID=SB&LegID=119533&SessionID=109&SpecSess=1), an education omnibus bill (including relief to the Illinois State Board of Education and allowing retired substitute teachers to keep working; SB1569, "Bill Status of SB1569: Education - Various." *Illinois General Assembly*, June 18, 2020. https://ilga.gov/legislation/billstatus.asp?DocNum=1569&GAID=15&GA=101&DocTypeID=SB&LegID=118568&SessionID=109&SpecSess=1), and several healthcare provisions, including Medicaid expansion to cover undocumented individuals over the age of 65, Budget Implementation Act, HB 357, "Bill Status of HB0357: Procedure Domestic Products." *Illinois General Assembly*, June 10, 2020. https://ilga.gov/legislation/billstatus.asp?DocNum=357&GAID=15&GA=101&DocTypeID=HB&LegID=114556&SessionID=109&SpecSess=1.

[110] "COVID-19 Information and Updates." *Illinois Courts*, accessed September 2020. http://www.illinoiscourts.gov/Administrative/covid-19.asp.

[111] Munks, Jamie."Illinois Supreme Court consolidates lawsuits challenging Go. J.B. Pritzker's coronavirus orders." *Chicago Tribune*, August 11, 2020. https://www.chicagotribune.com/coronavirus/ct-coronavirus-pritzker-court-challenge-20200811-lrljtstzrfcnxeqjt5g5pgfqbi-story.html.; Sigel, Gabrielle and Leah Song. "Federal Courts Beat Back Legal Challenges to Illinois Gov. Pritzker's COVID-19 Executive Orders." *Jennifer & Block: Corporate Environmental Lawyer Blog*, August 7, 2020. https://environblog.jenner.com/corporate_environmental_l/2020/08/federal-courts-beat-back-legal-challenges-to-illinois-governor-pritzkers-covid19-executive-orders.html.; Sigel, Gabrielle and Leah Song. "State Court Legal Challenge to Illinois Gov. Pritzker's COVID-19 Executive Orders." *Jennifer & Block: Corporate Environmental Lawyer Blog*, August 12, 2020. https://www.lexology.com/library/detail.aspx?g=df83cb2a-d441-420a-8d5f-bc2fa63e77ae.

[112] Within the first couple days of hearing these emergency motions, more than 20 of the 150 detained youth were ordered to be released. Crepeau, Megan, and Annie Sweeney. "Hearings start on releasing some youths from Cook County juvenile detention over COVID-19 fears." *Chicago Tribune*, May 24, 2020. https://digitaledition.chicagotribune.com/infinity/article_share.aspx?guid=0814974d-c14e-4e39-9fb0-de18ef43965d.

[113] Illinois Supreme Court Guidelines for Resuming Illinois Judicial Branch Operations During the COVID-19. Pandemic. May 20, 2020. https://courts.illinois.gov/Administrative/covid/052020_SC_GL.pdf

[114] "Gov. Pritzker Partners with United Way of Illinois, Alliance of Illinois Community Foundations to Launch Illinois COVID-19 Response Fund." *Office of the Governor*, March 26, 2020. https://www2.illinois.gov/Pages/news-item.aspx?ReleaseID=21306&fbclid=IwAR1aaSqMLJkodXGrzmrlMb2ERH5LRzqnd9X_AhBS2d1zOs6VmayJMuY1sI0.

[115] "Illinois COVID-19 Response Fund." *The United Way of Illinois and the Alliance of Illinois Community Foundations, in collaboration with the Office of Governor JB Pritzker*, accessed September 2020. https://www.ilcovidresponsefund.org/.

[116] Blow, Charles M. "Social Distancing is a Privilege." *The New York Times*, April 5, 2020. https://www.nytimes.com/2020/04/05/opinion/coronavirus-social-distancing.html?smid=em-share.; Kendi, Ibram X. "Stop Blaming Black People for Dying of the Coronavirus." *The Atlantic*, April 14, 2020. https://www.theatlantic.com/ideas/archive/2020/04/race-and-blame/609946/.; WBEZ reported that in Chicago, 70% of COVID-19 deaths were of Black people and in Cook County, Black residents accounted for 58% of the COVID-19 deaths even though they make up only 23% of the population. Inés, María and Elliot Ross. "In Chicago, 70% of COVID-19 Deaths are Black." *Wbez*, April 5, 2020. https://www.wbez.org/stories/in-chicago-70-of-covid-19-deaths-are-black/dd3f295f-445e-4e38-b37f-a1503782b507.; Statewide, as already noted, Latinx children make up the largest group of infected children. Rabin, Roni Caryn."Why the Coronavirus More Often Strikes Children of Color." *The New York Times*, September 1, 2020. https://www.nytimes.com/2020/09/01/health/coronavirus-children-minorities.html?smid=em-share.

[117] This happened during an arrest for Mr. Floyd's allegedly using counterfeit money.

[118] Dooley, Danielle G., Jacqueline Dougé, and Maria Trent. "The Impact of Racism on Child and Adolescent Health" *American Academicy of Pediatrics*, 1 (August 2019). DOI: https://doi.org/10.1542/peds.2019-1765.

[119] Jones CP, Truman BI, & Elam-Evans LD 92008, Using "socially assigned race" to probe white advantages in health status. *Ethn Dis.,* **18**(4):496–504 pmid:19157256, as cited in Dooley, Danielle G., Jacqueline Dougé, and Maria Trent. "The Impact of Racism on Child and Adolescent Health" *American Academicy of Pediatrics*, 1 (August 2019). DOI: https://doi.org/10.1542/peds.2019-1765.

[120] Liu, S. R., & Modir, S. (2020, June 18). The Outbreak That Was Always Here: Racial Trauma in the Context of COVID-19 and Implications for Mental Health Providers. Psychological Trauma: Theory, Research, Practice, and Policy. Advance online publication. http://dx.doi.org/10.1037/tra0000784

[121] Anxiety, depression, substance use disorder, and suicide rates among children have been steadily growing over the past decade. COVID-19 is only expected to exacerbate these concerns, as many children have spent months in social isolation, often while families experienced both economic hardship and health distress. High numbers of parents are reporting that their children are facing social and emotional health challenges, including loneliness, anxiety, and depression. In addition to disrupted routines and ongoing uncertainty, some children will endure traumatic experiences related to COVID-19 that may further undermine their sense of safety and stability. Exposure to trauma can have long-term impacts on children's daily lives, including their mental health and ability to learn. As households experience significantly increased levels of stress, strengthening both family and school-based behavioral health services can work to identify unmet needs, prevent additional traumatic experiences, and build resilience in children and their families.
[122] Mental and behavioral health disparities have been long documented for racial and ethnic minorities, particularly African Americans. The consequences of this pandemic are dire, particularly for African American citizens and other communities of color, who suffer disproportionately from the structural racism embedded within our society, including our health care system. Better health for our population requires targeting solutions to populations who need it most.
[123] "Mental Health and Racism." *Mental Health America*, September 1, 2020. https://mentalhealthsummit.wordpress.com/2020/06/22/mental-health-and-racism/.
[124] Ibid.
[125] Ibid, 2.
[126] Smedley, A., & Smedley, B. D. (2005). Race as biology is fiction, racism as a social problem is real: Anthropological and historical perspectives on the social construction of race. *American Psychologist, 60*(1), 16–26. https://doi.org/10.1037/0003-066X.60.1.16.
[127] Onwuachi-Willig, A. (2019) Reconceptualizing the harms of discrimination: How *Brown v. Board of Education* helped to further white supremacy. *Virginia Law Review* 105 (2) 343-369.
[128] Ibid, 344.
[129] Ibid, 362.
[130] Ibid, 362.
[131] Ibid, 369.
[132] For similar arguments, DiAngelo, Robin. "White Fragility: Why It's So Hard For White People To Talk About Racism." *Beacon Press*, 2018. https://www.robindiangelo.com/publications/.; Wilkerson, Isabel. "America's Enduring Caste System." *The New York Times*, July 1, 2020. https://www.nytimes.com/2020/07/01/magazine/isabel-wilkerson-caste.html.
[133] Bellafante, Gina. "Why Amy Cooper's Use of "African American' Stung." *The New York Times*, May 29, 2020. https://www.nytimes.com/2020/05/29/nyregion/Amy-Cooper-Central-Park-racism.html. This second case not only points to the systemic racism and power of our current systems, it also adds in the nuance of gender roles. The White woman is the "fair creature" in need of protection from the dangerous Black man, and the police traditionally offer that protection, enforcing the system's racism.
[134] For a description of these reactions, DiAngelo, Robin. "White Fragility: Why It's So Hard For White People To Talk About Racism." *Beacon Press*, 2018. https://www.robindiangelo.com/publications/.
[135] Mbekeani-Wiley, Michelle."Handcuffs in Hallways: The State of Policing in Chicago Public Schools." *Sargent Shriver National Center on Poverty Law*, February 2017. https://www.povertylaw.org/article/handcuffs-in-hallways-the-state-of-policing-in-chicago-public-schools/.
[136] Boyd, Rhea W., Angela M. Ellison, and Ivor B. Horn. "Police, Equity, and Child Health." *Pediatrics: Official Journal of the American Academy of Pediatrics*, March 2016. https://pediatrics.aappublications.org/content/137/3/e20152711.
[137] Fisher, B. W.**,** Higgins, E. M., Kupchik, A., Viano, S., Curran, F. C., Overstreet, S., Plumlee, B., & Coffey, B. "Protecting the Flock or Policing the Sheep? Differences in School Resource Officers' Perceptions of Threats by School Racial Composition."2020, forthcoming.
[138] Parker-Pope, Tara. "How to Raise an Anti-Racist Kid." *The New York Times*, June 24, 2020. https://www.nytimes.com/2020/06/24/well/family/how-to-raise-an-anti-racist-kid.html?smid=em-share.
[139] Schwartz, Matthew S. "Trump Tells Agencies To End Trainings on 'White Privilege' and 'Critical Race Theory.'" *NPR*, September 5, 2020. https://www.npr.org/2020/09/05/910053496/trump-tells-agencies-to-end-trainings-on-white-privilege-and-critical-race-theor.
[140] Nolan, Mike."Gov. Pritzker marches with hundreds in Matteson, demanding racial equality." *Chicago Tribune*, June 9, 2020. https://www.chicagotribune.com/suburbs/daily-southtown/ct-sta-matteson-march-pritzker-st-0610-20200609-dig6tag4bzezhnoftw537hxxde-story.html.
[141] Earley, Neal. "Lawmakers want money to rebuild areas wracked by looting and reforms to end racism that 'has torn us apart.'" *Chicago Sun-Times*, June 2, 2020. https://chicago.suntimes.com/politics/2020/6/2/21278724/illinois-black-legislative-caucus-reforms-racism-executive-order-george-floyd?fbclid=IwAR2spuCCunYxhlOZLivwcXEwUiEzMhZZtdT6BGHYM1dLT0o8YsDYGURm85I.

[142] "Revised: Restore Illinois Recommendations and Guidance for Home Visiting, Doula, and Coordinated Intake Programs." *Developed by GOECD in consultation with the major funders of home visiting and the Executive Committee of the Home Visiting Task Force*, August 31, 2020. https://www2.illinois.gov/sites/OECD/Documents/Revised%20Restore%20IL%20Guidance%20for%20HV%20Doula%20CI%20DHS%20MIECHV%20Head%20Start%20DFSS%202020.08.31.pdf.

[143] The JEO Initiative was established by executive order in February 2019 and centralizes the state's criminal justice reform efforts within the Lieutenant Governor's office. JEO Initiative staff advise the Governor and the Lieutenant Governor on justice reform policy and legislation, oversee several criminal justice-related agencies, and convene advocates and stakeholders to advance equity-focused policies and practices. "The Justice, Equity, and Opportunity Initiative: An Introduction." *Office of Lt. Governor Juliana Stratton*, accessed September 2020. https://www2.illinois.gov/sites/ltg/issueslist/Justice-Equity-and-Opportunity-Initiative/Pages/Introduction.aspx.

[144] "Resolution Affirming The State Board's Commitment to Eliminate Racial Injustice." *ISBE*, June 17, 2020. https://www.isbe.net/Documents_Board_Meetings/Resolution-Affirming-Boards-Commitment-Eliminate-Racial-Injustice-20200617.pdf.

[145] This work may lead to some additional curriculum supports to ensure districts are meeting Illinois curriculum mandates, such as the requirement to learn about the Holocaust and other acts of genocide. These efforts are the beginning of what ISBE believes will continue to be a concerted effort to supporting a socially responsible and just learning experience for Illinois students.

[146] Culturally Responsive Practice in the classroom refers to both: 1) the use of cultural knowledge to make learning encounters more relevant to and effective for all students and, 2) empowering students intellectually, socially, emotionally, and politically. Culturally responsive teaching and leading are critically important to students' wellbeing and equitable access to education in Illinois. Statewide, 52 percent of public-school children are students of color, yet only 17 percent of their teachers reflect this racial diversity. These standards will help to ensure that all students learn from educators who understand the various cultures and potential language barriers, so they can successfully reach all children and their families. ISBE's rules will be posted soon for public comment.

[147] Established by House Resolution 1098, the Task Force recently released a survey to local districts to gather information about the implementation of Black History across the state. The results of this survey will help inform the recommendations that the task force will make to the General Assembly and to ISBE. School districts have until Oct. 30, 2020, to complete the survey.

[148] Other forms of discrimination also impact the child welfare system, such as the ways in which lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQ) youth experience higher rates of abuse and neglect than heterosexual peers.

[149] Established in 2012, the Office of Racial Equity Practice oversees the Department's efforts to reduce and/or eliminate racial disproportionality and improve permanency outcomes for children and families of color in the Illinois child welfare system. To ensure collective impact, the Office supports three Regional Transformation Teams (Cook, Central and Southern regions) that meet regularly to analyze Department data, policy and practice through a racial equity lens.

[150] In 2016 the Racial Equity Practice Subcommittee (now a standing committee) of the Child Welfare Advisory Committee (CWAC) was chartered to embed racial equity principles and values into ongoing trainings, practice, and policy. The committee continues to work on a primary objective of establishing a 10-week web-based educational campaign, "Informing Our Practice by Race," targeting stakeholders to educate, promote and encourage greater awareness of racial equity and the impact of existing inequities in the Illinois child welfare practice and system. That campaign is currently targeted for launch in January of 2021.

[151] Earley, Neal. "Lawmakers want money to rebuild areas wracked by looting and reforms to end racism that 'has torn us apart.'" *Chicago Sun-Times*, June 2, 2020. https://chicago.suntimes.com/politics/2020/6/2/21278724/illinois-black-legislative-caucus-reforms-racism-executive-order-george-floyd?fbclid=IwAR2spuCCunYxhlOZLivwcXEwUiEzMhZZtdT6BGHYM1dLT0o8YsDYGURm85I.

[152] "QuickFacts: Illinois." *U.S. Census Bureau*, accessed September 23, 2020. https://www.census.gov/quickfacts/IL.

[153] 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. "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.

[154] *Ibid.*

[155] "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.

[156] "High School YRBS, Illinois 2019 Results." *Centers for Disease Control and Prevention*, accessed September 2019. https://nccd.cdc.gov/youthonline/App/Results.aspx?LID=IL.

[157] "High School YRBS: United States 2017 Results." *Centers for Disease Control and Prevention*, 2017. https://nccd.cdc.gov/Youthonline/App/Results.aspx?TT=A&OUT=0&SID=HS&QID=QQ&LID=XX&YID=2017&LID2=&YID2=&COL=

S&ROW1=N&ROW2=N&HT=QQ&LCT=LL&FS=S1&FR=R1&FG=G1&FA=A1&FI=I1&FP=P1&FSL=S1&FRL=R1&FGL=G1&FAL=A1&FIL=I1&FPL=P1&PV=&TST=False&C1=&C2=&QP=G&DP=1&VA=CI&CS=Y&SYID=&EYID=&SC=DEFAULT&SO=ASC.

[158] "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.

[159] Chavis, Lakeidra. "In Chicago, a Steep Rise in Suicide Among Black People." *The Trace in partnership with Chicago Sun-Times*, July 25, 2020. https://www.thetrace.org/2020/07/in-chicago-a-steep-rise-in-suicide-among-black-people/.;"Ring the Alarm: Crisis of Black Youth Suicide in America." *Representative Bonnie Watson Coleman*, accessed September 2020. https://watsoncoleman.house.gov/uploadedfiles/full_taskforce_report.pdf.

[160] This includes e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, ehookahs, and hookah pens.

[161] "High School YRBS, Illinois 2019 Results." *Center for Disease Control and Prevention*, 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)".

[162] "Outbreak of Lung Injury Associated with the Use of E-cigarette, or Vaping, Products." *Centers for Disease Control and Prevention,* updated February 25, 2020. https://www.cdc.gov/tobacco/basic_information/e-cigarettes/severe-lung-disease.html.;
"E-cigarette or Vaping Product Use-Associated Lung Injury (EVALI)." Yale Medicine, accessed September 23, 2020. https://www.yalemedicine.org/conditions/evali/.

[163] "Tetrahydrocannabinol." *Wikipedia*, accessed September 23, 2020. https://en.wikipedia.org/wiki/Tetrahydrocannabinol.

[164] "Smoking and Tobacco Use: Outbreak of Lung Injury Associated with E-cigarette Use, or Vaping." *Centers for Disease Control and Prevention*, last updated February 25, 2020. https://www.cdc.gov/tobacco/basic_information/e-cigarettes/severe-lung-disease.html#map-cases.

[165] Digitale, Erin. "Vaping Linked to COVID-19 Risk in Teens and Young Adults." *Standford Medicine*, August 11, 2020. https://med.stanford.edu/news/all-news/2020/08/vaping-linked-to-covid-19-risk-in-teens-and-young-adults.html.

[166] This is again reflected by the *N.B. v. Eagleson* Consent Decree. Originally filed in 2011, *N.B.* is a federal class action 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 February 2014, the court broadly defined the 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." The consent decree was approved in January 2018 and the final implementation plan was accepted by the court in December 2019,
"N.B. Consent Decree Implementation Plan." *HFS*, December 2, 2019.
https://www.illinois.gov/hfs/SiteCollectionDocuments/NBConsentDecreeImplementationPlanDecember22019.pdf. HFS' implementation plan *operationalized* this broad definition: [T]his process will identify all Medicaid-eligible children under the age of 21 (i.e., child or children) for whom: 1) an LPHA has completed the standardized, HFS approved Integrated Assessment and Treatment Planning (IATP) instrument (e.g., IM-CANS) indicating that the child has a mental or behavioral health diagnosis; and 2) supporting information, including but not limited to, claims or other utilization data, if available, indicates that the child meets eligibility criteria for intensive home and community-based services coordinated by an Integrated Health Home (IHH) (See p. 3 of Implementation Plan).The *N.B.* Consent Decree was meant to drive the public children's mental health system for years. However, by definition, it will not address youth in need of prevention and early intervention services and further limits the number of youth it will serve through the additional requirements of the IM-CANS and supporting information. For example, *N.B.* will not identify or ensure access to services for youth without a diagnosis/require mental health supports without the need to complete the lengthy IATP/IM+CANS assessment process, youth who receive mental health services by providers not completing the IM-CANS (discussed further in Section IV(A)(2) below), or youth who may not have prior supporting information because they are new to the system.

[167] Kluger, Jeffrey."The Coronavirus Seems to Spare Most Kids From Illness, but Its Effect on Their Mental Health Is Deepening." *Time*, July 23, 2016. https://time.com/5870478/children-mental-health-coronavirus/.; Imran, Nazish, Zainab Pervaiz, and Muhammad Zeshan. "Mental health considerations for children and adolescents in COVID-19 Pandemic." *Pakistan Journal of Medical Sciences*, May 2020.https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7306970/.; Branco-Sanchez, Dr. Edith."The full toll of COVID-19 on children's mental health won't be known for years." *CNN,* May 28, 2020. https://www.cnn.com/2020/05/28/health/coronavirus-mental-health-children/index.html.; Lee, Joyce."Mental health effects of school closures during COVID-19."*The Lancet: Child & Adolescent Health*, April 14, 2020. https://www.thelancet.com/journals/lanchi/article/PIIS2352-4642(20)30109-7/fulltext.

[168] "Integrated Care." *NIMH*, accessed September 2020. https://www.nimh.nih.gov/health/topics/integrated-care/index.shtml.

[169] *Ibid.*

[170] Barton, Jessica, Jonas Bromberg, David R. DeMaso, Glenn Focht, Ellen Goodman, Emily K. Trudell, Louis Vernacchio, Heather J. Walter, and Gregory J. Young. "Five-Year Outcomes of Behavioral Health Integration in Pediatric Primary Care." *Pediatrics*, July 2019. https://pediatrics.aappublications.org/content/144/1/e20183243.

[171] "Healthy Minds, Healthy Children, Healthy Chicago." Illinois Children's Healthcare Foundation, 2019. https://ilchf.org/wp-content/uploads/2019/09/Healthy-Minds-Healthy-Children-Healthy-Chicago.pdf.
[172] *Ibid,* 17.
[173] This also has implications for the *N.B.* Consent Decree. Through HFS' operationalization of the class definition, children will be required to have an IM-CANS assessment and treatment planning conducted. When the IM-CANS was initially released, training focused solely on CMHCs; it is unclear whether FQHCs or other healthcare settings are aware of the IM-CANS, have been trained in the IM-CANS, or whether they can bill for this service. Yet we know that these healthcare settings provide half of all mental health care. Without an integrated care model, such as ILCHF's H3 project, the extra step for a child and their family to go from a FQHC to a CMHC can be a huge barrier to care; those youth may not be properly identified by HFS as eligible for *N.B.* services.
[174] "Behavioral Health Workforce Education Center Task Force Report to the Illinois General Assembly." *Behavioral Health Workforce Education Center Task Force,* December 27, 2019, 2. https://www.ilga.gov/reports/ReportsSubmitted/693RSGAEmail1488RSGAAttachBH%20Workforce%20Task%20Force%20Report%2027DEC2019%20FINAL.pdf.
[175] Education advocates across Illinois observed this unintended consequence of schools depending more on police to address children's mental health occur after passage of school discipline reform measures. In 2015, SB100 or P.A. 99-0456 made significant reforms to school discipline procedures; most notably, it prohibited schools from suspending or expelling students before exhausting any alternative behavioral or disciplinary interventions. See "Full Text of SB0100." *Illinois General Assembly*, accessed September 2020. https://www.ilga.gov/legislation/fulltext.asp?DocName=&SessionId=88&GA=99&DocTypeId=SB&DocNum=100&GAID=13&LegID=83402&SpecSess=&Session=. These reforms did not provide training or access to these alternative interventions and as a result, advocates observed suspensions and expulsions going down but calls to the CARES mental health mobile crisis line seemed to increase. Teachers and other school officials were unprepared for addressing their students' needs.
[176] "Free Care Rule Reversal: Expanding Illinois' School Medicaid Program," Healthy School Campaign (August 2019).
[177] "CARES Act: AMA COVID-19 pandemic telehealth fact sheet." *AMA*, April 27, 2020. https://www.ama-assn.org/delivering-care/public-health/cares-act-ama-covid-19-pandemic-telehealth-fact-sheet.
[178] "Executive Order to Expand Telehealth Services and Protect Health Care Providers in Response to COVID-19 (COVID-19 Executive Order No. 7)." *State of Illinois Executive Department*, March 19, 2020. https://www2.illinois.gov/Documents/ExecOrders/2020/ExecutiveOrder-2020-09.pdf.
[179] Cunningham, Kelly. "Telehealth Services Expansion Prompted by COVID-19." *HFS*, March 20, 2020. https://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn200320b.aspx.
[180] "HHS Issues New Report Highlighting Dramatic Trends in Medicare Beneficiary Telehealth Utilization amid COVID-19." *HHS*, July 28, 2020. https://www.hhs.gov/about/news/2020/07/28/hhs-issues-new-report-highlighting- dramatic-trends-in-medicare-beneficiary-telehealth-utilization-amid-covid-19.html.
[181] "Gov. Pritzker Announces New Community-Based Approach to Transform Juvenile Justice in Illinois." *Office of the Governor*, July 31, 2020. https://www2.illinois.gov/Pages/news-item.aspx?ReleaseID=21879&utm_source=ICOY+Contacts&utm_campaign=025e2e40b6-Racial_Disparities_on_the_Rise_for_Youth10_6_2017_&utm_medium=email&utm_term=0_ba62da2d9f-025e2e40b6-219958981.
[182] One of the early major reform successes of the juvenile justice advocates in Illinois was the enactment of legislation extracting the Division of Juvenile Justice from the adult Illinois Department of Corrections and giving the new Illinois Department of Juvenile Justice (IDJJ) a mission to rehabilitate youth. When IDJJ was created in 2006, about 1,500 youth were incarcerated in eight juvenile prisons in Illinois. Through Redeploy Illinois and other legislative reforms, the number of youth in DJJ custody has been reduced significantly, and the state has closed three of the original eight youth prisons. This latest Transformation Model is based on research showing prison stays can traumatize and harm youth, and it is the natural progression of juvenile justice reforms many allies have supported for nearly two decades. Since its creation, IDJJ has become more rehabilitative and treatment-focused, and youth returning to their communities now receive more support to help them succeed. "Transforming IDJJ: A 21st Century Illinois Transformation Model." *IDJJ,* accessed September 2020. https://www2.illinois.gov/idjj/Pages/Transformation.aspx.
[183] "NB Stakeholder Subcommittee." *HFS*, accessed September 2020. https://www.illinois.gov/hfs/About/BoardsandCommisions/MAC/Pages/NBSubcommittee.aspx.
[184] "Title 59: Mental Health, Chapter IV: Department of Human Serivces, Part 132 Medicaid Community Mental Health Services Program, Section 132.25 Definitions." *Joint Committee on Administrative Rules*, accessed September 2020. https://www.ilga.gov/commission/jcar/admincode/059/059001320A00250R.html.
[185] Cunningham, Kelly."Informational Webinars Regarding the IM+CANS Provider Portal." *HFS*, June 12, 2020. https://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn200612a.aspx.

[186] Dunn, Barbara Ann. "Appropriate and Effective: How does managed care use the Child and Adolescent Needs and Strengths (CANS) tool?" *The Praed Foundation*, September 22, 2020. https://tcomconversations.org/2020/09/22/appropriate-and-effective-how-does-managed-care-use-the-child-and-adolescent-needs-and-strengths-cans-tool/.

[187] In FY20, the number of (unduplicated) children in substitute care and institutional care settings through DCFS along with overall expenditures is as follows:

Table X: DCFS FY2020 Expenditures by Youth Served		
Service Type	**Distinct Youth Served**	**Expenditures (1), (2)**
Paid Substitute Care	24,087	$499,880,978
Institutions & Group Homes	1,471	$146,642,567
Early Childhood Services	4,359	$2,855,049
Medicaid Mental Health Services	3,553	$15,513,075

Expenditure data is preliminary, and is subject to change. Institution & Group Home Expenditures exclude Medicaid Mental Health services. CYCIS Placement Data as of: 8-25-2020; MARS Payment Data as of: 8-25-2020.

[188] First, FFPSA allows Title IV-E funding to be used to fund up to one year of evidence-based prevention services for children and families who are "candidates for foster care," i.e., at "imminent risk" of child welfare involvement. Second, FFPSA regulates financial support for youth in congregate care settings to limit long stays in congregate care, provide residential treatment options for youth with clinical need, and establishes criteria for Qualified Residential Treatment Programs (QRTPs). The deadline for states to begin implementation of Title IV-E provisions is October 1, 2021. 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/).

[189] Children and families involved in child welfare systems often have co-occurring adverse childhood experiences. Research also shows that adverse childhood experiences which occur in early childhood, or the first thousand days, have significant impact on the experience dependent development of the brain. As 50% of child welfare involved cases nationwide include young children, the child welfare system encounters a great many young children at greater risk of mental health difficulties. In the past year, DCFS engaged in the following efforts to address the developmental needs of vulnerable children under 5 years of age. Expanded assessments- Children who come into care who receive an Integrated Assessment. For children under age 5, this comprehensive assessment process includes a developmental screening. In the past year, Integrated Assessments were expanded and began using the Devereux Early Childhood Assessment tool, which offers numeric scores that capture the emotional areas of need and strength for all young children, including infants. These enhancements reflect the Department's plan to sustain practices first adopted in Illinois' Title IV-E waiver demonstration, known as IB3. After six years of implementation, assessment of these young children ages 0-3 consistently found 50-60% of young children came into care were at high-risk of difficulties with their mental health owing to trauma experiences. Early intervention referrals- When the results of developmental screenings indicated the need for further evaluation through DHS Early Intervention, the DCFS/Erikson Early Childhood Project assures those referrals are made. In FY20, the DCFS/Erikson Early Childhood Project served 4,359 children and facilitated 1,269 referrals to DHS Early Intervention. As part of these efforts, project staff not only assured referrals to DHS Early Intervention, but also followed up with DHS Early Intervention to assure that the caregivers of the child engaged with the DHS Early Intervention Service Coordinator. The Early Childhood Project also facilitated 319 referrals for case study evaluations for children in care aged 3 to 5 years old to determine if they needed early special education services. These efforts include staff from the Chicago Public School system and staff creating partnerships with the 25 agencies statewide who administer DHS Early Intervention. The flexible and wide-ranging efforts needed to assure young children received the recommended evaluations and services are measured as consultations. Staff completed 987 such consultations last fiscal year. Child Parent Psychotherapy (CPP)- DCFS has invested in Child Parent Psychotherapy (CPP) services in for young children and parents involved in Early Childhood Court in Cook County. During the COVID-19 pandemic, DCFS staff and CPP providers have had ongoing collaborative planning. In March 2020, CPP services transitioned to remote delivery; and families have been very responsive. Therapists have worked with families by phone, video calls, and some even doing sessions outside with appropriate social distancing and wearing masks. CPP therapists have completed developmental screenings and necessary referrals. For the coming fiscal year, DCFS will expand CPP services to different areas statewide as a part of our efforts to strengthen the service array through FFPSA.

[190] Home visiting expansion in child welfare- The DCFS Home Visiting program has been developed as a component of FFPSA planning due to the its focus on preventing child welfare involvement for families with very young children. It provides a plan for expanding existing early childhood programming provided by DCFS through the DCFS/Erikson Early Childhood program to include home visiting services. Home visiting services target pregnant women and new parents for voluntary support during the most critical developmental period. When initiated prenatally in particular, home visiting services have strong evidentiary support for improving engagement and maternal and health outcomes, and parenting practices. In keeping with FFPSA, the program connects families with the home visiting intervention provided through partnerships with sister agencies. To maximize maternal and child health and well-being outcomes, as well as to align with HV program requirements, families with children pre-natal to 6 months old are the priority population. There are two primary target populations for home visiting services: 1) pregnant women and parents of children who meet the criteria for Illinois' Intact Family Services and Intact Family Recovery

programs (priority given to family members with children aged 6 months old or younger; however, families with children aged 3 years old and younger will be served by home visiting); and 2) pregnant and parenting youth in care, both those aged 13-17, and aged out youth 18-21 with newborns. DCFS facilitates effective linkage to home visiting programs for child welfare involved families with children pre-natal to 3 years old identified as in need of these home visiting services. As home visiting availability varies by community, this linkage will occur whenever there is a program the family qualifies for within the service area. In keeping with FFPSA, priority will be given to linkage to home visiting programs that have Well-Supported evidence ratings. DCFS included Healthy Families and Parents as Teachers in its plan, given their availability within the state and their Well-Supported evidence rating by the Title IV-E Clearinghouse. The program anticipates reaching 500 families in 2020-21.

[191] Improvements to residential treatment programs- DCFS aims to reshape the child welfare system culture to view a youth's entry into congregate care settings as a time-limited, focused, treatment intervention with a purpose and outcome to support youth pathways to permanency and youth living in family homes. We do this by transforming the continuum of placement approaches as well as the practices of providers, caseworkers and caregivers to provide more effective interventions and acknowledging the risk inherent in serving youth with high service needs in community settings and generating additional placement resources that provide intensive services in more family-like settings. This approach requires congregate care treatment providers to adequately and intently plan transitions for our youth in care and remain engaged in post-discharge linkage to community resources. Additionally, it requires caseworkers, foster parents, and families to remain engaged with the youth while they receive treatment interventions in congregate care settings. In doing this, we believe this will increase the effectiveness of congregate care interventions, shorten lengths of stay, promote successful transitions between settings, and promote engagement and longstanding connections between children and helping adults. FFPSA allows for us to embody this vision in that it requires congregate care programs to meet specific requirements to be designated as a Qualified Residential Treatment Program (QRTP) and thereby eligible for time-limited, federal Title IV-E Foster Care Maintenance Payments. FFPSA requires that QRTPs be licensed and accredited, have a trauma-informed treatment model, facilitate outreach to and participation of family members in the child's treatment program, have nursing staff and other licensed clinical staff, on-site in accordance with their treatment model, whom are available 24 hours a day and seven days a week, and provide six months of aftercare post discharge. To safeguard the intended practice and ensure valid financial claiming, DCFS underwent verification of state-contracted congregate care programs to ensure that they met these FFPSA requirements. Following the verification, several child care institutions were designated as QRTPs. There are several settings which are not required to meet FFPSA QRTP requirements, such as facilities that house pregnant and parenting youth; youth 18 years and older that live in a supervised, independent living setting; specialized placements for youth who are victims of, or at-risk of becoming victims of, sex trafficking; and residential family-based substance use disorder facilities.

[192] Trauma-Informed Treatment Model- FFPSA requires that a QRTP has a trauma-informed treatment model. DCFS has defined a trauma-informed treatment model as milieu and clinical treatment services that are provided under an organizational structure with a treatment framework that involves understanding, recognizing, and responding to the effects of trauma which are in accordance with recognized principles of a trauma-informed approach and trauma-specific interventions to address trauma's consequences and facilitate healing. There are several criteria that a program must meet to be considered a trauma-informed treatment model: (1) The program has an articulated model of trauma-informed care in accordance with recognized principles of a trauma-informed approach and trauma-specific interventions (2) The program conducts initial and ongoing training of milieu, clinical and ancillary support staff in the agency's model of trauma-informed care (3) The program conducts a trauma assessment and treatment planning for each child in care (4) The program provides trauma-specific milieu and clinical interventions in accordance with the child's assessed clinical needs (5) The program's supervisory and management practices support implementation of the model of trauma-informed care and provision of trauma-specific milieu and clinical intervention.

[193] 30-day independent assessment/60-day court review- FFPSA also requires an independent assessment of youth in care to determine if the QRTP placement is appropriate. The assessment must be conducted by a trained professional or licensed clinician who works in conjunction with the child's family and permanency team. The assessment must be completed within 30 days after the placement is made and may be completed within 30 days prior to the placement. The assessment must utilize a functional assessment tool that is age-appropriate and evidence-based. In addition, a court review and approval (or disapproval) of the child's QRTP placement must be conducted within 60 days of the child's placement. The 30-day assessment is intended to inform the court review process. DCFS has established a university contract for eight assessors and two supervisors who meet the same qualifications as an Integrated Assessment Screener which are a minimum master's degree and clinical licensure. The assessors will conduct the required QRTP independent assessment in conjunction with the Child and Family Team within 30 days after the placement is made utilizing the IM+CANS. The independent assessment will also be informed by the assessor's review of the child's clinical record including, but not limited to, summaries of prior Child and Family Team meetings, prior IM+CANS assessments, and documentation of the Clinical Intervention for Placement Preservation (CIPP) or other clinical staffing that preceded the QRTP placement. The assessor will complete required documentation of the independent assessment and prepare the required report for the 60-day Court Approval. Assessors will make themselves available as a statewide resource with the support of two supervisors.

[194] Judicial oversight- The Act envisions consistent and regular court monitoring of these QRTP admissions to ensure children needing specialized care receive such care until it is no longer needed based on the evidence. The court must: (1) Determine that admission into a QRTP occurs only for children whose needs cannot be met in foster care (2) Determine if the QRTP is the most effective and appropriate level of care in the least restrictive environment (3) Determine if the QRTP is consistent with short- and long-term goals in the permanency plan (4) Determine if the QRTP treatment is in the best interest of the youth and necessary and appropriate to the youth's plan and goal (5) Approve or disapprove of the youth's admission into a QRTP. The court must continue to demonstrate at each status review that the QRTP treatment is beneficial to the youth and DCFS must show that progress is being made in preparing a child to be placed with a family, in a foster family home, or another permanent living arrangement. What is of most importance is that QRTP treatment longer than 12-months consecutively (or 18-months non-consecutively), must have approval by DCFS agency head or for children under age 13, evidence must be submitted when the child has been in the QRTP more than six months. Utilizing and embracing the Department's vision and FFPSA philosophy, QRTPs will shift the culture and improve residential programs in the state of Illinois.

[195] YouthCare is a specialized healthcare program designed specifically to address the needs of youth currently and formerly in State care (https://www.ilyouthcare.com/). The program brings unprecedented levels of care coordination to DCFS youth focused solely on connecting youth and families with providers and ensuring they receive the quality care they deserve. The new model moves away from the previous fee-for-service model, which often left families lacking advanced care coordination as they navigated a complex health care system to find providers and services on their own. With YouthCare, families have a personal care coordinator who manages the youth's overall healthcare, researches providers, and schedules appointments. Youth in DCFS' care will automatically be enrolled in the YouthCare Health Plan starting September 1, 2020. Former youth in care were transitioned to YouthCare on February 1, 2020. The DCFS Guardianship Administrator can switch a youth into another Medicaid managed care plan if she feels it is in the youth's best interest. Youth aged 18 years old and older can choose another Medicaid managed care plan, if they wish. DCFS has worked in partnership with YouthCare to make sure this transition is as smooth as possible without any disruptions to healthcare services with provisions of a continuity of care period. This means that for the first six (6) months after the transition to YouthCare, youth in care will be able to continue to see any healthcare provider, even those who are not yet in the YouthCare network. The DCFS Advocacy Office serves as the single point of contact for healthcare coverage inquiries and dispute resolution. This includes issues finding healthcare providers, issues with YouthCare, and requesting a change in health plan if a different Managed Care Organization (MCO) is needed.

[196] The 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 for whom DCFS is legally responsible who are experiencing trauma reactions, emotional and behavioral challenges, and who are at risk of losing their current placement/living situations. In FY20, the Department invested about $6.6 million for IPS contracts serving 1659 unique clients (with a total of 1749 episodes) in FY20. Outcomes for the IPS program are measured in terms of both placement stabilization and improvement in clinical well-being, as reflected through changing scores in the Child and Adolescent Needs and Strengths (CANS). Based on closed cases with service time in FY20, a majority of youth IPS participants demonstrated placement stability such that 60.5% (376 youth) clients did not move during services, and 72.2% (449 youth) did not move within six months of services ending. Among youth "stepping down" from residential, group homes, or psychiatric hospitalization, 46.2% (48 youth) did not move during services and 60.6% (63 youth) did not move within six months of services ending.

[197] DCFS began implementing "Immersion Sites" in August 2016. Immersion Sites are implementing the DCFS Core Practice Model, enhanced services, enhanced qualitative case review, and administrative process changes. Enhanced services in Immersion Sites includes contracts for Wraparound Services with four POS agencies (Hoyleton, SPERO, NiCasa, and Bethany). As of March 31, 2020, these agencies reported serving 690 cases, about 55% of which are Intact cases. Implementation information showed that the four agencies had all implemented Wraparound Services in slightly different ways. Youth in care who received Wraparound Services appear to be more likely than youth in care who did not receive Wraparound Services to have supervised and unsupervised visits, to receive Child and Family Team Meetings, and to have an indicated investigation while in care. In state fiscal year 2021, DCFS plans to focus on standardizing the implementation across agencies and to target improving outcomes for children with significant mental health needs and their families.

[198] Dually involved youth are individuals that are simultaneously involved in the child welfare system and the criminal justice system. Implicit racial bias has contributed to disproportionate involvement in juvenile justice system of African American and other minority youth. This population experiences greater risks to permanency and has inequitable access to strong communities where they are protected from injury, neglect, and criminal activity. Youth may become dually involved while in the child welfare system by being adjudicated of a crime; or youth in the juvenile justice system may be mandated to the child welfare system. Youth in care that become deeper involved in the criminal justice system are the types of 12- to 21-year-olds that sequentially become stuck in state care, ultimately age out, and eventually end up in or dependent on another state system, i.e., Department of Corrections, Department of Human Services, and/or Department of Healthcare and Family Services. Throughout FY20, 135 youth in the care of DCFS (Females-27, Males-108) were transferred to either a state juvenile justice system or an adult correctional system. Regenerations Program- To support the needs of this population in Cook County, DCFS, the Circuit Court of Cook County Juvenile Justice Division, Cook County Juvenile Probation and Court Services, and the Cook County Juvenile Temporary Detention Center (JTDC) partnered with Lutheran Children and Family Services (LCFS) and the Youth

Advocate Program (YAP) to implement the Regenerations Program. The goal of this program is to shorten the release from detention, increase placements and placement length of stay in family or family-like settings, strengthen youth well-being outcomes, and reduce recidivism. The Regenerations Program serves a subset of the dually involved population—new and existing youth in DCFS care who are between 12 and 17 years of age, detained at the JTDC, and on the Release upon Request (RUR) list for DCFS care at the time of their referral. The RUR list includes youth who have been ordered released from the JTDC but remain there because no individual was present or appropriate in court to accept custody. In these instances, judges can court order the youth be released to a specific individual or designated agency, such as DCFS. In FY20, 95 youth participated in Regenerations programming. DCFS contracts totaling $4.2 million with LCFS and YAP provide intensive case management and care coordination; traditional mental health services such as individual therapy, family therapy, and psychiatric medication management; flex funds to access resources otherwise unavailable from traditional funding streams; mentoring and peer advocacy; and access to other supportive services. Chapin Hall Center for Children conducted an analysis of the effects of the pilot implementation from 2015-2017. The 2018 pilot study showed that compared to a historical matched comparison group, program participants had fewer days in juvenile detention facilities, a higher rate of being placed in a family-like setting, a lower rate of being released to residential care, and shorter stays in residential care. Program participants had a similar recidivism rate to comparison group participants, however. Conscience Community Network program- For approximately $2 million, DCFS contracts with the Conscience Community Network (CCN), a network of social services providers that includes Omni Youth Services, One Hope United, SGA Youth and Family Services, UCAN, and Youth Outreach Services. CCN has a performance-based metric contract with DCFS that incentivizes CCN to provide services that meet specified outputs and outcomes with dually-involved youth. In FY20, the program enrolled 111 youth while serving additional youth from FY19 with service delivery still in process. CCN's Wraparound model is designed to improve outcomes for youth and families by supporting the coordination of their care and identifying and implementing necessary resources and supports. The goals of the program are to safely support youth and families within their communities and develop a positive informal support team for each youth and family. Additionally, CCN strives to empower the family and informal support system to seek out support and problem solve challenges on their own, after they transition out of the program. CCN exceeded the expectations within its performance-based contract, as outlined below (n=95 through 7/1/19 – 3/31/20): CCN conducted an initial Family Team Meeting within the first month of enrollment for approximately 75% of enrolled youth; CCN conducts Family Team Meetings monthly. Just over 75% of closed youth sustained monthly meetings throughout their involvement; CCN strives to keep youth out of congregate care and detainment facilities. Based on baseline data, it is expected that 35% of youth would naturally avoid these placement types in any given month. 62% of CCN youth avoided these placement types in any given month, almost doubling the baseline data; CCN tracks usage of congregate care and detainment facilities for the six months post closure from our program. Similar to the performance target above, it is expected that 33% of youth would naturally avoid these placement types. 66% of CCN youth avoided these placement types during the six months post closure. CCN prioritizes data collection and improvement of outputs and outcomes. The organization continuously reviews data, strategizes on ways to improve, and implements new and innovative strategies.

[199] CWG also advises the Governor and the General Assembly on policy issues impacting women and girls in this State, including, but not limited to, providing proper standards of healthcare; allowing women and young girls to have legal protections and recourse in cases of sexual harassment in the workplace; preventing and protecting women from domestic violence; and giving significant attention to the inclusion of women of color in decision-making capacities and identifying barriers toward parity, and for leadership inclusion that works to realize American's founding principles of equity and opportunity for all. "Children of Incarcerated Parents Task Force." *Office of Lt. Governor Juliana Stratton*, accessed September 2020. https://www2.illinois.gov/sites/ltg/issueslist/Children-Incarcerated-Parents/Pages/default.aspx.; "Illinois Council on Women and Girls." *State of Illinois Appointments,* accessed September 2020. https://www2.illinois.gov/sites/bac/SitePages/AppointmentsDetail.aspx?BCID=1175.

[200] Specifically, the website contains guidance, resources, applicable statutory and regulatory references, best practices and links to companion programs. Further, the website hosts ISBE's non-regulatory guidance document on meeting the needs of transgender students and sample administrative procedures that may be used by districts, both of which were modeled after the recommendations of the Governor's Affirming and Inclusive School's Task Force. Finally, ISBE established an email address, supportallstudents@isbe.net, for use by students and staff support of LGBTQ issues in schools.

[201] Support and education may be offered to child welfare staff or consumers at any point in a family's contact with DCFS. Clinical staff can help ensure that practice comports with the Illinois Human Rights Act, and that there are supportive services for adults and children working with DCFS. These interventions must crafted to respect an individual's sexual orientation, gender identity, and gender expression (SOGIE).

[202] Illinois DCFS was the first state child welfare agency in the nation to enact policy specifically addressing work with LGBTQI+ youth. A core tenet of the policy is to maintain and promote a safe and affirming environment for LGBTQI+ youth and families served by DCFS or Purchase of Service (POS) agencies. This involves all children in DCFS care, including youth who are in DCFS contracted residential facilities and programs, foster care, and any other substitute care settings. LGBTQI+ youth in care have legal rights, including the right to be free from verbal, emotional, and physical harassment in their placements, schools, and

communities. The adults involved in their care have a legal and ethical obligation to ensure that they are safe and protected. These youth also have the right to be treated equally, and be open about their SOGIE.

[203] The LGBTQ Specialty Program was developed in 2010. The creation of the program established a source for clinical consultation with field staff as well as resource building for LGBTQI+ youth. Efforts susbsequently have been dedicated to build upon the initial consultation work of the program. DCFS worked with Dr. Gerald Mallon in 2013-2014 to revise policy and practice, engaging divisional stakeholders to reduce silos within DCFS. At that time the DCFS Guardian's Office became actively involved in the work with LGBTQI+ youth in care on a regular basis and DCFS created guidelines regarding gender-affirming healthcare for youth. DCFS and a researcher from Lurie Children's Hospital partnered in 2017 (and are still working together) to assess the experiences of LGBTQI+ youth in care. The guidelines around affirming care for transgender youths were enhanced in 2017 policy revisions. DCFS now has strong partnerships with gender clinics in Chicago and St. Louis, and is also working with Planned Parenthood. The Department continues to collaborate with the Human Rights Campaign regarding staff training and practice implementation. DCFS Clinical and the Office of Affirmative Action (OAA) are partnering to enhance the programmatic work for LGBTQI+ youths and families. The divisions are focusing on SOGIE data gathering to gain a better understanding of the number of LGBTQI+ youth served and examine their experiences in care. The research by Lurie's is a key factor to create the most comprehensive portrait of a youth's life.

[204] "Behavioral Health Workforce Education Center Task Force Report to the Illinois General Assembly." *Behavioral Health Workforce Education Center Task Force,* December 27, 2019. https://www.ilga.gov/reports/ReportsSubmitted/693RSGAEmail1488RSGAAttachBH%20Workforce%20Task%20Force%20Report%2027DEC2019%20FINAL.pdf.

[205] It notes "[l]ong wait times for appointments with psychiatrists—4 to 6 months in some cases— high turnover, and unfilled vacancies for social workers and other behavioral health professionals have eroded the gains in insurance coverage for mental illness and substance use disorder (SUD) under the Affordable Care Act (ACA) and parity laws. Illinois faces a statewide crisis in behavioral health access due to its inadequate workforce capacity." "Behavioral Health Workforce Education Center Task Force Report to the Illinois General Assembly." *Behavioral Health Workforce Education Center Task Force,* 2.

[206] "Behavioral Health Workforce Education Center Task Force Report to the Illinois General Assembly." *Behavioral Health Workforce Education Center Task Force,* 23-24.

[207] Other recommendations include: Establishing resources to develop an infrastructure available to support and coordinate behavioral health workforce development efforts; Establishing new financing systems that considers the cost of providing services and enables employee compensation commensurate with required education and levels of responsibility; Funding the Community Behavioral Health Care Professional Loan Repayment Program Act (HB 5109- 100-0882) and The Psychiatric Access Incentive Act; Broadening the Concept of "Workforce" – The state should expand the capacity in peer recovery and other non-traditional behavioral health roles and should authorize community-based agencies with certified peer specialists to bill for certain Medicaid substance use and mental health services; and Leveraging the requirements of consent decrees and settlement agreements for specific populations in need of behavioral health care to accelerate workforce development and collect more actionable data. "Behavioral Health Workforce Education Center Task Force Report to the Illinois General Assembly." *Behavioral Health Workforce Education Center Task Force,* 5.

[208] "Public Act 101-0461." *General Assembly*, accessed September 2020. https://www.ilga.gov/legislation/publicacts/101/101-0461.htm. This act became public law on August 26, 2019 with an effective date of January 1, 2020. Several provisions of the law have begun implementation, including the creation of a working group to make recommendations on providing preventative mental health services to children.

[209] "Nine-year-old charged with murder of five people in Illinois trailer park fire." *The Guardian*, October 9, 2019. https://www.theguardian.com/us-news/2019/oct/09/nine-year-old-charged-with-of-five-people-in-trailer-park-fire.

[210] Hawkins, Derek."A 9-year-old is facing five counts of murder. He didn't even know what 'alleged' meant." *The Washington Post*, October 21, 2019. https://www.washingtonpost.com/nation/2019/10/21/year-old-is-facing-five-counts-murder-he-didnt-even-know-what-alleged-meant/.

[211] Sheehan, Matt, and Will Stevenson."Woodford County Judge: nine-year-old boy charged with murder unfit to stand trial." *Central Illinois Proud*, July 9, 2020. https://www.centralillinoisproud.com/news/local-news/woodford-county-judge-nine-year-old-boy-charged-with-murder-unfit-to-stand-trial/.

[212] "A Call to Action: Racial Equity in Juvenile Justice." *Illinois Juvenile Justice Commission*, June 29, 2020. http://ijjc.illinois.gov/newsroom/call-action-racial-equity-juvenile-justice

[213] Illinois Justice Project. https://www.iljp.org/juvenile-justice

[214] "Juvenile Justice Initiative."https://jjustice.org.

[215] See p. 9 of Series of Policy Recommendations to Improve the Health of Illinois and America's Rural Communities. This report was a draft of a future publication primarily authored by SIU School of Medicine Department of Population Science and Policy staff. For more information contact Sameer Vohra MD, JD, MA, FAAP, at https://www.siumed.edu/popscipolicy/department-chair.html.

[216] "About Population Science and Policy." SIU School of Medicine, accessed September 2020. https://www.siumed.edu/popscipolicy.

[217] "The State of Rural Health in Illinois: Great challenges and a path forward." *Illinois Rural Health Summit Planning Committee*, October 2018. https://www.siumed.edu/sites/default/files/u9451/rhs_stateofillinois_final.pdf.
[218] This report was a draft of a future publication primarily authored by SIU School of Medicine Department of Population Science and Policy staff. For more information contact Sameer Vohra MD, JD, MA, FAAP, at https://www.siumed.edu/popscipolicy/department-chair.html.

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