2023 Annual Report to the Governor

December 26, 2023

Dear Governor Pritzker,

On behalf of the members and partners of the Illinois Children's Mental Health Partnership (ICMHP), I am pleased to present you with our 2023 Annual Report.

The Illinois Children's Mental Health Partnership, first created by statute in 2003 by the *Children's Mental Health Act*, is a unique statewide public/private partnership tasked with developing a plan using a public health approach focused on prevention, early intervention, and treatment. The purpose of the plan is to build a comprehensive and coordinated mental health system to better address the needs of Illinois children, youth, and their families. By statute, ICMHP is comprised of each child-serving state agency, experts representing a broad range of experiences (such as community mental health, children and family advocates, early childhood, education, health, substance use, violence prevention, and juvenile justice), and members of the General Assembly.

2023 marked a year of transition for ICMHP. ICMHP's originating statute (405 ILCS 49/5(b)) was revised by the General Assembly during the 2022 Legislative session calling for a new partnership composition and mandate effective January 1, 2023. The new composition allowed the opportunity for me to return to the partnership in August 2023, as the co-chair representing the governor's administration, having previously served as interim chair of the partnership from December 2020 – August 2022. It also provided the opportunity to re-appoint existing partnership members and, for the first time, appoint new members dedicated to addressing children's mental health challenges across Illinois. This new partnership met for the first time on August 28, 2023, and subsequently passed updated partnership's bylaws at a special meeting on September 26, 2023.

Despite the transition of the partnership, significant progress was still made by the members and staff to improve children's mental health across Illinois. Implementation of the revised ICMHP Children's Mental Health Plan 2022-2027 began, working closely with your Children's Behavioral Transformation Health Initiative, to move forward the plan's five recommendations. Additionally, the partnership also launched the Youth Commission, 10 youth from Illinois, advising the partnership and its members from their lived experiences on recommendations to improve children's mental health.

2024 will be an important year for the partnership, as its members work with your administration to continue to improve the health of Illinois' children and youth. We have additional members to appoint, operational decisions to make, and big efforts to pursue. We greatly appreciate your dedication to this important health issue and look forward to continuing the strong partnership with the Children's Behavioral Health Transformation Initiative. Our goal is to make the children's mental health system better all across Illinois. We will continue that journey in 2024, partnering to build a healthier Illinois for all children and youth across the state.

Yours in health,

Sameer Vohra

Sameer Vohra, MD, JD, MA
Director, Illinois Department of Public Health
Co-Chair, Illinois Children's Mental Health Partnership

I. INTRODUCTION

2023 marks 20 years since the passage of the original Children's Mental Health Act, forming the Illinois Children's Mental Health Partnership (ICMHP). On behalf of ICMHP and pursuant to the newly revised Children's Mental Health Act of 2022 (P.A. 102-0889), we are pleased to submit this annual report. The revised act represents the first attempt to modernize the legislation since 2003, updates the powers and duties of ICMHP, and adds the statutory authority to launch and maintain a youth council. Pursuant to the revised act, this report will provide a progress update on the implementation of the Illinois Children's Mental Health Plan of 2022-2027, recommendations regarding state policies, laws, or rules necessary to fulfill the purposes of the act, and additional recommendations regarding children's mental or behavioral health. Additionally, this report will include progress on implementing the operational steps required by the modernization and the initial steps of convening the Youth Council.

This report is divided into five main sections and includes six attachments:

- Update on Operational Changes to ICMHP
- Update on the Implementation of the Children's Mental Health Plan
- Recommendations regarding State Policies, Laws, or Rules
- Additional Recommendations related to Children's Mental and Behavioral Health
- Youth Council Recommendations

Appendices
1. Public Act 102-0889
2. Illinois Children's Mental Health Plan 2023 Evaluation Framework Final Report (June 2023)
3. ICMHP Revised Bylaws (Adopted by Members September 26, 2023)
4. Illinois Children's Mental Health Partnership Members (as of December 20, 2023)
5. Youth Council Recommendations and Report
6. Lessons Learned: A Landscape Scan of Mental Health Screening Practices in Illinois Schools

II. Update on Operational Changes to ICMHP

- **The revised statue (405 ILCS 49/5(b) includes specific changes to appointment of members and leaders: maintain a membership composed of state agencies, members of the General Assembly, representatives from the public, and two co-chairs (one representing the state and one the public).**

The membership of ICMHP is determined through appointments by the governor, state agencies, and the legislature and not by ICMHP directly. With the new composition requirements outlined under the statute effective January 1, 2023, ICMHP became a new task force requiring all members to be (re)appointed. Until at least one co-chair and half of the 25 required public members were appointed, ICMHP could not hold a meeting or move forward with new business. Enough members, and one co-chair (Dr. Sameer Vohra, director, Illinois Department of Public Health) were appointed to hold the first quarterly meeting of the year on August 28, 2023. Additionally, several appointments are currently undergoing the approval process and can be announced once finalized. The membership as of December 20, 2023 is included in Appendix 4.

- **Updating the ICMHP Bylaws to Reflect the New Statute**

The passage of P.A. 102-0899 and P.A. 102-1034 made significant changes and clarifications to ICMHP's role and responsibilities under a modernized version of the Children's Mental Health Act. These changes became effective January 1, 2023, and the April 2019 ICMHP bylaws no longer comply with current state law.

The ICMHP bylaws ensure full transparency and consistency across ICMHP actions, including what authority is granted to ICMHP members, staff, committees, and a fiscal agent.

A draft of proposed amendments to the ICMHP bylaws was provided to the ICMHP members at the August 28, 2023, quarterly meeting. These bylaws were reviewed by appointed members and voted on in a special meeting held September 26, 2023. These new bylaws are included in Appendix 3. Below is an overview of the substantive changes:

1) The draft bylaws now include the new statutory powers and duties that became effective January 1, 2023.

2) The membership composition has been updated to reflect the current member requirements, including the addition of term limits (which did not exist before) and language around reimbursement for reasonable expenses.

3) ICMHP staffing rules have been updated to ensure compliance with the statute, particularly regarding the duty of ICMHP members to lead staffing decisions. It also ensures a reporting structure between ICMHP members and ICMHP staff that will allow for a more efficient workflow of day-to-day operations.

4) Details were updated to the optional fiscal agent allowed under the new statute. Previously, ICMHP has operated through fiscal sponsor relationships. The fiscal sponsor relationship is more involved than a fiscal agent relationship. However, the new statute specifically calls for the use of a fiscal agent to ensure autonomy of the partnership and clear expectations of its fiscal sponsor.

5) A proposed definition of an executive committee as a standing committee of ICMHP was added. It is structured based off suggestions from the Roberts Rules of Order. Previously, the ICMHP Executive Committee was not formally defined by statute or our bylaws but upon informal agreement of the membership. The proposed composition ensures an odd number of members to prevent tied votes

and includes a staggered rotation of state agency and legislative officials as well as public members. It also places the executive director of ICMHP, as the lead staff member, as a voting member.

6) Details regarding the new adjunct Youth Council required under P.A. 102-1034, including composition and responsibilities, were added.

- **Loss of ICMHP Staff**

The final operational challenge posed this year was the loss of ICMHP staff. The two current ICMHP staff positions are the executive director and the operations and program manager. For the past several years, the day-to-day management of ICMHP and communication with both appointed members and the governor's office have been primarily managed by these two positions with engagement and oversight provided by the appointed chair and the Management Team that includes members of the Lurie Children's Center for Childhood Resilience (CCR) and Government Affairs Department. The executive director informed the Management Team and Chair Vohra of plans to move out of state in July 2023 with a proposed interim plan to continue to serve as executive director through December 2023. The logistics and ramifications of this proposal were explored, and the decision was made that this was not viable. Her resignation was accepted as of August 31, 2023. Following her departure, the staff member in the operations and program manager role also resigned to pursue new employment within Lurie Children's as of October 6, 2023.

As noted below, there is a proposal that was voted by current appointed ICMHP appointed members at the final quarterly meeting on December 5, 2023, to explore shifting the fiscal agent and managing agency for the ICMHP to the Illinois Department of Public Health. This proposal is intended to better align the work of the ICMHP with work being led by the governor's office and Dr. Dana Weiner within the Children's Behavioral Health Transformation Initiative (CBHTI). Specifically, by IDPH managing the ICMHP, the goal would be to ensure that there is a lead agency and associated advisory board that maintains the primacy of mental health promotion and early prevention in the state ecosystem transformation. All of these recommendations are an attempt to protect the legal interest of both ICMHP and a fiscal agent and are meant to prevent any conflict of interest. This anticipated move and alignment with the CHBTI work will require consideration of the appropriate staffing requirements for continued successful operations of the work of the ICMHP. Further, as noted later in this report, if the ICMHP is to provide an accountability and data analysis role as outlined in Appendix 2, then crucial additional staffing roles will need to be explored.

Given the resignation of the two ICMHP full-time staff and the uncertainty of a potential move from Lurie Children's as the fiscal sponsor as of June 30, 2024, a temporary staffing plan was constructed in lieu of a search for new employees. The Lurie CCR and Government Affairs team members that have participated in the Management Team during the tenure of the Lurie fiscal sponsorship of ICMHP, created a draft work plan and have submitted this for review and approval by both Chair Vohra and the Illinois Department of Healthcare and Family Services (HFS) legal team who are the current fiscal sponsors of ICMHP. This is in accordance with the revised by-laws and will enable the ICMHP to continue to meet the established statutorily defined obligations and the deliverables established within the current contract with HFS through June 30, 2024.

- **Addressing the Question of Fiscal Agent and a Permanent Funding Mechanism**

ICMHP's current fiscal agent is Ann and Robert H. Lurie Children's Hospital of Chicago. Questions surrounding the role of ICMHP to support the efforts of the CHBTI have been a frequent point of discussion among ICMHP appointed members and stakeholders throughout this year. There are longstanding issues that have negatively impacted the partnership's ability to advance stated goals. The main issue reflects uncertainty about how to ensure state funding for ICMHP. ICMHP does not currently have a permanent line item in the state budget and is funded out of an understood agreement among the state agencies to rotate funding. This is a major challenge for each agency as it works to identify ways to provide funding to our fiscal agent and under their unique processes. This presents an annual question around whether and how ICMHP will be funded for the next fiscal year, creating extensive uncertainty that is not sustainable, particularly for ICMHP staff whose compensation is dependent on this funding. A permanent solution to the fiscal agent and funding questions must be determined to prevent that level of uncertainty from occurring annually.

The ICMHP convened a special committee to consider options for finding a permanent home for the partnership that would align with CBHTI priorities, establish a permanent funding mechanism, and enhance the operational structure and statutory obligations in the fall of 2023. This special committee conferred with state leaders and reviewed documents to consider several options. A meeting was held November 16, 2023, and the committee voted to bring a recommendation to the full partnership to explore in depth the option of transferring the ICMHP to IDPH as the fiscal and executive sponsor for the work. This recommendation was shared with ICMHP at the quarterly meeting held December 5, 2023, and a vote was called with overwhelming support to proceed with further investigation into this possibility at the end of the fiscal year, June 30, 2024. The special committee will continue to work with the chair(s) and report to the membership on progress.

III. Implementation of the Illinois Children's Mental Health Plan 2022-2027

The Children's Mental Health Plan was updated and released after a 17-month development process during Children's Mental Health Awareness Week in May 2022. The plan outlined five goals to improve children's mental health throughout Illinois.

1) ***Increase public awareness on all issues connected to child mental health and wellness to decrease stigma, promote acceptance, and strengthen children, families, and communities to identify needs and access supports with resources and funding.***

2) ***Create a coordinating entity responsible for 1) conducting a comprehensive and cross-system needs assessment of programs, services, and policies that touch children's mental health; 2) monitoring and assessing spending on all child and family mental health and wellness services to determine scope and effectiveness; and 3) fostering innovation of adaptive and new practices to improve children's mental health.***

3) ***Develop, maintain, and ensure ongoing monitoring of a hub of programs, services, and policies easily accessible to the public to assist with navigation, resources, and funding.***

4) ***Grow, retain, diversify, and support the child-serving workforce, with special emphasis on professional development around child and family mental health and wellness, and services and supports to address needs.***

5) ***Fund the design, implementation, and evaluation of system of care strategies that prevent and treat mental health concerns and mitigate trauma by more effectively delivering services.***

The first step for ICMHP following the release of the plan was to develop an evaluation strategy. ICMHP contracted with the Ann & Robert H. Lurie Children's Hospital of Chicago Smith Child Health Catalyst Team to develop a set of evaluation recommendations by June 30, 2023. These recommendations are available in Appendix 2. The recommendation report was shared with ICMHP partnership members for review prior to the quarterly meeting held August 28, 2023. During the meeting, ICMHP members discussed the report and determined that now was not the best time to act on its recommendations. ICMHP is waiting to learn more about the state's goals and actions plans as it relates to the Children's Blueprint for Transformation and the Children's Behavioral Health Transformation Initiative (CBHTI).

In the interim, progress has been made in several of the key goals articulated in the plan:

1. ***Increase public awareness on all issues connected to child mental health and wellness to decrease stigma, promote acceptance, and strengthen children, families, and communities to identify needs and access supports with resources and funding.***

To contribute to the implementation of Goal 1 of the Children's Mental Health Plan (Public Awareness and Supports), ICMHP engaged in two awareness raising efforts throughout spring 2023.

First, ICMHP partnered with Baker McKenzie, the Youth Law Center, and the ACLU of Illinois to host the Youth Experiential Learning Simulation (YExLS) for approximately 50 ICMHP members, partners, and legislators on March 27, 2023. The YexLS is a unique and highly sought after program provided to professionals from youth-serving systems around the world and was developed alongside youth with lived experience in public systems. It was an opportunity for professionals working to address the needs of youth to understand first-hand the barriers youth face. Those ICMHP members and partners who were able to attend found the experience powerful. The hope is to bring the simulation back to Illinois leaders, including newly appointed ICMHP members and key policy makers.

Second, ICMHP staff were trained by the National Council for Mental Wellbeing to be instructors in Mental Health First Aid (MHFA). MHFA is an evidence-based early identification and intervention training program that teaches participants how to identify when a mental health or substance use issue is occurring and how to connect an individual struggling to appropriate supports and services. ICMHP staff participated in 104 hours of training to become certified to instruct the Adult MHFA, Youth MHFA, and Teen MHFA courses. The intention is for MHFA to be a standard education service provided free of charge by ICMHP to communities throughout the state. ICMHP staff provided a Youth MHFA course during Children's Mental Health Awareness Week in May 2023.

2. ***Create a coordinating entity responsible for 1) conducting a comprehensive and cross-system needs assessment of programs, services, and policies that touch children's mental health; 2) monitoring and assessing spending on all child and family mental health and wellness services to determine scope and effectiveness; and 3) fostering innovation of adaptive and new practices to improve children's mental health.***

Goal 2 of the Children's Mental Health Plan is currently being implemented by the state through the work of Dr. Dana Weiner and the Children's Behavioral Health Transformation Initiative (CBHTI). The CBHTI began its work in March 2022 in collaboration with ICMHP and other stakeholders. On February 24, 2023, the CBHTI released its initial report, the Blueprint for Transformation: A Vision for Improved Behavioral Healthcare for Illinois Children during a news conference attended by children's mental health leaders from across Illinois, including ICMHP. The blueprint identified several recommendations to address the internal capacity of state agencies to better address the treatment needs of youth with severe mental health challenges as well as recommendations to build a public health infrastructure that prioritizes the promotion, prevention, and early identification of mental health warning signs and investment in community and school-based strategies and interventions. The ICMHP is interested in continuing to engage with the CBHTI intervention to promote this public health approach.

3. ***Develop, maintain, and ensure ongoing monitoring of a hub of programs, services, and policies easily accessible to the public to assist with navigation, resources, and funding.***

Goal 3 of the Children's Mental Health Plan is also being implemented through the work of the CBHTI. The blueprint identified a similar need for a centralized hub and "Care Portal as [a] centralized resource for families seeking services for children with significant and complex needs (p. 15)." The CBHTI team is currently working with the state to build this hub. As the hub is built, ICMHP will continue to monitor it for ease of access and navigation, as well as ways to broaden the concept to serve *all* Illinois youth and families who may experience a mental health need, not just those with significant and complex needs. ICMHP's vision for this hub, as determined by the plan, is to serve as a prevention and early intervention tool in addition to serving those with immediate treatment needs.

4. ***Grow, retain, diversify, and support the child-serving workforce, with special emphasis on professional development around child and family mental health and wellness, and services and supports to address needs.***

Although ICMHP has not yet begun implementation efforts for Goal 4, several efforts have been put in place by the state. Some of these efforts are outlined below:

- In March 2023, Governor Pritzker and his administration launched a new Behavioral Health Workforce Education Center to increase Illinois' capacity to recruit, educate, and retain behavioral health professionals. This center was the culmination of years of efforts by mental health advocates, including a task force that released recommendations to the General Assembly on December 27, 2019, to address workforce needs in Illinois. One of those recommendations included the creation of this center and ICMHP testified in support of the center before the House Mental Health Committee and the Senate Human Services Committee in March 2020.

- A new loan forgiveness program, called the Community Behavioral Health Care Professional Loan Repayment Program, formally started with $5 million appropriated for FY24. Although the legislation establishing the program was passed and signed by Governor Pritzker in 2019, no appropriations were made to the program until FY23 with revenue from the state's cannabis program.

- On August 8, 2023, Governor Pritzker and IDPH announced two sets of children's mental health grants totaling $13 million. The first $10 million was for grants to strengthen mental health services in schools. The funding, which is authorized by the American Rescue Plan Act of 2021, is allocated to two program areas: $6.9 million for enhancing post-COVID-19 recovery efforts (such as expansion of workforces, purchasing mental health training materials, and employing programs and resources to enhance student mental health) and $3 million for preventing adverse childhood experiences (ACEs) post-COVID-19. Further, an additional $3.5 million dollars was distributed to 18 communities November 3, 2023 to advance proposed community-level innovations to meet the mental health needs of children and adolescents.

5. ***Fund the design, implementation, and evaluation of system of care strategies that prevent and treat mental health concerns and mitigate trauma by more effectively delivering services.***

All of the efforts described above contribute to the implementation of Goal 5 of the Children's Mental Health Plan. Additional activities will need to be determined as operational challenges for ICMHP are resolved.

In addition to the Children's Mental Health Plan, the partnership was also assigned two other sets of primary duties as it relates to the new statute.

- **405 ILCS 49/5(b-5): Develop an adjunct Youth Council to make recommendations to ICMHP on youth mental health, from the perspective of youth.**

- **405 ILCS 49/5(d) Powers and Duties with technical and administrative support to be provided by the Department of Healthcare and Family Services.**

The statute separately outlines five additional duties of ICMHP, with technical and administrative support from HFS. HFS currently supports ICMHP by providing the state's operational funding. ICMHP is still determining the best path forward to pursue the five powers and duties outlined below:

1. ***Conduct research assessments to determine the needs and gaps of programs, services, and policies that touch children's mental health.***
2. ***Develop policy statements for interagency cooperation to cover all aspects of mental health delivery, including social determinants of health, prevention, early identification, and treatment.***
3. ***Recommend policies and provide information on effective programs for delivery of mental health services.***
4. ***Fund pilot programs or research activities to resource innovative practices by organizational***

partners that will address children's mental health.

5. ***On or before December 30 of each year, submit an annual report to the governor and General Assembly on the progress of the plan, any recommendations regarding state policies, laws, or rules necessary to fulfill the purposes of this act, and any additional recommendations regarding mental or behavioral health that the partnership deems necessary.***

IV. Recommendations on State Policies, Laws, or Rules

We applaud the state for taking numerous steps to implement the goals recommended in the Children's Mental Health Plan. Through the launch of the Children's Behavioral Health Transformation Initiative, progress has already been realized in improving state coordination and the beginning stages of a centralized hub to streamline children's mental health assessment and navigation. Additionally, the state is moving to establish a behavioral health workforce education center to address major gaps within our workforce. We are also optimistic by the passage of the federal Safer Communities Act, offering Illinois an unprecedented funding opportunity to support child and family mental health, including development of awareness campaigns within the school system consistent with the plan's first goal.

In addition, several pieces of legislation were adopted in 2023 that support the continuation of this work and provide opportunities for the ICMHP to contribute to advancing children's mental health.

HB 2847 Mental Health Equity Access and Prevention Act (Representative LaPointe/ Senator Fine)

- Provides that subject to appropriation, IDPH shall undertake a public educational campaign to bring broad public awareness to communities across the state on the importance of mental health and wellness.
  - Public Act 103-0535: https://www.ilga.gov/legislation/publicacts/fulltext.asp?name=103-0535&GA=103&SessionId=112&DocTypeId=HB&DocNum=2847&GAID=17&SpecSess=&Session=

SB 724 Children's Behavioral Health Services Act (Senator Feigenholtz and Representative LaPointe)

- Implements key provisions of the Children's Mental Health Transformation Blueprint. It creates the Interagency Children's Behavioral Health Services Act and establishes a children's behavioral health transformation officer.
  - Public Act 103-0546: https://www.ilga.gov/legislation/publicacts/103/103-0546.htm

V. Additional Recommendations on Children's Mental and Behavioral Health

In addition to the work led by the CBHTI and the investments of the state in developing the children's behavioral work force described in Section III, several additional efforts are underway that will impact the eco-system of children's mental and behavioral health. Specifically, the recommendations from the Whole Child Task Force in March 2022 have led to follow-up legislation that continues to promote a comprehensive approach to children's mental health from a systems perspective. This includes specific legislation that was adopted to advance

recommendations that the state adopt key definitions and explore universal mental health screening in schools. The first step of universal screening goal was to create a landscape analysis of current practices in the state. This report entitled "Lessons Learned: A Landscape Scan of Mental Health Screening Practices in Illinois Schools" was released December 15 (see Addendum 6). In addition, separate legislation called for the creation of a Healing Centered Task Force, convened by the lieutenant governor, to launch in January 2024. Both efforts underscore the critical need to address not just the clinical symptoms of mental health but also the underlying conditions, including racism and other social influencers of health that place children, families, and communities at risk for negative health and mental health outcomes. Integrating the work of the ICMHP into these public health efforts is a critical opportunity for the appointed members to enhance innovation and to reflect cultural and community priorities from a life span perspective.

HB 342 Whole Child Task Force Legislation (Senator Lightford/Representative Ammons)

- Implements recommendations from the Whole Child Task Force, which lays out a comprehensive set of steps to create a safe, supportive, healing centered K-12 education system in Illinois.
    - Public Act 103-0413: https://ilga.gov/legislation/publicacts/103/103-0413.htm

SB 646 Task Force to Create Healing Centered Illinois (Senator Pacione-Zayas/Representative Hirschauer)

- Creates the task force for a Healing-Centered Illinois to design a state level comprehensive and equitable strategy for addressing trauma.
    - Public Act 103-0545: https://www.ilga.gov/legislation/publicacts/fulltext.asp?Name=103-0545

VI. Youth Council Recommendations

1. **Consistent with section (b-5) of P.A. 102-1034, the ICMHP shall appoint a minimum of 10 members of an adjunct council elevating youth voice and the ICMHP will conduct a minimum of four meetings of the adjunct council by the end of 2023 and annually thereafter.**

The Youth Council was convened during the summer of 2023 and met during the fall of 2023 to create a list of recommendations to be shared with the appointed ICMHP members. The details of this process, including the participants and sponsors and reflections on next steps, are included in Appendix 5. These recommendations were shared at the final ICMHP quarterly meeting on December 5, 2023, by two youth leaders from the Youth Commission. Sen. Mike Simmons, the Senate sponsor of the legislation to create the commission, was present. The recommendations are listed below. An invitation to the commission members to serve in this role during spring 2024 has been issued and all of the youth members expressed interest in continuing to serve in this role for the remainder of the year. This group will be reconvened in early 2024.

Recommendation 1: Illinois Mental Health Access and Provider Support Initiative

To enhance mental health affordability, reduce wait times, and support mental health providers in Illinois by

expanding funding for non-profit agencies, increasing health insurance coverage, facilitating education pathways, and providing additional support for mental health providers.

- **Funding For Non-Profit Agencies (Affordability) –** Allocate additional state funding to increase the financial resources available to non-profit mental health agencies. This increased funding will allow these agencies to expand services and subsidize mental health care costs for individuals who cannot afford it through a sliding fee scale.
- **Health Insurance –** Advocate for the expansion of health insurance coverage to include a broader range of mental health services across various agencies. Support this initiative by presenting evidence of the effectiveness of comprehensive mental health coverage in improving overall health outcomes and reducing societal costs.
- **Education Requirements and Scholarship Opportunities –** Reduce education requirements for certain mental health positions to facilitate faster entry into the field. Create more career opportunities for bachelor's level clinicians working under licensed professionals. Establish structured mentorship and supervision programs that pair bachelor's level clinicians with experienced licensed professionals. Outline specific responsibilities and tasks that bachelor's level clinicians can undertake under the guidance and supervision of licensed professionals.
- **Scholarships –** Establish specialized scholarship programs specifically targeting individuals from underrepresented communities (e.g., racial/ethnic minorities, LGBTQ+ individuals, individuals with disabilities) pursuing mental health education. These scholarships will cover tuition, fees, and living expenses from undergraduate to graduate studies. Collaborate with undergraduate educational institutions across Illinois to identify and recruit students from underrepresented backgrounds interested in mental health fields. Encourage and support their transition to graduate-level mental health programs.
- **Supporting Mental Health Providers –** Allocate resources to provide mental health services specifically tailored for mental health providers. This includes access to counseling, therapy, and mental health check-ups to address stress, burnout, and emotional challenges faced in their profession. Create structured support groups for mental health providers, providing a platform for them to share experiences, seek advice, and receive emotional support from peers facing similar challenges. These groups can be both in-person and virtual to accommodate different preferences and schedules. Implement wellness days dedicated to mental health providers, allowing them a day off for self-care, relaxation, and rejuvenation. Conduct regular workshops focused on stress management, mindfulness, and resilience-building techniques.

Recommendation 2: LGBTQ+ Youth Mental Health

State leaders should work in conjunction with LGBTQ+-focused organizations, school districts, young people, and other state agencies to address the root causes of the LGBTQ+ mental health crisis and dispel misinformation.

- **Task Force** – Develop a task force between the Illinois State Board of Education and trauma-informed organizations with an effort to modernize and adapt our school curriculum to include Stonewall, Harvey Milk, AIDS-HIV, and proper Health and Sex Ed.
- **Statewide social media campaign** – To be designed by young people (13-25) to affirm all young people, regardless of sexuality, gender, ethnicity, race, religion, etc., with a focus on mental health.

- **Training –** Work in conjunction with school districts to fund a mandatory trauma-informed care class for school counselors that encompass LGBTQ+ affirming environments and dispelling misinformation. Scholarships and grants to encourage LGBTQ+ counselors.
- **Data Collection –** Collect data on LGBTQ+ youth mental health outcomes and experiences to identify disparities and inform evidence-based interventions and policies.
- **Represent State Government** – Assigning a "youth liaison" designated to lead discussions surrounding serving youth in our communities and leading programs to prevent youth from being left out of youth conversations. This position benefits all young people and allows a youth-led LGBTQ+ movement.

Recommendation 3: Culturally Responsive Mental Health Care

Mental health initiatives, specifically in the Middle Eastern and other non-White communities, have often focused on older children and adolescents, however, intergenerational trauma and other factors parents experience can play a large role in a child's mental health. The state should also prioritize helping the parents understand what struggling with mental health is and how it can be helped. When the focus is redirected on the parents' understanding, then the parents can aid their children during their struggles and hardships.

- **House of Worship Mental Health Discussions** – Allocate state funds to support houses of worship that are willing to open safe spaces, staffed with certified mental health professionals who understand the cultural and linguistic needs of the community for individuals seeking mental health support.
- **Community Healing and Resilience Centers** – Recognize the importance of youth educating their parents about mental health. Encouraging open discussions and breaking cultural taboos surrounding mental health issues can lead to greater acceptance and support within families.
- **School-Based Trauma-Informed Practices and State Funded Curriculum** – Support educational programs within schools that focus on mental health awareness, resilience-building, and the normalization of seeking help. Empowering Middle Eastern youth and other marginalized populations to understand and address mental health concerns can facilitate open conversations within their families and communities. Provide state funding for schools that integrate the struggles and experiences of Middle Eastern communities, including smaller groups like Assyrians, into their curriculums. This educational initiative aims to address mental health struggles among Middle Eastern youth and reduce stigma.
- **Support and Funding for Lesser-Recognized Middle Eastern Communities** – Allocate resources for research initiatives focusing on the needs, challenges, and strengths of lesser-recognized populations in Illinois to inform policy solutions and resource allocation. Allocate funding and resources specifically aimed at shedding light on and supporting lesser-recognized Middle Eastern communities, like the Assyrians, to bring awareness to their cultural identity and unique needs.

Recommendation 4: Culturally Responsive Mental Health in Schools

To prioritize mental health awareness, social and emotional learning (SEL), inclusivity, and access to resources within Illinois schools to support the holistic well-being of students and address root causes of challenges like substance abuse and social pressures.

- **Culturally Responsive SEL Curriculum and Courses** – Mandate the incorporation of a culturally responsive

SEL curriculum from grades K through 12 as part of the mandated health curriculum. This program will address social problems, bullying, substance abuse, and stress while fostering emotional intelligence, self-awareness, and social skills among students.

- Ensure the SEL curriculum is taught by qualified professionals, including counselors, mental health educators, and specialists trained in cultural competence. Provide professional development opportunities to educators for effective delivery of the curriculum.
- Integrate DEI education into the SEL curriculum, addressing biases, stereotypes, and promoting inclusivity. Focus on minimizing biases, fostering empathy, and understanding diverse perspectives through interactive lessons and discussions.
- Collaborate with community organizations, cultural groups, and experts to support the development and implementation of the culturally responsive SEL curriculum. Encourage involvement and input from diverse communities to ensure relevance and inclusivity. Increase visibility and representation of diverse role models, adults, and community members from various backgrounds within the SEL curriculum.

- **Illinois Youth Mental Health Day** – Mandate the designation of a specific day within the academic year as "Mental Health Awareness Day" in all Illinois schools aimed at fostering education, outreach, support, and encouraging career and educational pathways within the mental health field. Allocate this day for targeted mental health education and activities across grade levels.
- **School Staff Training** – Implement mandatory training programs for teachers focusing on recognizing symptoms of anxiety, depression, panic attacks, and stress in students. Provide guidance on handling acute mental health circumstances in the classroom setting. Provide teachers with crisis management plans, offering protocols for receiving external help. Include DEI training in mental health education for teachers. Emphasize cultural sensitivities and diverse experiences when handling student mental health crises, ensuring inclusivity, and understanding of various cultural perspectives.
- **Restorative Substance Abuse Policies** – Develop and implement substance abuse programs that prioritize mental health and healing for youth. Focus on understanding underlying mental health issues, trauma, and stressors that contribute to substance abuse. Establish an amnesty policy for first-time substance abuse offenses among students. Replace disciplinary punishments with warning and follow-up support, such as mandated meetings with counselors and opportunities for rehab or counseling. Shift focus from punitive measures to restorative action in handling substance abuse incidents. Conduct thorough assessments to understand the root causes behind the student's behavior and address underlying issues.
- **Regular Mental Health Screeners** – Equip schools with tools to conduct regular assessments to identify stressors affecting students' mental health. Recognize academic pressure, family issues, homelessness, financial stress, and other environmental factors that contribute to mental health challenges and adjust school resources and policies accordingly. Just like youth get vision and hearing tested in school, they should be able to opt into mental health screeners.
- **Access to Mental Health Resources and Culturally Responsive Care** – The state should provide scholarships, incentives, and mentorship for counselors from underrepresented backgrounds to go into the profession. Students should have the opportunity to connect with a counselor that shares a similar identity and, if this is not possible, connect students to outside resources with things such as telehealth. Equip schools to implement mental health support groups of affinity spaces for students to gather peer support with similar identities.

VII. CONCLUSION

The Illinois Children's Mental Health Partnership continues to be important. The state of Illinois has a unique opportunity to leverage growing public awareness of the critical role that mental health plays. 2024 begins a new opportunity for ICMHP to better align its work with the Children's Behavioral Health Transformational Initiative and the state's public health agency. We remain thankful for the support of Gov. JB Pritzker and the General Assembly in helping the ICMHP address the challenges of mental health in our state's youth.

VIII. ADDENDUM

Appendices

1. Public Act 102-0889
2. Illinois Children's Mental Health Plan 2023 Evaluation Framework Final Report (June 2023)
3. ICMHP Revised Bylaws (Adopted by Members September 26, 2023)
4. Illinois Children's Mental Health Partnership Members (as of December 20, 2023)
5. Youth Council Recommendations and Report
6. Lessons Learned: A Landscape Scan of Mental Health Screening Practices in Illinois Schools

405 ILCS 49/1 and 49/5
Statutory Authority for the Illinois Children's Mental Health Partnership
as amended by P.A. 102-0899 and P.A. 102-1034, effective January 1, 2023

(405 ILCS 49/1)
Sec. 1. Short title. This Act may be cited as the Children's Mental Health Act.
(Source: P.A. 102-0899, eff. 1-1-23.)

(405 ILCS 49/5)
Sec. 5. Children's Mental Health Partnership; Children's Mental Health Plan.

(a) The Children's Mental Health Partnership (hereafter referred to as "the Partnership") created under Public Act 93-495 and continued under this amendatory Act of the 102nd General Assembly shall advise State agencies on designing and implementing short-term and long-term strategies to provide comprehensive and coordinated services for children from birth to age 25 and their families with the goal of addressing children's mental health needs across a full continuum of care, including social determinants of health, prevention, early identification, and treatment. The recommended strategies shall build upon the recommendations in the Children's Mental Health Plan of 2022 and may include, but are not limited to, recommendations regarding the following:

(1) Increasing public awareness on issues connected to children's mental health and wellness to decrease stigma, promote acceptance, and strengthen the ability of children, families, and communities to access supports.
(2) Coordination of programs, services, and policies across child-serving State agencies to best monitor and assess spending, as well as foster innovation of adaptive or new practices.
(3) Funding and resources for children's mental health prevention, early identification, and treatment across child-serving State agencies.
(4) Facilitation of research on best practices and model programs and dissemination of this information to State policymakers, practitioners, and the general public.
(5) Monitoring programs, services, and policies addressing children's mental health and wellness.
(6) Growing, retaining, diversifying, and supporting the child-serving workforce, with special emphasis on the professional development around child and family mental health and wellness services.
(7) Supporting the design, implementation, and evaluation of a quality-driven children's mental health system of care across all child services that prevents mental health concerns and mitigates trauma.
(8) Improving the system to more effectively meet the emergency and residential placement needs for all children with severe mental and behavioral challenges.

(b) The Partnership shall have the responsibility of developing and updating the Children's Mental Health Plan and advising the relevant State agencies on implementation of the Plan. The Children's Mental Health Partnership shall be comprised of the following members:

(1) The Governor or his or her designee.

(2) The Attorney General or his or her designee.
(3) The Secretary of the Department of Human Services or his or her designee.
(4) The State Superintendent of Education or his or her designee.
(5) The Director of the Department of Children and Family Services or his or her designee.
(6) The Director of the Department of Healthcare and Family Services or his or her designee.
(7) The Director of the Department of Public Health or his or her designee.
(8) The Director of the Department of Juvenile Justice or his or her designee.
(9) The Executive Director of the Governor's Office of Early Childhood Development or his or her designee.
(10) The Director of the Criminal Justice Information Authority or his or her designee.
(11) One member of the General Assembly appointed by the Speaker of the House.
(12) One member of the General Assembly appointed by the President of the Senate.
(13) One member of the General Assembly appointed by the Minority Leader of the Senate.
(14) One member of the General Assembly appointed by the Minority Leader of the House.
(15) Up to 25 representatives from the public reflecting a diversity of age, gender identity, race, ethnicity, socioeconomic status, and geographic location, to be appointed by the Governor. Those public members appointed under this paragraph must include, but are not limited to:
  (A) a family member or individual with lived experience in the children's mental health system;
  (B) a child advocate;
  (C) a community mental health expert, practitioner, or provider;
  (D) a representative of a statewide association representing a majority of hospitals in the State;
  (E) an early childhood expert or practitioner;
  (F) a representative from the K-12 school system;
  (G) a representative from the healthcare sector;
  (H) a substance use prevention expert or practitioner, or a representative of a statewide association representing community-based mental health substance use disorder treatment providers in the State;
  (I) a violence prevention expert or practitioner;
  (J) a representative from the juvenile justice system;
  (K) a school social worker; and
  (L) a representative of a statewide organization representing pediatricians.
(16) Two co-chairs appointed by the Governor, one being a representative from the public and one being a representative from the State.

The members appointed by the Governor shall be appointed for 4 years with one opportunity for reappointment, except as otherwise provided for in this subsection. Members who were appointed by the Governor and are serving on the effective date of this amendatory Act of the 102nd General Assembly shall maintain their appointment until the term of their appointment has expired. For new appointments made pursuant to this amendatory Act of the 102nd General Assembly, members shall be appointed for one-year, two-year, or four-year terms, as determined

by the Governor, with no more than 9 of the Governor's new or existing appointees serving the same term. Those new appointments serving a one-year or 2-year term may be appointed to 2 additional 4-year terms. If a vacancy occurs in the Partnership members, the vacancy shall be filled in the same manner as the original appointment for the remainder of the term.

The Partnership shall be convened no later than January 31, 2023 to discuss the changes in this amendatory Act of the 102nd General Assembly.

The members of the Partnership shall serve without compensation but may be entitled to reimbursement for all necessary expenses incurred in the performance of their official duties as members of the Partnership from funds appropriated for that purpose.

The Partnership may convene and appoint special committees or study groups to operate under the direction of the Partnership. Persons appointed to such special committees or study groups shall only receive reimbursement for reasonable expenses.

(b-5) The Partnership shall include an adjunct council comprised of no more than 6 youth aged 14 to 25 and 4 representatives of 4 different community based organizations that focus on youth mental health. Of the community-based organizations that focus on youth mental health, one of the community-based organizations shall be led by an LGBTQ-identified person, one of the community-based organizations shall be led by a person of color, and one of the community-based organizations shall be led by a woman. Of the representatives appointed to the council from the community-based organizations from the community-based organizations, at least one representative shall be LGBTQ-identified, at least one representative shall be a person of color, and at least one representative shall be a woman. The council members shall be appointed by the Chair of the Partnership and shall reflect the racial, gender identity, sexual orientation, ability, socioeconomic, ethnic, and geographic diversity of the State, including rural, suburban, and urban appointees. The council shall make recommendations to the Partnership regarding youth mental health, including, but not limited to, identifying barriers to youth feeling supported by and empowered by the system of mental health and treatment providers, barriers perceived by youth in accessing mental health services, gaps in the mental health system, available resources in schools, including youth's perceptions and experiences with outreach personnel, agency websites, and informational materials, methods to destigmatize mental health services, and how to improve State policy concerning student mental health. The mental health system may include services for substance use disorders and addiction. The council shall meet at least 4 times annually.

(c) (Blank).

(d) The Illinois Children's Mental Health Partnership has the following powers and duties:

(1) Conducting research assessments to determine the needs and gaps of programs, services, and policies that touch children's mental health.

(2) Developing policy statements for interagency cooperation to cover all aspects of mental health delivery, including social determinants of health, prevention, early identification, and treatment.

(3) Recommending policies and provide information on effective programs for delivery of mental health services.

(4) Using funding from federal, state, or philanthropic partners, to fund pilot programs or research activities to resource innovative practices by organizational partners that will

address children's mental health. However, the Partnership may not provide direct services.

(5) Submitting an annual report, on or before December 30 of each year, to the Governor and the General Assembly on the progress of the Plan, any recommendations regarding State policies, laws, or rules necessary to fulfill the purposes of the Act, and any additional recommendations regarding mental or behavioral health that the Partnership deems necessary.

(6) Employing an Executive Director and setting the compensation of the Executive Director and other such employees and technical assistance as it deems necessary to carry out its duties under this Section.

The Partnership may designate a fiscal and administrative agent that can accept funds to carry out its duties as outlined in this Section.

The Department of Healthcare and Family Services shall provide technical and administrative support for the Partnership.

(e) The Partnership may accept monetary gifts or grants from the federal government or any agency thereof, from any charitable foundation or professional association, or from any reputable source for implementation of any program necessary or desirable to carry out the powers and duties as defined under this Section.

(f) On or before January 1, 2027, the Partnership shall submit recommendations to the Governor and General Assembly that includes recommend updates to the Act to reflect the current mental health landscape in this State.
(Source: P.A. 102-0899, eff. 1-1-23; P.A. 102-1034, eff. 1-1-23.)

Illinois Children's Mental Health Plan 2023 Evaluation Framework

Final Report

June 2023

Smith Child Health Outcomes, Research, and Evaluation Center

Stanley Manne Children's Research Institute™

Executive Summary

The Illinois Children's Mental Health Partnership (ICMHP) has worked with stakeholders from across the state to develop a systematic, comprehensive, and interdisciplinary Children’s Mental Health Plan for Illinois that will address the needs of children, families, and communities. In order to serve the mental health and wellness of all children, families, and communities, ICMHP developed five goals:

(1) Awareness, Acceptance, and Supports

(2) Coordination, Needs Assessment, and Innovation

(3) Centralized Hub

(4) Child Serving Workforce

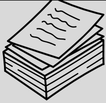
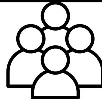
(5) Systems of Care

ICMHP has partnered with the Catalyst team to develop an evaluation framework for these goals. This report summarizes evaluation strategies for each goal and the specific data collection methods needed for the evaluation. The report concludes with recommendations and considerations for implementing the full evaluation.

Stanley Manne
Children’s Research Institute™

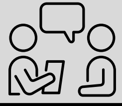
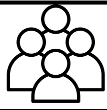
Goal-Specific Evaluation Strategies

Evaluation Methods for Goal 1: Awareness, Acceptance, and Support

Interviews 1:1	Surveys	 Document Review	 Focus Groups

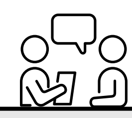
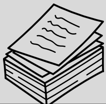
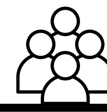
	Mental Health Workforce	Illinois Residents
Goal 1: Increase public awareness on all issues connected to child and family mental health and wellness to decrease stigma, promote acceptance, and strengthen children, families, and communities to identify needs and access supports with resources and funding.		1) Conduct an annual **survey** of Illinois residents with questions related to mental health perceptions (stigma and acceptance measure).
Goal 1A: Identify, define, and align key terms across sectors and services related to child and family mental health and wellness.	1) Conduct **interviews** with professionals across the different sectors to discuss how terms are used. 2) **Survey** professionals across the different sectors on how terms are used. 3) **Review** various documents from across the different sectors to see how terms are used.	
Goal 1B: Strengthen and fund local cross-sector forums that promote dialogue, encourage collaboration, facilitate learning, and seed connections to break down the stigma of mental health.	1) **Review** the annual budget to see how cross-sector forums were or were not funded. 2) Create a **bank of survey questions**/tools that forum organizers could use in pre-and/or post-event questionnaires to assess impact.	1) Create a **bank of survey questions** that can be used for the Illinois Residents survey as well as in community settings after events, etc. to measure change in stigma.

Evaluation Methods for Goal 1: Awareness, Acceptance, and Support

 Interviews 1:1	Surveys	Document Review	 Focus Groups

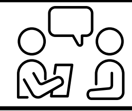
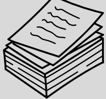
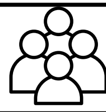
	Mental Health Workforce	Illinois Residents
Goal 1C: Invest in a cross-sector, coordinated public health campaign focused on strengthening mental health in all aspects of life, promoting best practices, and decreasing stigma.	1) **Measure** whether the investment was made in the campaign. 1a) **Measure** the depth/extent of investment by reviewing fundraising reports and/or budgets. 2) **Measure** the reach/media impressions of the campaign (measured as "impressions," provided by campaign contractor/vendors (i.e. clicks to a campaign website).	1) **Measure** reduction of stigma and the strengthening of mental health via questions in survey of Illinois residents and survey item bank (for multi-use). 2) **Measure** campaign reach by surveying Illinois residents and inquiring about their exposure to the campaign ("have you seen XX campaign?").
Goal 1D: Promote awareness and expansion of evidence-based models that work across sectors and provide education and outreach to children, families, and communities.	1) **Determine** via document review how many organizations are using evidence-based models. 2) **Measure** the level of expansion of the evidence-based models and the resources devoted to them.	1) Include survey items on **survey** of Illinois residents about their access to or perceptions of access to services.

Evaluation Methods for Goal 2: Coordination, Needs Assessment, Innovation

 Interviews 1:1	Surveys	 Document Review	 Focus Groups

	Mental Health Workforce
Goal 2: Create a coordinating entity responsible for 1) conducting a comprehensive and cross-system needs assessment of programs, services, and policies that touch children's mental health, 2) monitoring and assessing spending on all child and family mental health and wellness services to determine scope and effectiveness, and 3) fostering innovation of adaptive and new practices to improve children's health.	1) **Measure** whether the needs assessment was conducted. 2) **Measure** the level of spending/investment across services. 3) **Document** the number of innovations.
Goal 2A: Fund the establishment of a university-based institute focused on helping the State of Illinois research, design, and implement innovative children's mental health practices, including taking the lead to coordinate efforts across state agencies and the private sector ("a coordinating entity").	1) **Measure** the level of funding provided. 2) **Document** the number of innovative practices established.
Goal 2B: Commission a comprehensive and cross-system needs assessment and study on the efficacy of statewide programs that are being funded to assess and improve children's mental health and wellness.	1) **Measure** whether the needs assessment was conducted. 2) **Review** what was done with the results of the assessment (what was done to increase the efficacy of programs) and conduct a follow-up assessment as needed.

Evaluation Methods for Goal 2: Coordination, Needs Assessment, Innovation

 Interviews 1:1	Surveys	 Document Review	 Focus Groups

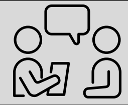
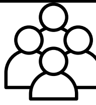
	Mental Health Workforce
Goal 2C: Ensure the creation and modernization of a cross-system and intergovernmental authority, represented by all child-serving state agencies and members of the public and private sectors, tasked with finding alignment, avoiding duplication of efforts, and ensuring appropriate coordination in the implementation of programs and services.	1) **Measure** whether the authority was created. 2) **Measure** the number of agencies and sectors that were represented. 3) **Survey** sector professionals on their perspective on changes in their work before and after the cross-system and intergovernmental authority are created.
Goal 2D: Review and align the efforts of all programs, commissions, and task forces responsible for improving child and family mental health and wellness.	1) **Measure** whether the review and alignment of efforts were achieved and by what means. 2) **Survey** sector professionals on their perspective on changes in their work post alignment (pre and post-survey).

Evaluation Methods for Goal 3: Centralized Hub

Interviews 1:1	Surveys	Document Review	Focus Groups

	Mental Health Workforce	Illinois Residents
Goal 3: Develop, maintain, and ensure ongoing monitoring of a hub of programs, services, and policies easily accessible to the public to assist with navigation, resources, and funding.	1) Conduct an assessment of the hub including; its existence, its impact, how monitoring is going, etc. through **interviews and/or focus groups** with the workforce. 2) Conduct a **survey** of sector professionals that includes questions about the hub and how people are using it.	1) **Survey** Illinois residents on their awareness of and use of the hub.
Goal 3A: Commission a study led by the above referenced coordinating entity and with the support of state agencies to create a set of consistent cross-sector quality measures that determine the mental health strength and/or vulnerability of children and families in a community.	1) Conduct an assessment of the existence, use, and quality of the quality measures through **interviews, focus groups, or surveys.**	
Goal 3B: Invest in technical assistance and infrastructure programs that allow communities to appropriately share data across child-serving sectors to ensure that the needs of the whole child are met.	1) Document the level of investment and assess the level of data sharing through **surveys/interviews** of sector professionals across defined sectors. 2) **Review budgets** to determine the level of investment in the infrastructure.	
Goal 3C: Build an appropriate communication tool or platform that allows all communities, as well as the professionals that serve them, to have access to the information necessary to find appropriate and available services and supports.	1) **Measure** the existence and use of the tool/platform (impressions, clicks, downloads, etc.).	1) **Survey** Illinois residents on their awareness and use of the tool.

Evaluation Methods for Goal 4: Child-Serving Workforce

 Interviews 1:1	Surveys	Document Review	 Focus Groups

	Mental Health Workforce
Goal 4: Grow, retain, diversify, and support the child-serving workforce, with special emphasis on professional development around child and family mental health and wellness, and services and supports to address needs.	1) **Assess** the number of people obtaining mental health professional credentials and reassess annually. 2) **Assess** the diversity of individuals obtaining credentials and reassess annually.
Goal 4A: Prioritize reimbursement strategies that provide greater parity between public and private payers to ensure greater access to existing mental health services.	1) Conduct **interviews** with a few key informants to help guide the document review of current reimbursement strategies (i.e. what to look for).
Goal 4B: Develop mental and behavioral health core competencies, including trauma, for all professionals serving children and families and fund programs that foster integration of mental health with health services and other social supports.	1) Assess whether core competencies were created and disseminated through **interviews** with sector leaders.
Goal 4C: Fund robust loan forgiveness, scholarships, and other incentive programs to further grow and diversify child-serving workforces, particularly in mental health.	1) **Review documents** of available state scholarships and loan forgiveness opportunities for mental health professionals.
Goal 4D: Establish and invest in workforce health and wellness promotion models to address the increased rates of stress and burnout seen across all child-serving workforces.	1) **Identify** whether health and wellness promotion models were initiated/established. 2) Assess burnout rates and stress either by a **survey** of providers or through data about individuals with expired credentials over time.

Evaluation Methods for Goal 5: Systems of Care

Interviews 1:1	Surveys	Document Review	Focus Groups

	Mental Health Workforce	Illinois Residents
Goal 5: Fund the design, implementation, and evaluation of system of care strategies that prevent and treat mental health concerns and mitigate trauma by more effectively delivering services.	1) **Review** the budget to determine if this was funded and at what level.	1) **Survey** Illinois residents to assess the effectiveness of the delivery of services.
Goal 5A: Review statewide legal, compliance, and privacy rules and regulations across sectors and identify models of data integration.	1) **Review documents** for data integration opportunities, possibly in partnership with other groups.	
Goal 5B: Invest in state-based community funding that purposefully engages community-based professionals and families to collaboratively create a child-centered and family-focused system of care.	1) **Budget review** of funding for programs that meet this definition.	1) **Survey** Illinois residents to measure the impact of the investment.
Goal 5C: Prioritize reimbursement changes that incorporate the concept of a medical home with integrated behavioral and child healthcare.	1) **Review** reimbursement strategies.	
Goal 5D: Establish a Children's Mental Health Fund that supports innovative community strategies to build systems of care to address child and family mental health and wellness.	1) **Identify** whether the fund was established. 2) **Review** the fund budget.	

Method-
Specific
Evaluation
Strategies
Stanley Manne
Children's Research Institute
Illinois Children's
Mental Health
Partnership
SMITH CHILD HEALTH
Catalyst

Evaluation Method: Surveys

Survey of Illinois Residents		
Community Mental Health Perceptions	**Goal 1, Activity 1c**	Annual survey of Illinois residents to measure stigma, acceptance, and campaign engagement.
	Activity 1b	Create a bank of survey questions that the workforce can use to create pre and post-questionnaires that measure the change in stigma in an effort to compare results across the sector.
	Activity 1c	Survey bank questionnaires for campaign engagement.
Community access and awareness to resources	**Activity 1d**	Annual survey of Illinois residents to measure access or perceptions of access to services.
	Goal 3 and Activity 3c	Annual survey of Illinois residents to measure awareness and use of the “hub” and resource communication tool.
	Goal 5 and Activity 5b	Annual survey of Illinois residents to assess the effectiveness of delivery of services and impact of investment in child-centered and family-focused care.
Mental Health Workforce Survey		
Centralized Hub	**Goal 3**	Annual survey of the workforce includes questions about the hub and how people are using it.
	Activity 3b	Survey of the workforce to measure the level of investment, and assessment of data sharing.
	Activity 3a	Survey of the workforce to assess the existence, use, and quality of the quality measures.
Workforce	**Goal 4**	Assess the number of people obtaining mental health professional credentials; and the diversity of individuals obtaining credentials through a survey of the workforce.
	Activity 4d	Assess burnout rates and stress through a survey of workforce.

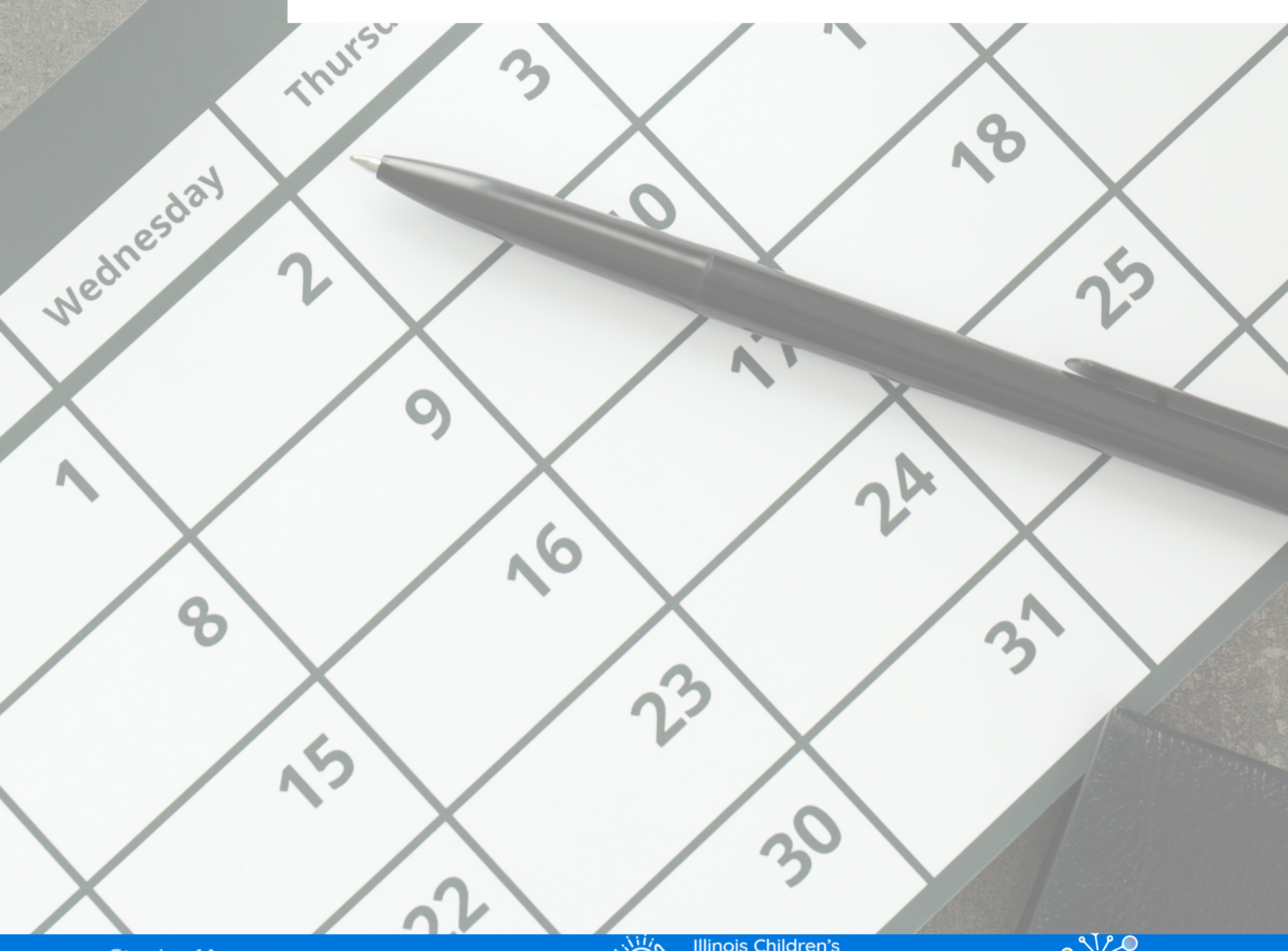
Evaluation Method: Focus Groups & Interviews

Focus Groups with Mental Health Professionals		
Focus Groups with Mental Health Professionals	**Goal 3**	Assessment of the hub - its existence, its impact, and how monitoring is going through interviews and/or focus groups with the workforce
	Goal 3A	Focus groups with individuals from the workforce to assess the existence, use, and quality of quality measures.
Interviews with Mental Health Workforce		
Interviews 1:1	**Goal 4A**	Discussions/interviews with a few key informants to help guide the document review of current reimbursement strategies.
	Goal 1A	Interviews to examine how they use terms across sectors.

Evaluation Method: Data or Document Review

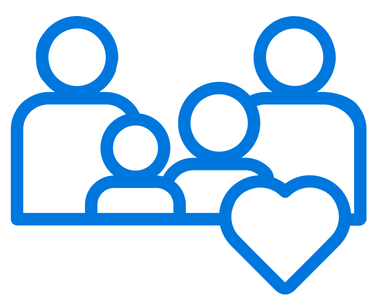
Document Review		
Funding Review	Activity 1B	Review annual budget for funding to cross-sector forums.
	Goal 5	Review of budget to determine if this was funded and at what level.
	Activity 5A	Document review for data integration opportunities (in partnership with other groups).
	Activity 5B	Budget review of funding for programs that meet this definition.
	Activity 5C	Review reimbursement strategies.
	Activity 5D	Identify whether fund was established and review the fund budget.
	Activity 4A	Document review of current reimbursement strategies.
Quality Checks	Activity 1C	Measure whether the investment was made in the campaign and measure the depth/extent of investment by looking at fundraising and/or budgets.
	Activity 1D	Determine how many organizations are using evidence-based models via document review. Measure the level of expansion of the models and the resources devoted to them.
	Activity 4D	Identify whether health and wellness promotion models were initiated/established;
	Activity 3B	Documentation of level of investment.
	Activity 3C	Review the existence and use of the tool/platform (clicks, downloads, etc.).

Considerations for Evaluation Methods



Considerations and Recommendations

Survey of Illinois Residents



During the first year of the evaluation, we recommend dedicating approximately 3 months to designing the survey questions, creating a promotional plan, and building the survey into a survey platform. Approximately 1.5 months should be used for fielding the survey.

We also recommend obtaining a representative sample from a reputable survey distribution company/vendor. An RFP for survey vendors and companies can be created to hire this company. If utilizing a survey vendor is not feasible we recommend distribution via family-centered organizations in each region or via social media, etc. Lastly, we recommend adding incentives to increase participation.

Survey of Mental Health Workforce

During the planning phase for workforce surveys, we recommend developing a recruitment plan in addition to developing and programming surveys. For example, putting flyers in lunch or break rooms with a QR code, distributing via listservs, etc. The planning phase should also allow enough time to develop the survey and program survey. This planning phase will take approximately 3 months.

Fielding of the survey may take approximately 3 months and can be repeated as needed

Focus groups with Mental Health Workforce

Development of focus group guides may take up to 1.5 months. Focus groups should be around 7-12 people per group with representation from various groups of the workforce including region, job title, length of time in the field, public vs. private employer, certification vs. degree, etc. Focus groups can be virtual or in-person. We also recommend compensating participants for their time.

We also recommend allowing the hub to be in place for 1 year before conducting focus groups about its impact and conducting focus groups on the quality measures every 6 months.

Interviews with Mental Health Workforce

During the planning phase for the interviews we recommend allotting one month to create interview guides, one month to identify who will be interviewed, and one month to conduct the interviews. The interviews will be reoccurring throughout the evaluation period.

Note: when conducting interviews to learn about how key terms are used across the sector we recommend conducting interviews before and after key terms are introduced to the sector. Six months should be given to participants to use the term before post-interviews occur.

Stanley Manne
Children's Research Institute™

Document Review and Quality Checks

The document review for this evaluation will be similar to conducting an audit across the sector and will be time and resource intensive. At the beginning of the evaluation, it may be helpful to determine:

- When it will be feasible to review funding structures and conduct quality checks (yearly, quarterly, etc).
- Determine if will be feasible to dedicate one full-time staff member that will lead a panel of document reviewers OR hire an audit company to carry out the work.

This concludes the evaluation report for the evaluation framework for each of the 5 goals of the Children's Mental Health Plan

Those responsible for **concept and coordination of this** evaluation report include:

- Adam Becker, Scientific Lead - Community Engaged and Qualitative Studies
- Marie Heffernan, Scientific Lead - Survey Science
- Zecilly Guzman, Behavioral Research Coordinator
- MicKayla Jones, Research Program Manager

The Smith Child Health Catalyst thanks you for your partnership.

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Illinois Children's Mental Health Partnership BYLAWS

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1.0 Origin, Mission, and Responsibilities

The Illinois Children's Mental Health Partnership (ICMHP or the Partnership) was created by the Illinois Children's Mental Health Act of 2003 and continues under the amendatory Public Act 1020899 and Public Act 102-1034 effective January 1, 2023 (405 ILCS 49/5; see Appendix A). The Partnership is responsible for advising State agencies on designing and implementing short-term and long-term strategies to provide comprehensive and coordinated services for children from birth to age 25 and their families with the goal of addressing children's mental health needs across a full continuum of care, including social determinants of health, prevention, early identification, and treatment. In order to meet these obligations, the Partnership adopts the following bylaws.

1.1 Powers and Duties

The Partnership has the responsibility of developing and updating the Children's Mental Health Plan and advising the relevant State agencies on implementation of the Plan. To meet this responsibility, the Partnership shall have the following powers and duties (405 ILCS 49/5(D)):

1. Conducting research assessments to determine the needs and gaps of programs, services, and policies that touch children's mental health.

2. Developing policy statements for interagency cooperation to cover all aspects of mental health delivery, including social determinants of health, prevention, early identification, and treatment.

3. Recommending policies and providing information on effective programs for delivery of mental health services.

4. Using funding from federal, state, or philanthropic partners, to fund pilot programs or research activities to resource innovative practices by organizational partners that will address children's mental health. However, the Partnership may not provide direct services.

5. Submitting an annual report, on or before December 30, of each year, to the Governor and the General Assembly on the progress of the Plan, any recommendations regarding State policies, laws, or rules necessary to fulfill the purposes of the Act, and any additional recommendations regarding mental or behavioral health that the Partnership deems necessary.

6. Employing an Executive Director and setting the compensation of the Executive Director

and other such employees and technical assistance it deems necessary to carry out its duties as outlined in this Section.

2.0 Partnership Structure

In order to meet its responsibilities (see §1), the Partnership is composed of a statutorily required membership composed of gubernatorial, legislative, and state agency appointees.

2.1 Appointed Membership

2.1.1 Composition

Under the Illinois Children's Mental Health Act, Appointed Members are statutorily required (405 ILCS 49/5(b)). The Partnership shall be comprised of the following members:

1. The Governor or his or her designee.
2. The Attorney General or his or her designee.
3. The Secretary of the Department of Human Services or his or her designee.
4. The State Superintendent of Education or his or her designee.
5. The Director of the Department of Children and Family Services or his or her designee.
6. The Director of the Department of Healthcare and Family Services or his or her designee.
7. The Director of the Department of Public Health or his or her designee.
8. The Director of Juvenile Justice or his or her designee.
9. The Executive Director of the Governor's Office of Early Childhood Development or his or her designee.
10. The Director of the Criminal Justice Information Authority or his or her designee.
11. One member of the General Assembly appointed by the Speaker of the House.
12. One member of the General Assembly appointed by the President of the Senate.
13. One member of the General Assembly appointed by the Minority Leader of the Senate.
14. One member of the General Assembly appointed by the Minority Leader of the House.
15. Up to 25 representatives from the public reflecting a diversity of age, gender identity, race, ethnicity, socioeconomic status, and geographic location, to be appointed by the Governor. Those public members appointed under this paragraph must include, but are not limited to:
    a. a family member or individual with lived experience in the children's mental health system;
    b. a child advocate;
    c. a community mental health expert, practitioner, or provider;
    d. a representative of a statewide association representing a majority of hospitals in the State;

e. an early childhood expert or practitioner;
f. a representative from the K-12 school system;
g. a representative from the healthcare sector;
h. a substance use prevention expert or practitioner, or a representative of a statewide association representing community-based mental health substance use disorder treatment providers in the State;
i. a violence prevention expert or practitioner;
j. a representative from the juvenile justice system;
k. a school social worker;
l. a representative of a statewide organization representing pediatricians.

Two co-chairs appointed by the Governor, one being a representative of the public and one being a representative from the State.

2.1.2 Terms

The members appointed by the Governor shall be appointed for 4 years with one opportunity for reappointment, except as otherwise provided for in this subsection. Members shall be appointed for one-year, two-year, or four-year terms, as determined by the Governor, with no more than 9 of the Governor's new or existing appointees serving the same term. Those new appointments serving a one-year or 2-year term may be appointed to 2 additional 4-year terms. If a vacancy occurs in the Partnership members, the vacancy shall be filled in the same manner as the original appointment for the remainder of the term.

2.1.3 Compensation

The members of the Partnership shall serve without compensation but may be entitled to reimbursement for all necessary expenses incurred in the performance of their official duties as members of the Partnership from funds appropriated for that purpose.

2.1.4 State Trainings

Appointed members are required to complete annual trainings as required by the Open Meetings Act (5 ILCS 120), the State Officials and Employees Ethics Act (5 ILCS 430), and the Data Security on State Computers Act (20 ILCS 450):

1. The Open Meetings Act
2. Ethics Training for State Employees and Appointees
3. Harassment & Discrimination Prevention Training
4. Security Awareness Training
5. Diversity, Equity, and Inclusion Training

6. HIPAA & Privacy Training (this training is not required but highly recommended)

With the exception of the Open Meetings Act training, which is completed only once upon being appointed, all trainings must be taken annually. Additional trainings may be added pursuant to state law. Partnership staff will work with the State to coordinate and ensure completion of all trainings.

2.2 Operations

The appointed members are supported in the day-to-day operations of the Partnership through staff and any technical assistance it deems necessary to carry out its duties.

2.2.1 Staffing

At a minimum, the Partnership will be staffed by an Executive Director. The compensation of the Executive Director, and any additional staff, is set by the Partnership (405 ILCS 49/5(d)(6)). Additional staff, including compensation, will also be determined by the Partnership.

2.2.2 Reporting

The Executive Director reports to the Partnership Co-Chairs and Executive Committee (see §3.1.1). All other staff and technical assistance, including consultants, independent contractors, or a fiscal agent, shall report to the Executive Director or his or her designee.

2.2.3 Contingencies

During a period when the ICMHP has minimal to no staff, the day-to-day operations of the Partnership will be determined in partnership between the co-chairs and fiscal agent in compliance with applicable laws and rules. Adjustments to the Partnership budget to accommodate this collaboration must be submitted for approval within 30 days by the designated Agency providing state funding for the Partnership.

2.3 Funding

The Partnership may accept monetary gifts or grants from the federal government or any agency thereof, from any charitable foundation or professional association, or from any reputable source for implementation of any program necessary or desirable to carry out the power and duties (405 ILCS 49/5(e)).

2.4 Fiscal Agent

The Partnership may designate a fiscal and administrative agent that can accept funds to carry out its duties (450 ILCS 49/5(d)).

2.4.1 Definition

A fiscal agent is an entity contracted to perform fiscal responsibilities on behalf of the Partnership. "A fiscal agent is utilized for technical, regulated financial matters to allow [the Partnership] to focus on other operational core competencies to meet its statutory obligations."[1] The Partnership shall remain independent of the fiscal agent in all substantive matters to carry out its powers and duties, including but not limited to policy decisions and recommendations to the State.

2.4.2 Responsibilities

The role and responsibilities of a fiscal agent shall be defined in a written, signed memorandum of understanding (MOU). At a minimum, the MOU must specify agreed upon fees for clearly defined fiscal services and any administrative services provided to the Partnership.

2.4.3 Conflict of Interest

The Partnership and a designated fiscal agent shall disclose possible conflicts of interest. The relevant party shall recuse itself from participating in any situation where a conflict with the other arises.

3.0 Committees

The Partnership may convene and appoint special committees or study groups to be operated under the direction of the Partnership. Persons appointed to such special committees or study groups shall only receive reimbursement for reasonable expenses (405 ILCS 49/5(b)).

3.1 Standing Committees

The Partnership shall maintain two standing committees: the Executive Committee and the Youth Council.

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[1] The Children's Mental Health Act allows the Partnership to designate a fiscal agent, which is distinct from a fiscal sponsor. According to the State of Illinois, "[a] Fiscal Sponsor assumes legal accountability, fiduciary oversight, fiscal management, and other administrative services." In contrast, a fiscal agent "is much more limited in scope than a fiscal sponsor … a Fiscal Agent is an entity contracted to perform fiscal responsibilities on behalf of a related party." Grant Accountability and Transparency Act, State of Illinois, "GATA Framework for a Grantee Fiscal Agent Function", September 21, 2017, https://gata.illinois.gov/content/dam/soi/en/web/gata/documents/archived-forms/webinar-fall-2018/fiscal-agent-framework.pdf.

3.1.1 Executive Committee

(a) The Partnership shall appoint from its membership an Executive Committee who shall have all the power of the Partnership between meetings of the full Partnership, except that the Executive Committee cannot modify any action taken by the full Partnership.[2] Additionally, recommendations made by the Partnership to the State must be approved by the full Partnership. The Executive Committee shall provide oversight of all Partnership operations, including approving an annual budget and staffing. Other duties of the Executive Committee shall be determined by the full Membership.

(b) The Executive Committee shall be composed of the following roles, totaling nine (9) members, with the Partnership Co-Chairs steering the meeting:

i. Co-Chairs
ii. Representative of the Agency providing state funding for the Partnership
iii. Representative of the Fiscal Agent
iv. Executive Director
v. Representatives of 2 additional State Agencies appointed by the Partnership (*membership solicited from full Partnership and chosen by the Co-Chairs and Governor's Office*)
vi. Two appointed members representing the public (*membership solicited from full Partnership and chosen by the Co-Chairs and Governor's Office*)

If Standing Committees are present, those chairs will be added to Executive Committee membership.

(c) Members chosen by the full membership shall be appointed for two-year terms and may be appointed for consecutive terms.

3.1.2 Youth Council

(a) The Partnership shall include an adjunct council comprised of no more than 6 youth aged 14 to 25 and 4 representatives of 4 different community-based organizations that focus on youth mental health. Of the community-based organizations that focus on youth mental health, one of the community-based organizations shall be led by an LGBTQ-identified person, one of the community-based organizations shall be led by a person of color, and one of the community-based organizations shall be led by a woman. The council members shall be appointed by the Co-Chairs of the Partnership and shall reflect the racial, gender identity, sexual orientation, ability, socioeconomic, ethnic, and geographic diversity of the State, including rural, suburban, and urban appointees.

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[2] Robert's Rules of Order, "50. Boards of Managers or Directors, Boards of Trustees, Executive Committees, etc.", http://www.rulesonline.com/rror-09.htm

(b) The council shall make recommendations to the Partnership regarding youth mental health, including, but not limited to, identifying barriers to youth feeling supported by and empowered by the system of mental health and treatment providers, barriers perceived by youth in accessing mental health services, gaps in the mental health system, available resources in schools, including youth's perceptions and experiences with outreach personnel, agency websites, and informational materials, methods to destigmatize mental health services, and how to improve State policy concerning student mental health. The mental health system may include services for substance use disorders and addiction.

(c) The council shall meet at least 4 times annually.

3.2 Operations

3.2.1 Committee Participation

Partnership members may request to serve on a committee or can be invited by the Partnership Co-Chairs to serve on a committee. Appointed members may serve on multiple committees. The Partnership Co-Chairs, in consultation with the committee chair(s), may invite other interested persons who are not appointed members to serve on committees.

3.2.2 Committee Structure

Except for the standing committees (see §3.1), each committee shall be run by at least one chair, appointed by the Partnership Co-Chairs. Other interested persons may serve as a committee chair. Committees may create sub-committees and identify additional experts to participate on subcommittees or attend sub-committee meetings.

3.2.3 Committee Process

Committee chair(s) report to the Executive Director. Committees shall link their work and integrate efforts where appropriate to other relevant advisory committees, state projects, and initiatives. Partnership staff, in consultation with the committee chair(s) will prepare agendas, send notices, and draft minutes from each committee meeting. Any committee meeting that has a quorum of the members appointed to its committee present is subject to the Open Meetings Act (5 ILCS 120/) (i.e. if a committee has 6 Partnership members on the committee, then 4 members constitute a quorum and that meeting is subject to the Open Meetings Act).

4.0 Meetings

The Partnership will meet quarterly. Committee meetings and special meetings may be scheduled as needed. Partnership staff, in consultation with the Partnership Co-Chairs or

committee chair(s) as applicable, will prepare agendas, send notices, and post minutes in compliance with the Open Meetings Act (5 ILCS 120/).

4.1 Open Meetings

Partnership meetings are open to the public in compliance with the Open Meetings Act (5 ILCS 120/). Appointed members may participate by phone, video, or other electronic communication methods. These members count towards a quorum for the meeting and may vote at that meeting. Additional persons attending do not constitute part of the appointed member quorum required and do not have voting privileges.

4.2 Quorum

Half of the members appointed by the Governor plus one are required to constitute a quorum at the meetings. Ex-Officio members (state agency representatives and legislators, who serve because of their roles) are not included in the count when determining the number needed for a quorum and they are not be counted when determining if a quorum is present (i.e. if all 27 appointed positions [25 representatives of the public and the co-chairs] are filled, 14 appointed members must be present at a quarterly meeting to constitute a quorum).

4.3 Voting

A quorum is required to vote on any agenda item at a meeting. Both members appointed by the Governor and ex-officio members may vote. Ex-officio board members have voting privileges as allowed by their respective positions and ethical guidelines. Members of the public attending the open meeting do not having voting privileges. A majority of those voting at the meeting are required to pass an item (i.e.. if 14 appointed members are present at a quarterly meeting plus 6 ex-officio members [for a total of 20], 11 must vote in favor of an item for it to pass).

5.0 Policy Decisions

5.1 Policy Positions, Recommendations, or Statements

Substantive policy positions, as allowed by federal and state law and contractual agreements of the Partnership, on children's mental health issues shall be approved by a majority of the voting Partnership members. Additionally, the Partnership may issue policy statements that do not take final positions on proposed legislation on substantive children's mental health issues. In this way, the Partnership meets its mandate to disseminate information to Illinois policymakers, practitioners, and the public through training, technical assistance, and educational materials.

5.1.1 Procedure

Policy positions, recommendations, or statements may be requested by the Partnership members, staff, or outside stakeholders. When a relevant issue to the Partnership's statutory mandate is raised, the Partnership Co-Chairs and/or Executive Director will ask a committee to draft a position, recommendations, or statement addressing the issue. The Partnership Co-Chairs may appoint a special committee to complete this task.

5.1.2 Independence of Members

Members of the Partnership may take whatever position they wish in their professional and personal capacities, independent of the Partnership. Being a member of the Partnership does not preclude a member from directly supporting or opposing legislation, court rulings, or other proposals or directives, though a member may not say they are representing the Partnership whey they do so unless previously approved the Partnership. Any position, recommendations, or statement released by the Partnership will contain the following disclaimer:

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

5.2 Letters of Support

The Partnership may participate in grant applications related to its statutory mandate to address child and family mental health, such as issuing a letter of support.

5.2.1 Procedure

The Partnership Co-Chairs and/or Executive Director may issue or sign on to letters of support that are consistent with policy positions, recommendations, or statements already taken by the Partnership. The Executive Director will notify the appointed members of these actions at the next meeting of the full Partnership.

6.0 Bylaw Amendments

These bylaws may be amended with the approval of the majority of Partnership members. If changes are made to the Children's Mental Health Act, then these bylaws must be reviewed and amended, if necessary, to ensure compliance with the Partnership's statutory obligations prior to any substantive decisions can be made by the Partnership.

Appendix

405 ILCS 49/1 and 49/5

Statutory Authority for the Illinois Children's Mental Health Partnership as amended by P.A. 102-0899 and P.A. 102-1034, effective January 1, 2023

(405 ILCS 49/1)

Sec. 1. Short title. This Act may be cited as the Children's Mental Health Act. (Source: P.A. 102-0899, eff. 1-1-23.)

(405 ILCS 49/5)

Sec. 5. Children's Mental Health Partnership; Children's Mental Health Plan.

(a) The Children's Mental Health Partnership (hereafter referred to as "the Partnership") created under Public Act 93-495 and continued under this amendatory Act of the 102nd General Assembly shall advise State agencies on designing and implementing short-term and long-term strategies to provide comprehensive and coordinated services for children from birth to age 25 and their families with the goal of addressing children's mental health needs across a full continuum of care, including social determinants of health, prevention, early identification, and treatment. The recommended strategies shall build upon the recommendations in the Children's Mental Health Plan of 2022 and may include, but are not limited to, recommendations regarding the following:

(1) Increasing public awareness on issues connected to children's mental health and wellness to decrease stigma, promote acceptance, and strengthen the ability of children, families, and communities to access supports.

(2) Coordination of programs, services, and policies across child-serving State agencies to best monitor and assess spending, as well as foster innovation of adaptive or new practices.

(3) Funding and resources for children's mental health prevention, early identification, and treatment across child-serving State agencies.

(4) Facilitation of research on best practices and model programs and dissemination of this information to State policymakers, practitioners, and the general public.

(5) Monitoring programs, services, and policies addressing children's mental health and wellness.

(6) Growing, retaining, diversifying, and supporting the child-serving workforce, with special emphasis on the professional development around child and family mental health and wellness services.
(7) Supporting the design, implementation, and evaluation of a quality-driven children's mental health system of care across all child services that prevents mental health concerns and mitigates trauma.
(8) Improving the system to more effectively meet the emergency and residential placement needs for all children with severe mental and behavioral challenges.

(b) The Partnership shall have the responsibility of developing and updating the Children's Mental Health Plan and advising the relevant State agencies on implementation of the Plan. The Children's Mental Health Partnership shall be comprised of the following members:

(1) The Governor or his or her designee.
(2) The Attorney General or his or her designee.
(3) The Secretary of the Department of Human Services or his or her designee.
(4) The State Superintendent of Education or his or her designee.
(5) The Director of the Department of Children and Family Services or his or her designee.
(6) The Director of the Department of Healthcare and Family Services or his or her designee.
(7) The Director of the Department of Public Health or his or her designee.
(8) The Director of the Department of Juvenile Justice or his or her designee.
(9) The Executive Director of the Governor's Office of Early Childhood Development or his or her designee.
(10) The Director of the Criminal Justice Information Authority or his or her designee.
(11) One member of the General Assembly appointed by the Speaker of the House.
(12) One member of the General Assembly appointed by the President of the Senate.
(13) One member of the General Assembly appointed by the Minority Leader of the Senate.
(14) One member of the General Assembly appointed by the Minority Leader of the House.
(15) Up to 25 representatives from the public reflecting a diversity of age, gender identity, race, ethnicity, socioeconomic status, and geographic location, to

be appointed by the Governor. Those public members appointed under this paragraph must include, but are not limited to:

(A) a family member or individual with lived experience in the children's mental health system;

(B) a child advocate;

(C) a community mental health expert, practitioner, or provider;

(D) a representative of a statewide association representing a majority of hospitals in the State;

(E) an early childhood expert or practitioner;

(F) a representative from the K-12 school system;

(G) a representative from the healthcare sector;

(H) a substance use prevention expert or practitioner, or a representative of a statewide association representing community-based mental health substance use disorder treatment providers in the State;

(I) a violence prevention expert or practitioner;

(J) a representative from the juvenile justice system;

(K) a school social worker; and

(L) a representative of a statewide organization representing pediatricians.

(16) Two co-chairs appointed by the Governor, one being a representative from the public and one being a representative from the State.

The members appointed by the Governor shall be appointed for 4 years with one opportunity for reappointment, except as otherwise provided for in this subsection. Members who were appointed by the Governor and are serving on the effective date of this amendatory Act of the 102nd General Assembly shall maintain their appointment until the term of their appointment has expired. For new appointments made pursuant to this amendatory Act of the 102nd General Assembly, members shall be appointed for one-year, two-year, or four-year terms, as determined by the Governor, with no more than 9 of the Governor's new or existing appointees serving the same term. Those new appointments serving a one-year or 2-year term may be appointed to 2 additional 4-year terms. If a vacancy occurs in the Partnership members, the vacancy shall be filled in the same manner as the original appointment for the remainder of the term.

The Partnership shall be convened no later than January 31, 2023 to discuss the changes in this amendatory Act of the 102nd General Assembly.

The members of the Partnership shall serve without compensation but may be entitled to reimbursement for all necessary expenses incurred in the performance of their official duties as members of the Partnership from funds appropriated for that purpose.

The Partnership may convene and appoint special committees or study groups to operate under the direction of the Partnership. Persons appointed to such special committees or study groups shall only receive reimbursement for reasonable expenses.

(b-5) The Partnership shall include an adjunct council comprised of no more than 6 youth aged 14 to 25 and 4 representatives of 4 different community-based organizations that focus on youth mental health. Of the community-based organizations that focus on youth mental health, one of the community-based organizations shall be led by an LGBTQ-identified person, one of the communitybased organizations shall be led by a person of color, and one of the community-based organizations shall be led by a woman. Of the representatives appointed to the council from the community-based organizations from the community-based organizations, at least one representative shall be LGBTQ-identified, at least one representative shall be a person of color, and at least one representative shall be a woman. The council members shall be appointed by the Chair of the Partnership and shall reflect the racial, gender identity, sexual orientation, ability, socioeconomic, ethnic, and geographic diversity of the State, including rural, suburban, and urban appointees. The council shall make recommendations to the Partnership regarding youth mental health, including, but not limited to, identifying barriers to youth feeling supported by and empowered by the system of mental health and treatment providers, barriers perceived by youth in accessing mental health services, gaps in the mental health system, available resources in schools, including youth's perceptions and experiences with outreach personnel, agency websites, and informational materials, methods to destigmatize mental health services, and how to improve State policy concerning student mental health. The mental health system may include services for substance use disorders and addiction. The council shall meet at least 4 times annually.

(c) (Blank).

(d) The Illinois Children's Mental Health Partnership has the following powers and duties:

(1) Conducting research assessments to determine the needs and gaps of programs, services, and policies that touch children's mental health.

(2) Developing policy statements for interagency cooperation to cover all aspects of mental health delivery, including social determinants of health, prevention, early identification, and treatment.

(3) Recommending policies and provide information on effective programs for delivery of mental health services.
(4) Using funding from federal, state, or philanthropic partners, to fund pilot programs or research activities to resource innovative practices by organizational partners that will address children's mental health. However, the Partnership may not provide direct services.
(5) Submitting an annual report, on or before December 30 of each year, to the Governor and the General Assembly on the progress of the Plan, any recommendations regarding State policies, laws, or rules necessary to fulfill the purposes of the Act, and any additional recommendations regarding mental or behavioral health that the Partnership deems necessary.
(6) Employing an Executive Director and setting the compensation of the Executive Director and other such employees and technical assistance as it deems necessary to carry out its duties under this Section.
The Partnership may designate a fiscal and administrative agent that can accept funds to carry out its duties as outlined in this Section.
The Department of Healthcare and Family Services shall provide technical and administrative support for the Partnership.

(e) The Partnership may accept monetary gifts or grants from the federal government or any agency thereof, from any charitable foundation or professional association, or from any reputable source for implementation of any program necessary or desirable to carry out the powers and duties as defined under this Section.

(f) On or before January 1, 2027, the Partnership shall submit recommendations to the Governor and General Assembly that includes recommend updates to the Act to reflect the current mental health landscape in this State.
(Source: P.A. 102-0899, eff. 1-1-23; P.A. 102-1034, eff. 1-1-23.)

Illinois Children's Mental Health Partnership Members
as of December 2023

Appointed Members

State Co-Chair

Dr. Sameer Vohra, *Illinois Department of Public Health*

Governor's Office Liaison

Grace Hou, *Deputy Governor of Health and Human Services*

Gubernatorially Appointed Experts

- **Heather Alderman**, *Illinois Children's Healthcare Foundation*
- **Christina Bruhn**, *Aurora University School of Social Work*
- **Colleen Cicchetti**, *Lurie Children's Hospital Center for Childhood Resilience*
- **Betsy Clarke**, *Juvenile Justice Initiative*
- **Ray Connor,** *Mental Health America*
- **Andrea Durbin,** *Illinois Collaboration on Youth*
- **Karen Freel**, *IL Assoc. for Infant Mental Health*
- **Carol Gall**, *Sarah's Inn*
- **Gaylord Gieske,** *Illinois Childhood Trauma Coalition*
- **Cynthia Goodman**, *IL Association of School Social Workers Board*
- **Gene Griffin,** *ICMHP Past Chair*
- **Debbie Humphrey**, *Association of Community Mental Health Authorities of Illinois*
- **Alexa James,** *NAMI Chicago*
- **Ginger Meyer**, *SIU School of Medicine*
- **Quinn Rallins,** *Fmr. IL Lt. Governor's Office*
- **Carla Marquez Ripley**, *Your Story Counseling*
- **Jennie Pinkwater**, *IL Chapter of AAP*
- **Joel Rubin**, *National Association of Social Workers, IL Chapter*
- **Mary Satchwell**, *Illinois School Psychologists Association*
- **Nneka Jones Tapia,** *Chicago Beyond*
- **Marlita White**, *Chicago Department of Public Health*
- **Paula Wolff**, *Illinois Justice Project*

State Agency Representatives

Office of the Attorney General
- **Wendy Cohen**

Illinois Criminal Justice Information Authority
- **Delrice Adams** (ICJIA Executive Director)
- **Dr. Millicent McCoy**, Designee

State Board of Education
- **Jeff Aranowski**

Governor's Office of Early Childhood Development
- **Jamilah Jor'dan**

Department of Children and Family Services
- ***Verletta Saxon***

Department of Healthcare and Family Services
- **Kristine Herman**

Department of Human Services
- **Lisa Betz**

Department of Juvenile Justice
- **Jennifer Jaworski**

Department of Public Health
- **Dr. Kyran Quinlan**
- **Lisa Masinter, Designee**

Legislators

Illinois House of Representatives
- **Representative William Davis (D-30)**
- **Representative Angelica Guerrero-Cuellar (D-22)**
- **Former Representative David A. Welter (R-75)**
- **Representative Patrick Windhorst (R-118)**

Illinois Senate
- **Senator Donald DeWitte (R-33)**
- **Senator Laura Fine (D-09)**
- **Senator Dave Syverson (R-35)**
- **Senator Karina Villa (D-25)**
- **Senator Ram Villivalam (D-08)**

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Final Report for Illinois Children's Mental Health Partnership (ICMHP)

The Illinois Children's Mental Health Partnership (ICMHP) has committed itself to creating new recommendations, goals, and strategies to ensure that Illinois continues to prioritize mental health and wellness. With the recent release of Illinois Children's Mental Health Plan and the passing of HB HB212.The HB212 dictated the formation of youth voice adjunct council (section b-5) that will meet a minimum of 4 times annually. Membership consisted of no more than 6 youth aged 14 to 25 and 4 representatives from different community-based organizations focused on youth mental health (appointed by the co-chairs).

The council's key obligation has been to make recommendations to the Partnership regarding youth mental health, including but not limited:

- Identify barriers to youth feeling supported by and empowered by mental health system and treatment providers
- List barriers perceived by youth in accessing mental health services
- Outline gaps in mental health system
- Highlight available resources in schools, including youth's perceptions and experiences with outreach personnel
- Create agency websites, and informational materials
- Provide methods to destigmatize mental health services

ICMHP partnered with Mikva Challenge to support and help facilitate youth-led discussions this past fall. The youth council convened youth members, Community-Based Organization (CBO) leaders and youth council partners across the State to elevate youth voice and inform state policy with the goal of improving youth mental well-being.

List of Members

- Atra Kachaochana, *Youth Council Member*
- Arya Raj Sreedhar, *Youth Council Member*
- Aydin Tariq, *Youth Council Member*
- Michelle Morales, *Youth Council Member*
- Kaleb Evan Goodlow, *Youth Council Member*
- Alex Bogle, *Youth Council Member*
- Sharday Hamilton, *National Runaway Safeline Youth Fellow*
- Carolina Kuhl, *Bilingual Clinical Therapist, Arcus Behavioral Health & Wellness, Inc*
- James Long, *Program Manager, Public Health Institute of Metropolitan Chicago*
- Maddie Poole, *Program Manager, Mikva Challenge*
- Dr. Tara Gill, *Psychologist and Mental Health Consultant, Lurie Children's Center for Childhood Resilience (CCR)*

Council Session Overview

Mikva Challenge has two decades of civic leadership work with youth in Chicago, DC and beyond. Our work has shown that excluding young people from conversations about how to address the challenges in their communities results in a significant deficit in decision-making that overlooks some of the best experts who can personally attest to conditions on the ground. When institutions/systems invest in young people, they not only grow profoundly as individuals, but they become leaders with the tools, opportunities, and framework to have their voices heard. Furthermore, Mikva knows that systems and policies are more equitable when the people they affect are directly involved in their making.

In order to advance Illinois Children's Mental Health Partnership (ICMHP) work, Mikva worked directly with both youth and adult council members over the course of the last two months. Council members were guided in Mikva Challenge's six-step Action Civics problem-solving process: they identified problems, explored research, analyzed data, considered power structures and relevant stakeholders, and began to formulate concrete public policy recommendations in order to present them to key decision-makers at the state-level. Throughout these sessions, youth members learned invaluable problem-solving skills, including how to identify issues that are affecting them and how to develop remedies.

Session Date	Session Focus	Session Agendas + Relevant Content / Tools
October 10, 2023 4:30 – 6:30 p.m.	• Built Community by learning more about one another's identity, mental health interests, and created collective community beliefs.	Agenda + Slides + Identity Slides
October 24, 2023 4:30 – 6:30 p.m.	• Took mental space for current events, learned about and formed recommendations based on the root cause analysis method.	Agenda + Slides
November 7, 2023 4:30 – 6:30 p.m.	• Collaborated with CBO and conducted online research to further refine and make our recommendations more specific.	Agenda + Slides
November 14, 2023 4:30 – 6:30 p.m.	• Edit and review recommendations, apply feedback and learnings from issue experts, and prepare for presentation to decision-maker.	Agenda +Slides
December 5, 2023 2:00 – 4:00 p.m.	• Present policy recommendations to Senator Michael Sims at ICMHP quarterly meeting.	Slides

The following recommendations offer solutions to barriers that our state faces in supporting children and young people's mental health. Their aim is to increase the impact and reach of comprehensive and coordinated mental health services, programs, and support for children and their families across the state.

Policy Recommendations

Recommendation 1: Illinois Mental Health Access and Provider Support Initiative

To enhance mental health affordability, reduce wait times, and support mental health providers in Illinois by expanding funding for non-profit agencies, increasing health insurance coverage, facilitating education pathways, and providing additional support for mental health providers.

- **Funding For Non-Profit Agencies (Affordability) –** Allocate additional state funding to increase the financial resources available to non-profit mental health agencies. This increased funding will allow these agencies to expand their services and subsidize mental health care costs for individuals who cannot afford it through a sliding fee scale.
- **Health Insurance –** Advocate for the expansion of health insurance coverage to include a broader range of mental health services across various agencies. Support this initiative by presenting evidence of the effectiveness of comprehensive mental health coverage in improving overall health outcomes and reducing societal costs.
- **Education Requirements and Scholarship Opportunities –** Reduce education requirements for certain mental health positions to facilitate faster entry into the field. Create more career opportunities for bachelor's level clinicians working under licensed professionals. Establish structured mentorship and supervision programs that pair bachelor's level clinicians with experienced licensed professionals. Outline specific responsibilities and tasks that bachelor's level clinicians can undertake under the guidance and supervision of licensed professionals.
- **Scholarships –** Establish specialized scholarship programs specifically targeting individuals from underrepresented communities (e.g., racial/ethnic minorities, LGBTQ+ individuals, individuals with disabilities) pursuing mental health education. These scholarships will cover tuition, fees, and living expenses from undergraduate to graduate studies. Collaborate with undergraduate educational institutions across Illinois to identify and recruit students from underrepresented backgrounds interested in mental health fields. Encourage and support their transition to graduate-level mental health programs.

- **Supporting Mental Health Providers –** Allocate resources to provide mental health services specifically tailored for mental health providers. This includes access to counseling, therapy, and mental health check-ups to address stress, burnout, and emotional challenges faced in their profession. Create structured support groups for mental health providers, providing a platform for them to share experiences, seek advice, and receive emotional support from peers facing similar challenges. These groups can be both in-person and virtual to accommodate different preferences and schedules. Implement wellness days dedicated to mental health providers, allowing them a day off for self-care, relaxation, and rejuvenation. Conduct regular workshops focused on stress management, mindfulness, and resilience-building techniques.

Recommendation 2: LGBTQ+ Youth Mental Health

Illinois State Leaders should work in conjunction with LGBTQ+-focused organizations, Illinois school districts, young people, and other state agencies to address the root causes of the LGBTQ+ mental health crisis and dispel misinformation.

- **Task Force** – Develop a task force between ISBE and trauma-informed organizations with an effort to modernize and adapt our school curriculum to include Stonewall, Harvey Milk, AIDS-HIV, and proper Health and Sex Ed.
- **Statewide social media campaign** – To be designed by young people (13-25) to affirm all young people, regardless of sexuality, gender, ethnicity, race, religion, etc., with a focus on mental health.
- **Training –** Work in conjunction with school districts to fund a mandatory trauma-informed care class for school counselors that encompass LGBTQ+ affirming environments and dispelling misinformation. Scholarships and grants to encourage LGBTQ+ counselors.
- **Data Collection –** Collect data on LGBTQ+ youth mental health outcomes and experiences to identify disparities and inform evidence-based interventions and policies.
- **Represent State Government** – Assigning a “Youth Liaison” designated to lead discussions surrounding serving youth in our communities and leading programs to prevent youth from being left out of youth conversations. This position benefits all young people and allows a youth-led LGBTQ+ movement.

Recommendation 3: Culturally Responsive Mental Health Care

Mental Health initiatives, specifically in the Middle Eastern and other non-white communities, have often focused on older children and adolescents, however, intergenerational trauma and other factors parents experience can play a large role in a child’s mental health. The state should also prioritize helping the parents understand what struggling with mental health is and how it can be helped. When the focus is redirected on the parents' understanding, then the parents can aid their children during their struggles and hardships.

- **House of Worship Mental Health Discussions** – Allocate state funds to support houses of worship that are willing to open safe spaces, staffed with certified mental health professionals who understand the cultural and linguistic needs of the community, for individuals seeking mental health support
- **Community Healing and Resilience Centers** – Recognize the importance of youth educating their parents about mental health. Encouraging open discussions and breaking cultural taboos surrounding mental health issues can lead to greater acceptance and support within families.
- **School-Based Trauma-Informed Practices and State Funded Curriculum** – Support educational programs within schools that focus on mental health awareness, resilience-building, and the normalization of seeking help. Empowering Middle Eastern youth and other marginalized populations to understand and address mental health concerns can facilitate open conversations within their families and communities. Provide state funding for schools that integrate the struggles and experiences of Middle Eastern communities, including smaller groups like Assyrians, into their curriculums. This educational initiative aims to address mental health struggles among Middle Eastern youth and reduce stigma.
- **Support and Funding for Lesser-Recognized Middle Eastern Communities** – Allocate resources for research initiatives focusing on the needs, challenges, and strengths of lesser-recognized populations in Illinois to inform policy solutions and resource allocation. Allocate funding and resources specifically aimed at shedding light on and supporting lesser-recognized Middle Eastern communities, like the Assyrians, to bring awareness to their cultural identity and unique needs.

Recommendation 4: Culturally Responsive Mental Health in Schools

To prioritize mental health awareness, social and emotional learning (SEL), inclusivity, and access to resources within Illinois schools to support the holistic well-being of students and address root causes of challenges like substance abuse and social pressures.

- **Culturally Responsive SEL Curriculum and Courses** – Mandate the incorporation of a Culturally Responsive SEL curriculum from grades K through 12 as part of the mandated health curriculum. This program will address social problems, bullying, substance abuse, and stress while fostering emotional intelligence, self-awareness, and social skills among students.
  - Ensure the SEL curriculum is taught by qualified professionals, including counselors, mental health educators, and specialists trained in cultural competence. Provide professional development opportunities to educators for effective delivery of the curriculum.
  - Integrate DEI education into the SEL curriculum, addressing biases, stereotypes, and promoting inclusivity. Focus on minimizing biases, fostering empathy, and understanding diverse perspectives through interactive lessons and discussions.
  - Collaborate with community organizations, cultural groups, and experts to support the development and implementation of the Culturally Responsive SEL curriculum. Encourage involvement and input from diverse communities to ensure relevance and inclusivity. Increase visibility and representation of diverse role models, adults, and community members from various backgrounds within the SEL curriculum.
- **Illinois Youth Mental Health Day** – Mandate the designation of a specific day within the academic year as "Mental Health Awareness Day" in all Illinois schools aimed at fostering education, outreach, support, and encouraging career and educational pathways within the mental health field. Allocate this day for targeted mental health education and activities across grade levels.
- **School Staff Training** – Implement mandatory training programs for teachers focusing on recognizing symptoms of anxiety, depression, panic attacks, and stress in students. Provide guidance on handling acute mental health circumstances in the classroom setting. Provide teachers with crisis management plans, offering protocols for receiving external help. Include DEI training in mental health education for teachers. Emphasize cultural sensitivities and diverse experiences when handling student mental health crises, ensuring inclusivity and understanding of various cultural perspectives.
- **Restorative Substance Abuse Policies** – Develop and implement substance abuse programs that prioritize mental health and healing for youth. Focus on understanding underlying mental health issues, trauma, and stressors that contribute to substance abuse. Establish an Amnesty Policy for first-time substance abuse offenses among students. Replace disciplinary punishments with warning and follow-up support, such as mandated meetings with counselors and opportunities for rehab or counseling. Shift focus from punitive measures to restorative action in handling substance abuse incidents. Conduct thorough assessments to understand the root causes behind the student's behavior and address underlying issues.
- **Regular Mental Health Screeners** – Equip schools with tools to conduct regular assessments to identify stressors affecting students' mental health. Recognize academic pressure, family issues, homelessness, financial stress, and other environmental factors that contribute to mental health challenges and adjust school resources and policies accordingly. Just like youth get vision and hearing tested in school, they should be able to opt into mental Health Screeners.
- **Access to Mental Health Resources and Culturally Responsive Care** – The State should provide scholarships, incentives, and mentorship for counselors from underrepresented backgrounds to go into the profession. Students should have the opportunity to connect with a counselor that shares a similar identity, and if this is not possible, connect students to outside resources with things such as telehealth. Equip schools to implement mental health support groups of affinity spaces for students to gather peer support with similar identities.

Reflection and Lesson Learned

It is important to begin the reflection by recognizing that the young people engaged in this work have already been transformed as part of this policy-making experience. Youth council participants were able to exercise and refine a range of skills, including research and critical analysis, public speaking and formal writing, leadership and team-building, and

social emotional skills like self-awareness and communication. This experience has positioned the participants to become leaders in their communities who understand their power and are committed to effect meaningful change.

It is commendable that the genesis of this council was due to a state legislator's recognition of the power of youth participation in policy and decision-making. One of the most difficult barriers when it comes to engaging and empowering young people in the decisions that shape their lives is getting institutions/organizations to create formal mechanisms for youth voice and youth leadership. Many times, although youth issues may be the main concern in the community or within the organization, adults are most often at the forefront of the decision-making process, with little discussion or input from youth. Having HB212 dictated the formation of a youth voice adjunct council with specific requirements around meeting cadence and council member representation was powerful and a crucial component in the success of launching this council.

The conversation around child and youth mental health can be deeply personal for young people. As the council moves forward with this work, time for members of the council to continue to build community and trust is essential and should remain a top priority. Continue to encourage a positive and safe space in which youth are able to talk honestly to each other and to/about each other's community. Be consistent in adhering to the council's established group norms and encourage continued discussions about how the council members will hold each other accountable to those norms.

Equitable inclusion was at the top of mind in Mikva's/ICMHP's planning for the implementation of this council. First of all, it is important to continue to provide council participants with a stipend for their commitment to this work. This practice is in line with giving value to the voice and lived experience of the youth council members. The only modification to the stipend agreements for young people would be to extend the commitment to include more than just the HB212 required convening. Policy and advocacy work is long and slow, and therefore a year-round commitment, that includes attending external meetings and participating in community engagement activities is a more accurate ask for this type of work. Another inclusive practice to highlight was having the council meetings virtually. This allowed for the inclusion of young people from across the whole state. However, when creating virtual options, it is essential that every youth has the same access to the relevant content equipment according to their specific needs and reliable internet. Also moving forward, the modality and meeting times should continue to factor in the youth council members home and academic responsibilities and schedules. It will be important for ICMHP to continue to support ways to ensure this youth leadership opportunity is available to all youth.

Having a seasoned youth worker on the council and facilitating sessions ensured all agenda content and activities were focused and led to the creation of draft policy recommendations. Council members were guided in Mikva Challenge's six-step Action Civics problem-solving process: they identified problems, explored research, analyzed data, considered power structures and relevant stakeholders, and began to formulate concrete public policy recommendations in order to present them to key state's decision-makers. Mikva Challenge's curriculum provided a framework for how to engage youth in policy that emphasizes inquiry, interdisciplinary content, and taking informed action. And while the final council meeting did result in the creation of draft recommendations, time constraints did not allow the group to fully dive into some of the recommended action steps required for impactful youth policy and advocacy. The following highlights best practices that should be considered as critical next steps for this council. Firstly, the youth council members did not have time to gather input from other youth via surveys or focus groups to help narrow their issues areas and recommendations. Accessing broader input for young people across the state is necessary to ensure there is consensus around what is needed to support children/youth mental health. An additional next step in order to refine the final recommendations is to analyze whether there are existing policies and initiatives that align with the draft recommendations. Sometimes policy and law already exists, and the issue becomes whether there are enough resources and support allocated to help state agencies and CBOs to implement said policy. Moreover, the council did not have time to invite issues experts to learn more about any specific given topic. Convening a panel of issues experts to review the draft policy recommendations allows for the inclusion of cited books, articles, and documents as evidence to support each policy recommended by the council.

The final reflection and lesson learned through this work is around supporting sustainable models of youth voice. Many adults reach out to youth that they think will act and perform like adults. As a result, it may be easier to engage youth whom have already been identified as leaders. Current council members may be tapped to also participate in other teen health initiatives, committees or taskforces. And since there is already an overlap with those key leaders, organizations and institutions engaged in statewide health priorities, consideration for how to find a balance in when and how youth are incorporated into all of these workstreams is key. Perhaps a broader conversation with state elected officials and key leaders in this field is a needed next step to ensure there is a state-wide comprehensive and coordinated structures to support youth voice and youth participation in decision-making. For example, one current initiative that should be

considered in how to move forward with this council is the J.B. Pritzker's Behavioral Health Transformation Initiative which was created to develop an intentional, coordinated strategy to ensure that families get the help they need. Including Dr. Dana Weiner, a Chapin Hall Senior Policy Fellow and the chair leading this effort to develop a blueprint for behavioral health services for Illinois youth in a conversation on how the ICMHP council's work can remain top of mind for the state, may be helpful. The Resilience Education to Advance Community Healing (REACH) Statewide Initiative and the Healing-Centered Illinois Task Force are other areas of focus for the state that should be taken into consideration for this council as well. The Healing-Center IL Task Force, like this council, was a product of a state legislation (Senate Bill 646) that hopes to move Illinois into a trauma-informed direction. The task force would align definitions and goals laid out in the Whole Child Task Force, Children's Mental Health Plan, and the recent Children's Mental Health Transformation Initiative.

M E M O R A N D U M

TO: The Honorable JB Pritzker, Governor
The Honorable Tony McCombie, House Minority Leader
The Honorable Don Harmon, Senate President
The Honorable John Curran, Senate Minority Leader
The Honorable Emanuel "Chris" Welch, Speaker of the House

FROM: Dr. Tony Sanders
State Superintendent of Education

DATE: December 15, 2023

SUBJECT: Public Act 103-0546

The Illinois State Board of Education respectfully submits this report entitled "Lessons Learned: A Landscape Scan of Mental Health Screening Practices in Illinois Schools" to the Governor and General Assembly pursuant to Public Act 103-0546.

This report is transmitted on behalf of the State Superintendent of Education. For more specific information, please contact the Executive Director of Legislative Affairs Dana Stoerger at 217-782-4338 or Dstoerge@isbe.net.

cc: Secretary of the Senate
Clerk of the House
Legislative Research Unit
State Government Report Center

Lessons Learned:

A Landscape Scan of Mental Health Screening Practices in Illinois Schools

December 15, 2023

isbe.net

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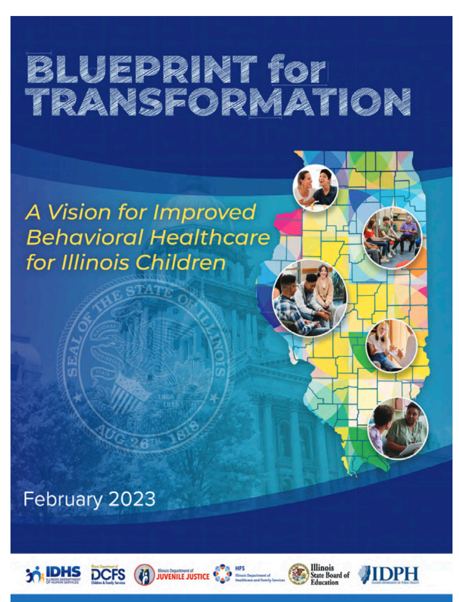
Executive Summary

In a 2019 report, the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) highlighted the impact that early detection of emotional and behavioral health concerns can have on quality of life for children and adults. "Students are routinely screened for physical health issues (e.g., vision, hearing). However, emotional or behavioral health issues are generally detected after they have already emerged. It is time for that to change" (SAMHSA, 2019). It is in the spirit of that charge for change that the Illinois State Board of Education (ISBE) shares this report and our recommendations for universal mental health screening of students in schools.

Illinois emerged from the COVID-19 pandemic with a greater understanding of the barriers students and families have long experienced with respect to accessing high-quality mental health services in our state. Many school districts have responded to these more visible barriers by investing in wellness and resilience initiatives, including screening their students for emotional, behavioral, and mental health concerns. This report will provide details on the more than 70% of school districts that reported they are already doing some form of screening activity and will provide recommendations on how to close the gap so that in the future, all students are offered screening regularly. This report is a step along an essential journey Illinois must take toward better quality of life and improved academic outcomes for students.

The work described herein follows in the footsteps of important groundwork laid in the last few years by mental health experts across the state. One major piece of groundwork is the Blueprint for Children's Behavioral Health Transformation report, which was released by the Children's Behavioral Health Transformation team of the Office of the Illinois Governor in February 2023. It includes 12 recommendations to improve access to behavioral health services for children in Illinois. Recommendation No. 9 on page 35 states that universal mental health screening of students in education and pediatrics should be offered to identify students' needs earlier. Public Act 103-0546, which was filed by Senator Sara Feigenholtz, became law on August 11, 2023, and included a requirement that ISBE conduct a landscape scan of all school districts in Illinois and release a report that includes recommendations for implementation of mental health screenings in schools for students enrolled in kindergarten through Grade 12.



This report is a description of ISBE's landscape scan activities and includes detailed discussion on four ensuing recommendations:

1. Illinois should undertake a phased approach to universal mental health screening of all K-12 students enrolled in public school districts. Universal mental health screening of all K-12 students means mental health screening of every student in every grade enrolled in a school district each year.

2. ISBE, in consultation with relevant stakeholders, should compile and organize resources to support school districts in improving the mental health culture and climate in schools and reducing the stigma related to screening, referral, and participation in mental health services.

3. ISBE, in consultation with relevant stakeholders, should release guidance about (1) mental health screening tools available for school districts to use with students and (2) associated training for school personnel.

4. ISBE should oversee a process of model policy development with relevant stakeholders that supports school districts in implementing universal mental health screening of students.

This report was prepared by ISBE in consultation with Chapin Hall (an independent policy research center at the University of Chicago) and the Illinois Department of Public Health. ISBE is extremely grateful to Dr. Dana Weiner, the Children's Behavioral Health Transformation Initiative team, and Chapin Hall for the months of collaboration that resulted in this landscape scan and recommendations report.

Introduction

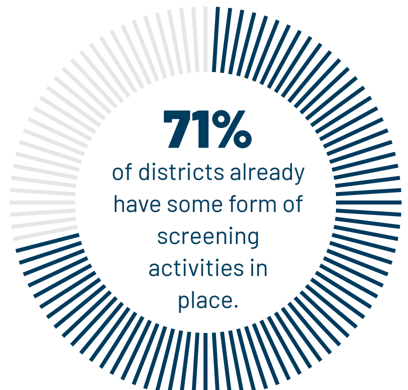
In Illinois, we understand that our students' academic success is deeply intertwined with their social and emotional well-being. Brain science tells us that students need to feel safe, valued, and have a sense of belonging at school to learn (McGaugh, McIntyre, & Power, 2002). Detecting problems early is fundamental to nurturing success in school that leads to resilient and thriving communities. One method of early detection is universal mental health screening of students in schools. This report will explore current screening practices to inform initial recommendations regarding such screening in Illinois public schools.

U.S. Surgeon General Vivek Murthy declared a youth mental health crisis in 2021. That same year, the Centers for Disease Control and Prevention reported 44% of high school students responding to a survey said they persistently felt sad or hopeless during the last 12 months (Jones, S., Ethier, K., Hertz, M., DeGue, S., Le, V., Thornton, J., Lim, C., Dittus, P., & Geda, S., 2022). A more recent survey of over 5,000 students in Grades 4-12 in Illinois indicated that students self-identified emotional regulation as an area of need (Daruwala, Pan, Shramko, Salinas, Ramesh, & Jiang, 2023). Data tell us that we need to do more to provide students with support and intervention for their mental health and social-emotional well-being.

In the midst of all that we know about the youth mental health crisis, ISBE is working every day to ensure that districts and schools have what they need to create safe school environments and promote students' mental health, including our work to implement recommendation No. 9 on page 35 of the Blueprint for Children's Behavioral Health Transformation report released in February 2023 by the Children's Behavioral Health Transformation team of the Office of the Illinois Governor. This report will focus on that work and its connection to overcoming some of our state's current mental health challenges and promoting resilience for all students.

Under the intervene earlier set of strategies in the Blueprint report, it was recommended that universal mental health screening of students in education and pediatrics be offered to identify students' needs earlier. To begin implementing this recommendation, ISBE conducted a landscape scan of all school districts and their current mental health screening practices during the summer and early fall of 2023 pursuant to Section 2-3.196 of Public Act 103-0546 (Please see Appendix 1.) Findings from this landscape scan generally show that our state is well on its way to phasing in universal mental health screening already, as we found that over a quarter of school districts already conduct universal mental health or social-emotional learning (SEL) screening for their students, and

71% of the districts have some form of wellness screening activities. However, these screening activities vary significantly by district size and geography – large districts are more likely to implement universal screening, with half of districts currently implementing universal screening located in the Chicago metropolitan area.



The following sections will explain the methods used during the landscape scan, expand on the findings of the scan, and describe ISBE's subsequent recommendations for the path forward.

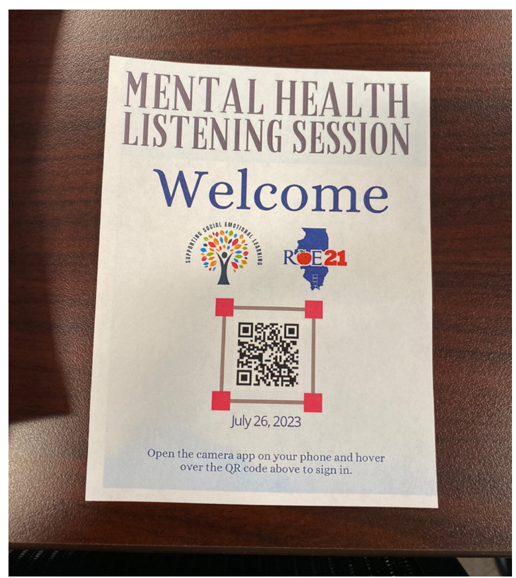
Landscape Scan Methodology

ISBE consulted with stakeholders during the spring, summer, and fall of 2023 and worked closely with the Children's Behavioral Health Transformation team, Chapin Hall, and the Illinois Department of Public Health (IDPH) to conduct a landscape scan of the current practices school districts and school entities employ regarding mental and behavioral health screening of students. Additionally, this effort gathered data exploring the field's perceptions about the benefits and challenges of universal screening. ISBE appreciates our collaboration with IDPH, as it offers a public health perspective regarding the screening process. The Children's Behavioral Health Transformation team and Chapin Hall have provided immense amounts of support for the entire body of work behind the landscape scan and ensuing recommendations, including administrative coordination, project management, data analysis, and assistance writing this report.

ISBE ensured that all voices were heard throughout the landscape scan process, with the primary participants being teachers, principals, superintendents, and school mental health providers (such as social workers, counselors, psychologists, and other staff). Illinois has 852 school districts and 3,840 schools, serving 1.9 million students. There are 134,896 full-time teachers and 13,214 school administrators (Illinois State Board of Education, 2023). The landscape scan included two elements: a feedback form distributed electronically to all school districts and in-person and virtual listening sessions. ISBE created a Mental and Behavioral Health Screening webpage and a dedicated email address to assist in communicating about the various components of this scan and to ensure that we could receive feedback from a broad array of stakeholders.

The feedback form data collection was managed internally at ISBE; participation by entity was optional. The form was released to 903 entities (all public school districts, Regional Offices of Education [ROEs], Intermediate Service Centers [ISCs], and state-authorized charter schools) on June 8, 2023, and closed on September 8, 2023. A copy of the form's questions is available in Appendix 2. It was electronically available on the ISBE Web Application Security (IWAS) system, which pushed it out to each district superintendent, who could then complete answers or assign someone else in their district to answer the questions. ISBE communicated about the opportunity to fill out this feedback form regularly via social media channels, the state superintendent's column in the ISBE Weekly Message, and via targeted emails to ROE/ISC superintendents and district superintendents. ISBE sent weekly reminders to all entities that had not yet completed the form using an IWAS Broadcast message. A total of 649 entities responded for the form, including 618 school districts, 23 ROEs, and eight charter entities representing 98 of the 102 counties in Illinois. Sample validation information is listed in Appendix 3. The state's two largest districts – Chicago Public Schools and Elgin U-46 – did not respond to the form; however, Chapin Hall interviewed these entities individually to ensure their voices were included in this report.

649 entities provided data about their screening practices



Flyer advertising the Landscape Scan Listening Session in Marion, IL hosted by SEL Hub 6.

The questions used on the feedback form were developed by the project team after consultation with the Illinois Association of Regional Superintendents of Schools (IARSS). ISBE presented this project to IARSS members at an in-person roundtable discussion on May 10, 2023, in Springfield to gather input and feedback before beginning the landscape scan data collection activities. IARSS members listened to ISBE staff explain plans for the landscape scan and offered feedback and advice about how to reach the most school personnel in their areas and what questions on the form would garner the most meaningful feedback. The results of the feedback form were shared with Chapin Hall once the form closed for data analysis. The data analysis of the feedback form data began by gathering additional district characteristics from the ISBE 2022-2023 Report Card that were then linked to the landscape scan data to supplement the information. A statistical analysis was conducted using Stata version 17. For categorical or ordinal characteristics (e.g., district size), the Chi-Square test of independence was used. For numeric characteristics (e.g., percent low-income), Analysis of Variance, or F-Test, was used to determine statistically significant differences. These tests are appropriate for determining whether there is a statistically significant association across categories.

The second element of the landscape scan was the listening sessions, which were managed through a research project overseen by Chapin Hall. These listening sessions were considered to involve human subject research with vulnerable populations, so we sought approval from an Institutional Review Board (IRB) under Principal Investigator Dr. Dana Weiner. The University of Chicago's IRB approved our research protocol, IRB23-1037, deeming it as involving minimal risk to participants. In accordance with IRB recommendations for how to best protect the privacy of participants, the listening sessions were not recorded, and we did not collect identifying information. We took detailed notes and de-identified them before analysis.

Chapin Hall, with support from ISBE, invited school personnel, parents/guardians/caregivers, community members, and students to the 13 listening sessions. The seven Social-Emotional Learning Hubs in Illinois, which are housed within Chicago Public Schools and six Regional Offices of Education, helped us to host many of the sessions around the state. The SEL Hubs provide professional development, training, and support to districts in their region to establish and expand SEL programs in Illinois schools. They were an excellent partner in ISBE's efforts to learn more about mental and behavioral health screening, which is closely tied to social-emotional learning.

557 people participated in listening sessions

Figure 1 includes a table indicating the date, host, format, target audience, and attendance of each listening session. Our scan reached 557 individuals via listening sessions. Appendix 4 includes a copy of the questions and prompts used to frame the discussion at the listening sessions, as well as a copy of the information provided at each session about the purpose of the activity and the need for participants to consent to participate. A slide deck was used at each session to cover this information, and copies of all slide decks and session flyers are available for review on the ISBE Mental and Behavioral Health Screening webpage.

Chapin Hall and ISBE were especially honored to hear from 30 students serving on two state agency advisory boards as part of this landscape scan. Some of these students serve on the Illinois Department of Children and Family Services (DCFS) Youth Advisory Board. This board has a mission to educate, advocate for, and empower all youth in care. Meetings are open to all youth in care and provide a forum for young people in care to address concerns, receive free and valuable resources, hear about changes within the department, and gain access to opportunities to learn more about policies and procedures that are relevant to them. The other students who participated in our second youth listening session make up the ISBE Student Advisory Council, which is a statewide group of high school students that meets periodically over a 10-month period throughout the school year to provide ISBE with student perspectives related to educational concerns across the state. The members are selected after participating in an application and interview process. The importance of the voice of those most closely impacted by the topic of this project – our students – was essential for us to hear and will continue to be a critical component of this work as recommendations are moved forward.

Figure 1. Listening session attendance by location

2023 Date	Host	Format	Target audience	Attendance
7/18	Area 2 SEL Hub (Northwest Illinois)	Virtual	School personnel	39
7/25	Area 5 SEL Hub (Metro East)	In-person in Collinsville	School personnel	145
7/26	Area 6 SEL Hub (Southern Illinois)	Hybrid in Marion	School personnel	40
7/27	Area 4 SEL Hub (Central Illinois)	In-person in Champaign	School personnel	15
7/31	Area 3 SEL Hub (West Central Illinois)	Virtual	School personnel	75
7/31	Area 1 SEL Hub (Chicago Metro)	Virtual	School personnel	46
8/2	Chicago Public Schools SEL Hub	In-person in Chicago	School personnel	10
8/4	Area 1 SEL Hub (Chicago Metro)	Virtual	School personnel	45
8/8	ISBE	Virtual	Parents/caregivers/ community members	41
9/8	DCFS Youth Advisory Board	In-person in Peoria	Students	12
9/20	ISBE (with Spanish interpretation)	Virtual	Parents/caregivers/ community members	41
9/26	Chicago Public Schools SEL Hub	Hybrid in Chicago	School personnel	30
10/10	ISBE Student Advisory Council	Virtual	Students	18
			Total	**557**

July 25, 2023 Landscape Scan Listening Session in Collinsville, IL hosted by SEL Hub 5

Chapin Hall coded the de-identified notes from the listening sessions using an inductive coding process. Eight major coding categories were determined by the feedback presented in the data, and four major themes were identified based on those categories. The qualitative results that follow in this report are based on these themes.

In summary, ISBE greatly appreciates the partnership that occurred with the Children's Behavioral Health Transformation team and Chapin Hall to administer both components of this landscape scan. Hearing the voices of so many across our state gives us confidence that the results and recommendations presented in further sections of this report represent a true picture of the state of mental health screenings in Illinois schools and the crucial elements of policy and practice to consider as this work moves forward.

Landscape Scan Results

The following sections will provide an analysis of both the qualitative and quantitative data collected as part of this project. We have organized the findings into four broad categories:

The value of mental health screening of students in schools

The importance of the culture and climate surrounding mental health in schools

Current mental health screening practices in Illinois schools

The need for policy and procedural resources related to mental health screening

The value of mental health screening of students in schools

One of the most prominent messages that participants expressed to us in the listening sessions was that students and schools have a lot of unmet needs related to mental health support and services that require attention. One student said that, ever since COVID-19, mental health issues have been at an all-time high, confiding that one of their peers had recently died by suicide, which had a traumatizing impact on the entire school body. One school administrator reported that one in five students in their school had suicidal ideation in the past six months to a year. School personnel further report many of their students are experiencing difficulties with self-regulation in the classroom and exhibiting aggressive behavior toward teachers and students alike, creating challenging learning environments.

The students we heard from in the listening sessions passionately expressed their desire for their peers and themselves to get the mental health care they needed. One student noted that everyone is going through something, and being able to talk about one's feelings helps enormously to alleviate the loneliness and fear that so often accompanies mental health challenges. This care and concern was echoed across adult listening sessions, where at times emotions ran high as school personnel talked about the individual cases of struggling students that they will never forget and wished they had known about sooner.

School personnel reported that they do their best to identify which students need mental or behavioral health support so that they can cultivate the most safe, productive learning environments possible. They said that, while some students' mental health needs are apparent without the use of a screening tool, screening is especially helpful in identifying students whose mental health needs might not be obvious from their behavior. A mental health coordinator reflected that students with externalizing behavior make themselves known, but the benefit of screening is that it helps identify students with internalizing symptoms. Several students lamented that, in general, students with good grades were less likely to get mental health support even though many of them were experiencing high levels of stress, anxiety, and other symptoms. They said that their schools use academic performance as an indicator of mental health need, but that metric excludes a large portion of high-achieving students who need mental health support.

Additionally, schools reported that universal screening allows for proactive intervention in mental health concerns. School personnel said that screening helps identify which students may benefit from increased supports and what interventions are needed at the student body level. The results of mental health screening tools also help schools assess need, evaluate practices, and advocate for more support. One school social worker noted the importance of data from screeners, saying that the administration needs to be able to use data from screeners to determine future plans for support and resources. We heard from many entities who are already employing the practice of universal screening that the aggregate data provided by results was extremely helpful to them in obtaining additional resources, strategic planning and school improvement efforts, in addition to those efforts aimed at individual or small groups of students.

Findings about the value of screenings are echoed in the literature. Studies have indicated that traditional approaches to mental health screening in schools often operate reactively, addressing issues after they've escalated. By focusing primarily on individual students, they might miss the broader picture or fail to catch problems early enough for effective intervention (Dvorsky, Girio-Herrera, & Owens, 2013). Universal mental health

screening in schools, on the other hand, can be a valuable tool for identifying students who may need additional support and is a fundamental aspect of a multi-tiered approach to mental health in schools, where interventions are tailored based on the students' needs (Siceloff, Bradley, & Flory, 2017). Despite the advantages of universal mental health screening, studies also point to number of challenges, including access (Dowdy, Ritchey, & Kamphaus, 2010); capacity (Glover & Albers, 2007); budget (Splett, Fowler, Weist, McDaniel, & Dvorsky, 2013); personnel (Siceloff et al., 2017); tools (Humphrey & Wigelsworth, 2016); and stigma (Castro-Ramirez et al., 2021; Mulfinger et al., 2019).

The discussion of the value of mental health screenings in our listening sessions did not occur in isolation from mention of current challenges facing schools, especially related to capacity. The current workforce shortage compounded with the student mental health crisis has created a perfect storm that has led to insufficient resources and high workloads for teachers and school staff, many of whom expressed exhaustion and said it is a challenge to manage their own mental health. Some districts say that incorporating mental health screening in schools would go so far beyond their capacity that it would not be possible for them in their current state – suggesting that implementing universal screening right now might be problematic. Many schools report struggling to support their students in even getting their basic needs met. One administrator told us that her district has some students who can't even get to school because there aren't any buses.

These themes regarding a lack of resources are supported by other recent Illinois reports. School support staff refers to staff who have a Professional Educator License with a particular endorsement from ISBE in school social work, school counseling, school psychology, school nursing, or school speech-language pathology. In the fall of 2022, IARSS reported that for the 2022-23 school year, 42% of school support staff positions posted went un/underfilled. "Among support staff positions, School Social Worker had the most un/underfilled positions and School Psychologist had the highest percent un/underfilled" (IARSS, 2022). This data does not reflect those who may be working in schools to support student mental health through another state license (such as one from the Illinois Department of Financial and Professional Regulation) or through community mental health partnerships with schools, but it still indicates quite a shortage.

A recurring theme in the listening sessions was that capacity support needs to go hand-in-hand with any policy to offer universal screening. Otherwise, participants emphasized, the mental health of teachers and school staff will suffer as a result. Overall, our listening session findings combined with the national landscape of a youth mental health crisis point to the need for growing interventions that detect problems earlier, such as mental health screenings; however, we learned that any growth in screening activity should be implemented in alignment with resources to respond to identified needs.

The importance of the culture and climate surrounding mental health in schools

We learned via our listening sessions that the culture and climate regarding mental health significantly impacts Illinois schools' ability to successfully implement and sustain screening practices in order to meet the needs of youth, and there are strategies in place that can work to reduce fear, shame, hesitancy, and stigma.

A resounding message that we heard in the listening sessions was that mental health issues impact nearly every student — if not directly, then indirectly. However, frank and candid conversations about mental health in school and community settings can be limited by a culture of fear and shame surrounding mental health. Students expressed dismay at the compounding cycle of silence that discourages them and many of the adults in their lives from discussing mental health concerns. In fact, students shared that many of their peers do not have a robust vocabulary for talking about how they are feeling due to the lack of education about mental health in general.

We heard from participants in the listening sessions that schools are working to create a culture and climate where students can feel safe expressing their true feelings and struggles, and mental health screening is a strategy that many schools use to promote more open conversations about mental health. Mental health screening in schools could help break this cycle by engendering conversation and teaching students how to express their mental health needs in a safe environment. Students and school personnel alike noted that integrating universal mental health screening might help reduce stigma by normalizing conversations about mental health and aligning it with other routine screenings, such as vision or hearing. This balance between the current culture of mental health stigma and shame possibly hindering the screening process, along with the simultaneous possibility of addressing culture and climate through doing more screening, was very interesting to hear.

The listening session participants also told us about several creative strategies for addressing fear and shame surrounding mental health conversation. Students told us about several ways that their peers offered environments of solidarity that significantly reduced the fear and hesitance that students felt in expressing their mental health concerns. For example, one student described a weekly peer-led mental health curriculum that cultivated an attitude of "we're in this together" and allowed for seniors to set good examples of resilience for the freshmen. Another student referenced a peer-led listening circle for students to share their experiences with mental health challenges. She said that this approach works well because students can empathize with their peers who are going through similar experiences.

Students also told us about ways that teachers and school administrators developed programing that would account for students' dual desire to express their feelings and seek help while maintaining privacy. For example, one student spoke about a teacher who taught acceptance about mental health

July 27, 2023 Landscape Scan Listening Session in Champaign, IL hosted by SEL Hub 4.

issues. This teacher offered her students private opportunities to reflect on their own mental health states and seek help in a confidential way. Another student reflected on the benefit of a free period in their school day when students could go into their social worker's office at a time of day when there were fewer students in the hallway. The success of such practices demonstrates the need for screening procedures that respect students' needs for privacy and discretion.

Despite these challenges, it is clear from this scan that teachers, school social workers, and other school staff are working relentlessly to meet the mental health needs of their students with what resources they do have. Some schools have developed creative arrangements for offering educational programming or mental health services, including resource-sharing between schools, peer support programs, and partnering with community-based mental health organizations.

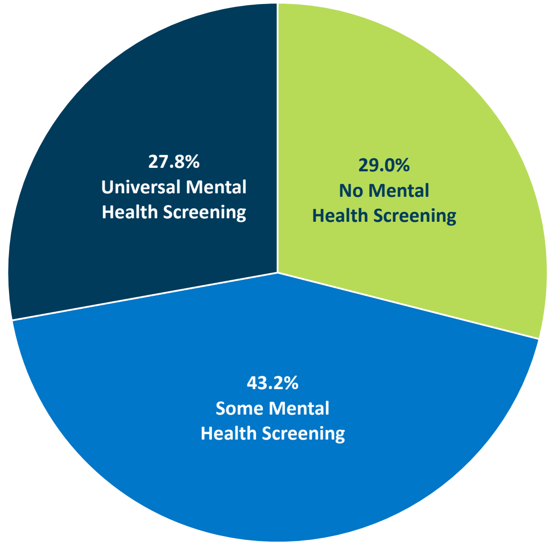
We heard that many districts are utilizing existing pandemic relief dollars and ISBE Learning Renewal programs to support mental health and wellness. However, many listening session participants noted that these funds will expire in September 2024. Two programs supporting school mental health efforts were identified by several participants: the Resilience Education to Advance Community Healing (REACH) Statewide Initiative and the SEL Hubs. The REACH program is an evidence-informed framework that provides educators with tools to support the resilience and well-being of their students and staff through a deep partnership with the SEL Hubs. Together, both programs provide schools a framework for fostering resilience through a needs assessment and action plan.

Current mental health screening practices in Illinois schools

To begin explaining our findings about current screening practices in Illinois, we want to make an important note about language: The Blueprint report and its ensuing legislation required ISBE to do a landscape scan about universal mental health screening of students. To clarify the definition of such screening, our scan activities pointed participants to specific definitions of mental health, behavioral health, screening, and assessment. (These definitions are listed in Appendix 2 at the top of the feedback form questions.) Further, we knew that many districts utilize screening tools that are categorized as social-emotional screeners, so we included popular social-emotional learning screening tools in the feedback form to capture the use of those tools in our scan. Our results, which will be described in the next section of this report, point to a mix of screening practices across the state. Some districts are using purely mental and behavioral health screening tools, some are using SEL screening tools, and many told us they use more than one from both categories. SEL is an important foundational component to the overall health of a school and can be woven into instruction depending on the needs of a particular district. The results of an SEL screener may point to the need for further follow up on mental or behavioral health issues but also may not ask directly about mental or behavioral health symptoms that are critical to know about detecting problems early. Further discussion about this is captured in Recommendation No. 3 regarding the next steps needed to move Illinois schools forward in their use of screening tools. When we use the terms mental health screening tool or screener throughout this report, we are talking about tools that fall into mental health, behavioral health, and social-emotional learning categories.

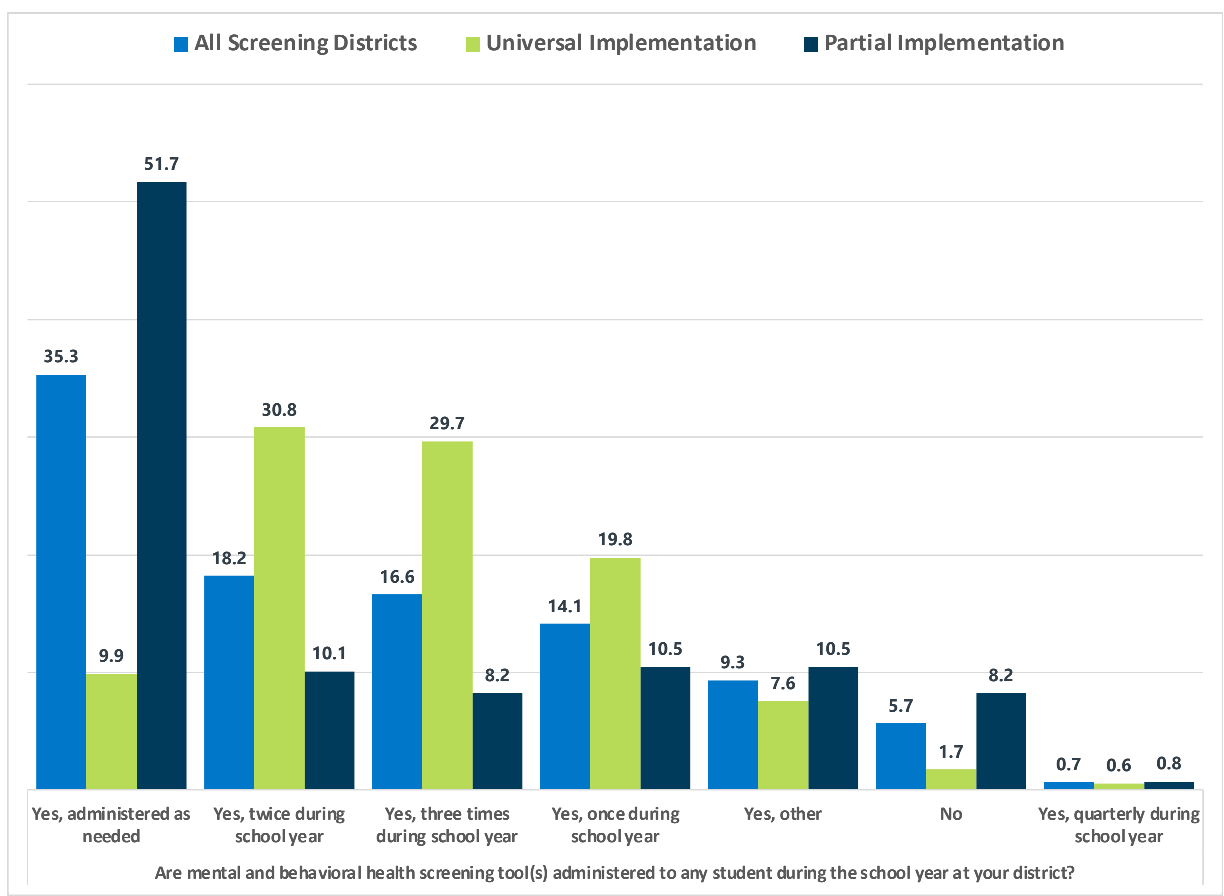
We learned from the feedback form sent to all 903 districts, ROEs, ISCs, and state-authorized charter schools that a considerable proportion of school districts in Illinois recognize the importance of mental health screening and are taking steps to address the mental well-being of their students, either through universal screening or targeted efforts. A total of 649 entities responded for the form, including 618 school districts, 23 ROEs, and eight charter entities representing 98 of the 102 counties in Illinois. Just over a quarter of school districts in Illinois (27.8%) reported that they are implementing mental health screening with all of their students. Furthermore, an additional 43.2% of the districts that responded to the feedback form reported offering screening to some of their students (Figure 2).

Figure 2. Mental Health Screening Status in Illinois School Districts



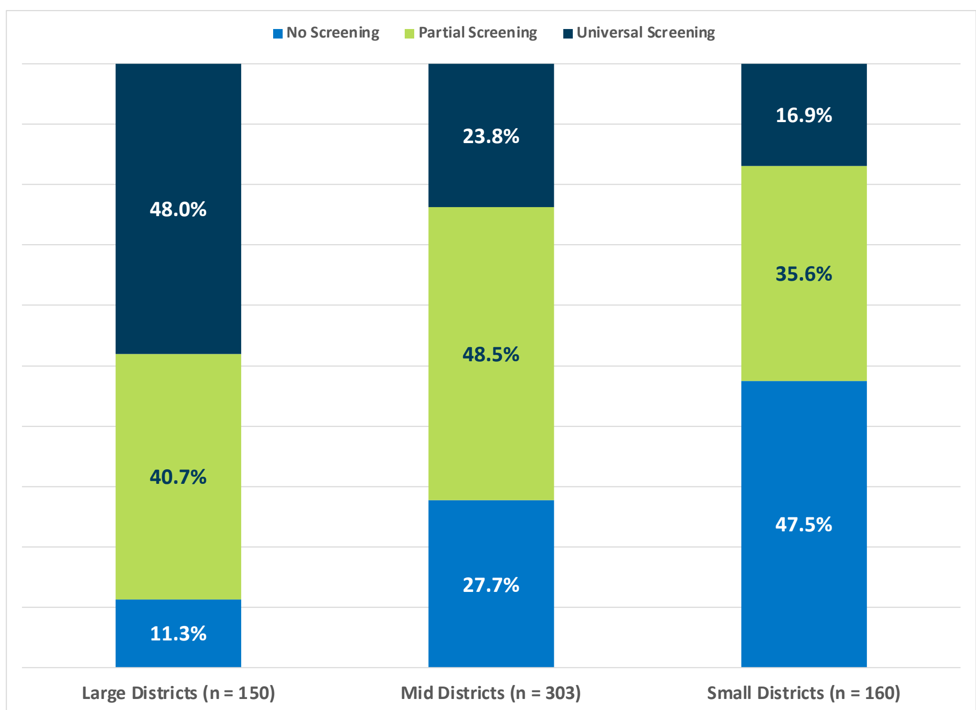
We learned that the frequency of administration significantly varies by implementation status. Nearly two-thirds of those districts implementing universal screening administer screening two or three times per school year, whereas approximately half of those districts with partial implementation administered "as needed" (Figure 3). Annual administration was relatively low compared to multiple administration or "as needed" approach, and quarterly administration was extremely rare.

Figure 3. Frequency of Mental and Behavioral Health Screening by Implementation Status (in percent)



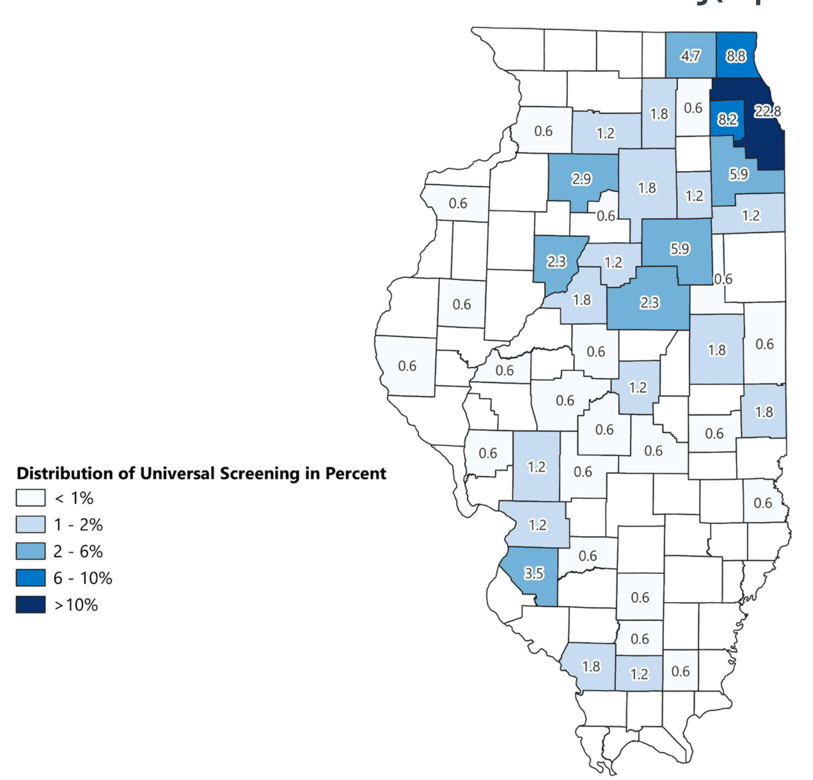
Our results indicate significant variation in the implementation of mental health screening activities based on the size of school districts: Larger school districts are more likely to implement universal mental health screening, while a higher percentage of small school districts do not have any screening activities in place. Mid-size districts fall somewhere in between (Figure 4). It is important to note that the two largest school districts in the state (Chicago Public Schools and Elgin U-46) did not submit the landscape scan feedback form. . To ensure we received their input, we met with both districts individually as part of this scan. Both districts indicated partial implementation, which raises the possibility that the survey result regarding the higher likelihood of universal implementation among large school districts may be inflated.

Figure 4. Mental Health Screening Status by District Size



The geographical distribution of school districts implementing universal mental health screening in Illinois, with a concentration in the Chicago metropolitan area (51%) and pockets of counties without any such programs in southern, western, and northwestern parts of the state, reflects possible disparities by urban vs. rural or population density (Figure 5). There are districts throughout the state with universal or partial screening activities, and we have highlighted four of varying size and geographic location as examples of district's current screening practices on the following four pages.

Figure 5. Distribution of School Districts with Universal Mental Health Screening (in percent)

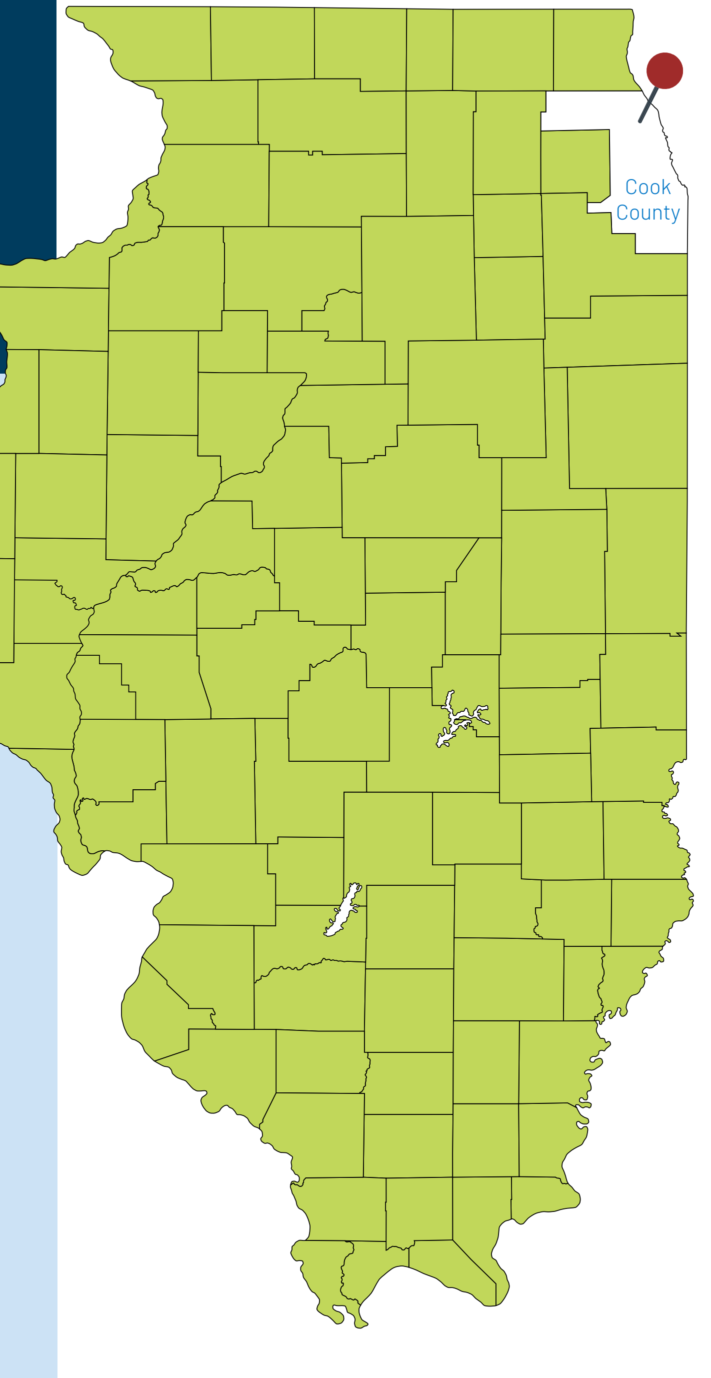


District Highlight

Skokie School District 69

3 schools serving PreK-8th grades

1,802 students enrolled



Current screening practices:

- All students 3 times a year (fall, winter, and spring) in Grades K-8
- PreK SEL screener prior to enrollment and three times during the year

Tools:

- The Social, Academic, and Emotional Behavior Risk Screener
- Brief Screening for Adolescent Depression
- Ages & Stages Questionnaire – Social-Emotional for PreK (ASQ: SE2) (administered prior to enrollment as part of screening)
- *MyTeachingStrategies* GOLD (PreK)

Administered by:

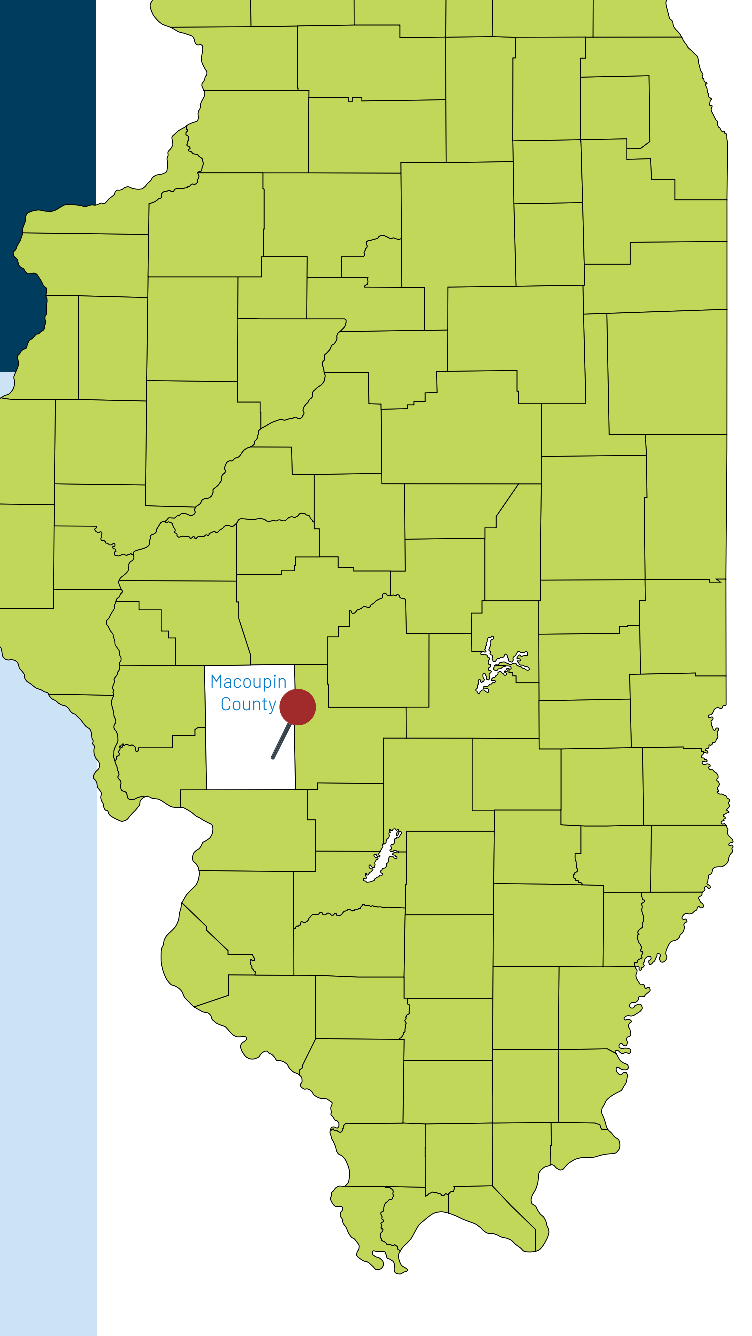
- Teachers
- Parents
- Self-reporting by student

District Highlight

Mount Olive Consolidated Unit School District 5

2 schools serving PreK-12th grades

486 students enrolled



Current screening practices:

- All students in 3rd – 12th grades twice annually

Tools:

- Basic Assessment System for Children-3 Behavioral and Emotional Screening System (BASC-3 BESS)

Administered by:

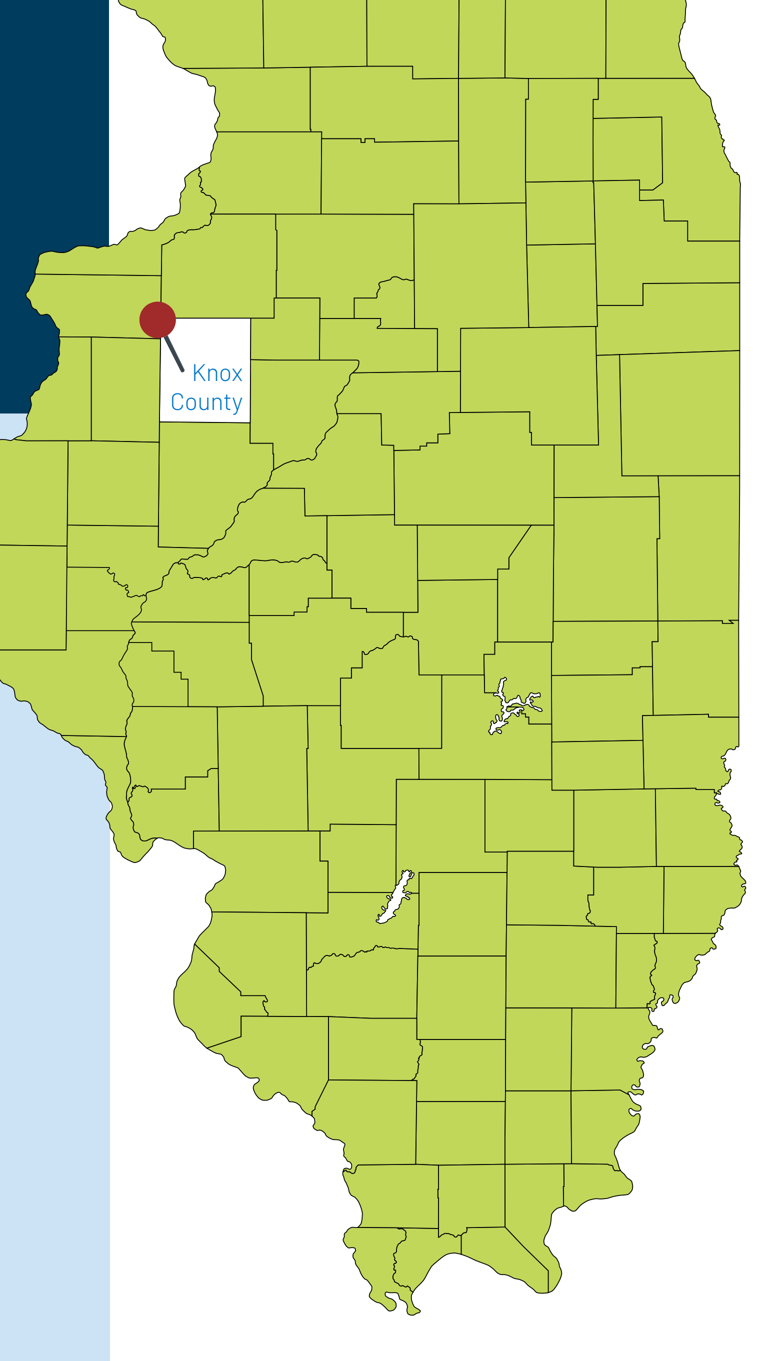
- Self-reporting by student

District Highlight

Galesburg Consolidated Unit School District 205

7 schools serving PreK-12th grades

3,884 students enrolled



Current screening practices:

- Some students as needed
- PreK – 12th Grades
- Pilot of new assessment (Social and Emotional Competency Assessment for Grades 6 and 9

Tools:

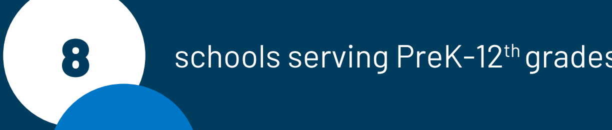
- BASC-3 BESS
- Columbia Suicide Severity Rating Scale
- Social and Emotional Competency Assessment

Administered by:

- Counselor
- Social worker
- Psychologist
- District/entity staff

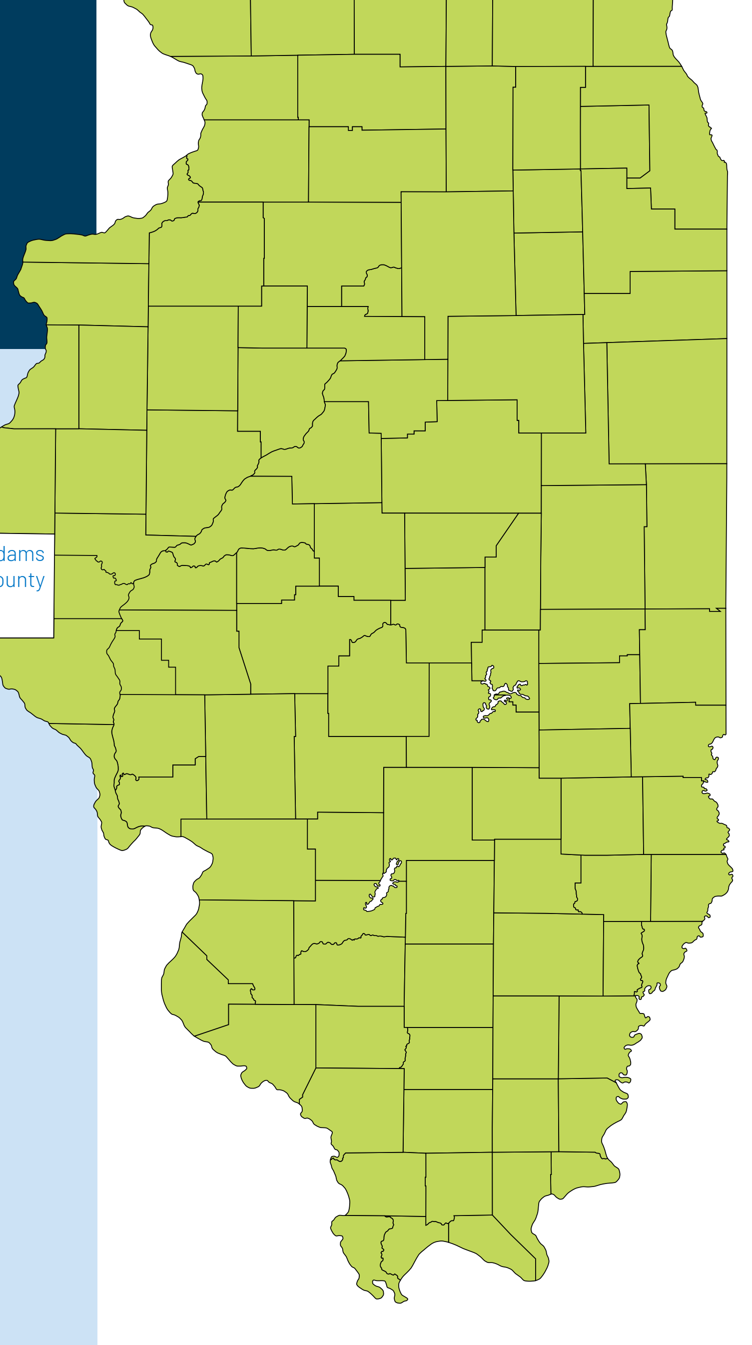
District Highlight

Quincy School District 172



8 schools serving PreK-12th grades

6,240 students enrolled



Current screening practices:

- All students PreK – 12th

Tools:

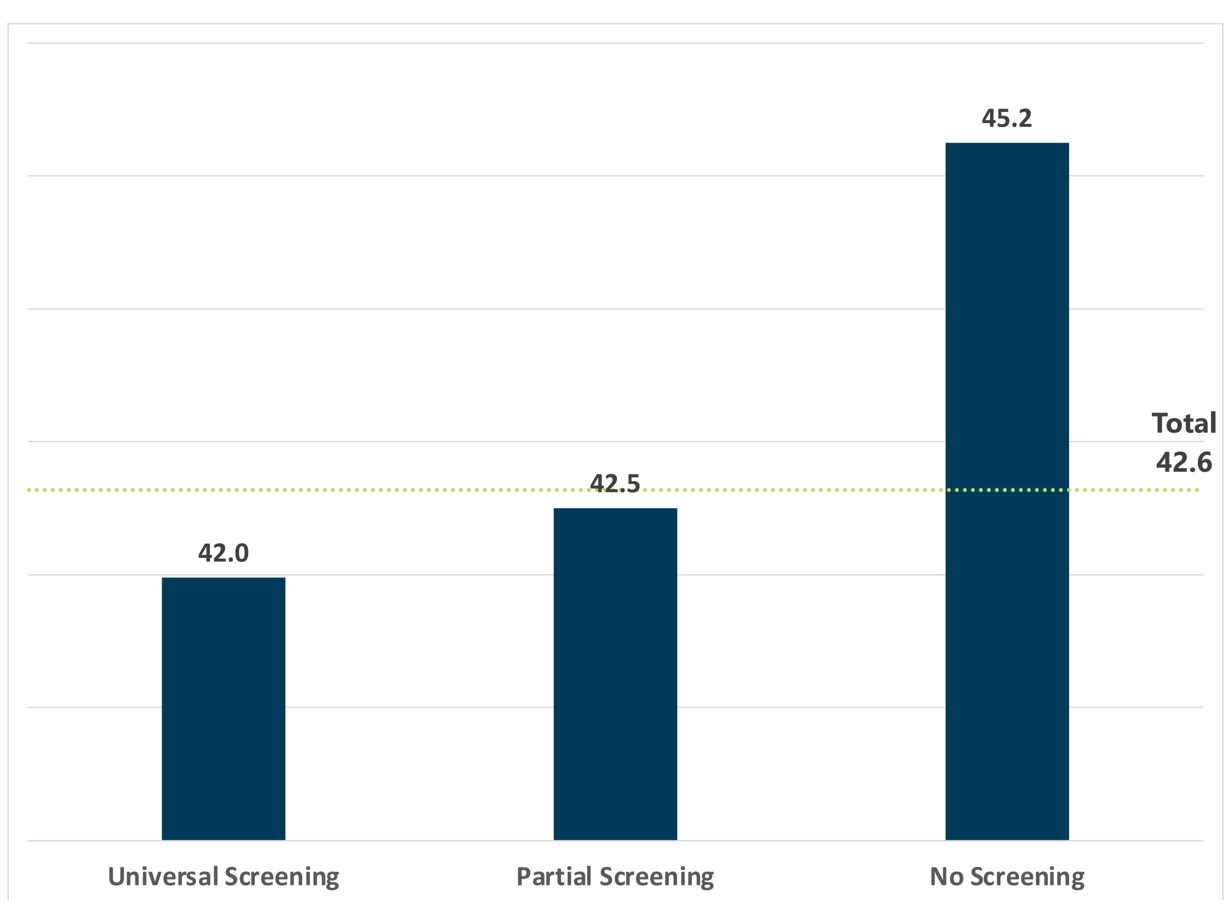
- Behavioral and Emotional Rating Scale – 3rd Edition (BERS)
- BASC-3 BESS Screening System
- Pediatric Symptom Checklist - Abbreviated (PSC)
- PSC – 17: Junior and senior high school

Administered by:

- Parent/guardian
- Self-reporting by student

In addition to geographic location, the feedback form data was analyzed considering socio-economic status across the state. Please see Figure 6. Comparison of the percentage of low-income students by screening status indicates there is no significant difference across screening activities (Figure 6). Despite there being no significant difference across screening activities, the percentage of low-income students may be underestimated in the survey sample. Low-income students are underrepresented in the landscape survey sample, with only 42.6% compared to nearly half (49%) of the students enrolled in the state being considered low-income. As the work of mental health screening of students in Illinois continues, more consideration is needed regarding equity in access to screening and ensuing mental health resources.

Figure 6. Percentage of Low-Income Students by Screening Status



The feedback form identified close to 40 screening tools used among school districts in Illinois through selections on a list provided or in written responses. Figure 7 displays the most widely used screening tools.[1] Some are useful for clinical diagnoses while others were developed to gauge risks for harm, including suicide. The identified screeners also included a number of social-emotional learning screening tools.

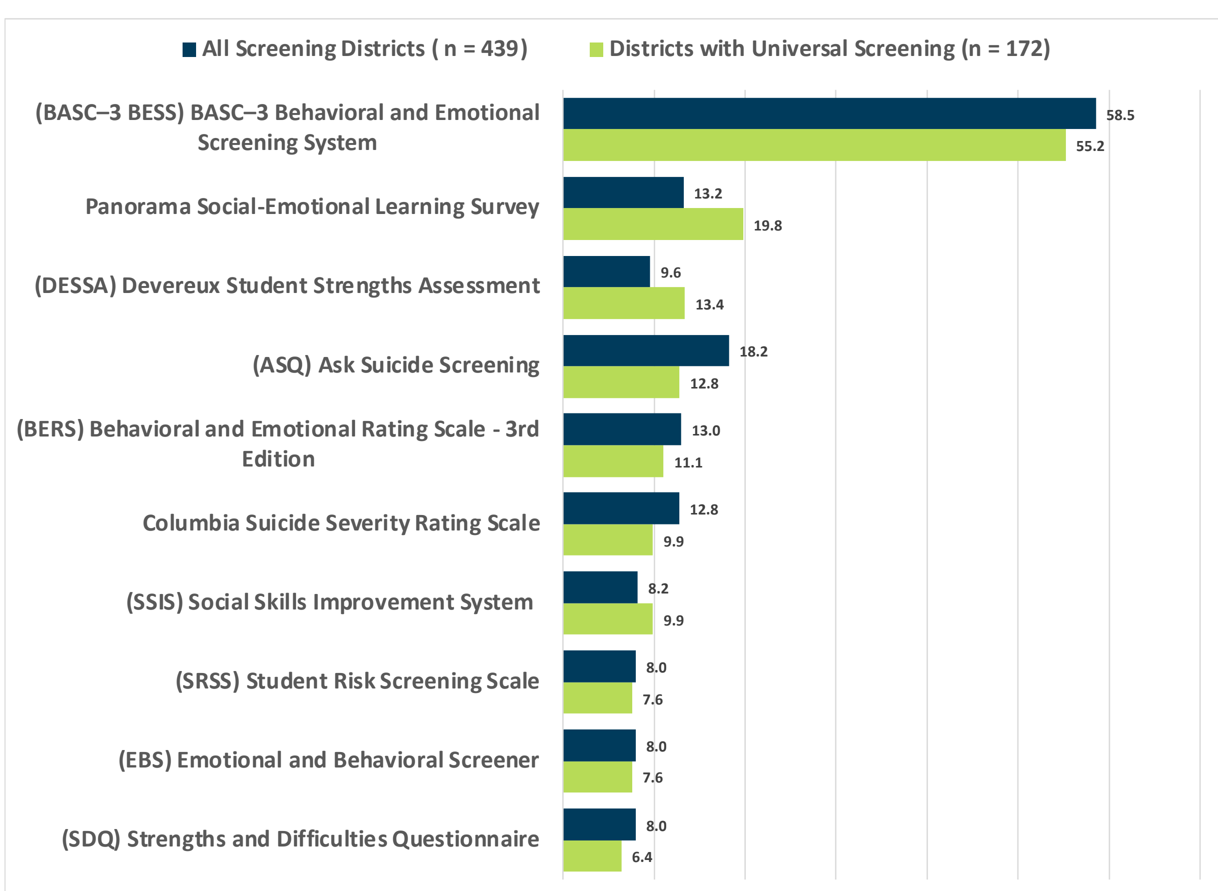
The most widely used screeners also varied in cost. Some on the list are free screeners developed by nonprofit organizations, government agencies, or academic institutions; they offer their tools without charge to promote widespread use and accessibility. Others on the list are licensed or proprietary screeners owned by publishers. These proprietary tools often come with additional features, technical support, and data management capabilities.

[1]Please note that nothing in this report constitutes a direct or indirect endorsement by ISBE of any screening tool or product. Any reference to screening tool names or products should not be construed as such. The names of the most widely-used tools are shared here for informational purposes only.

The Behavior Assessment System for Children-3 Behavioral and Emotional Screening System (BASC-3 BESS), an instrument designed to assist school personnel and other care providers determine behavioral and emotional strengths and weaknesses, was the most commonly used screening tool across all districts (58.5%) as well as among those districts implementing universal screening (55.2%). BASC-3 BESS also is known to be useful in the clinical diagnosis of disorders, such as attention-deficit hyperactivity disorder (ADHD), anxiety, and depression.

Unlike BASC-3 BESS, SEL screeners like the Panorama Social-Emotional Learning Survey are designed to measure various aspects of students' mindsets, behaviors, and attitudes, as well as their SEL competencies that are associated with success both in school and beyond the classroom.

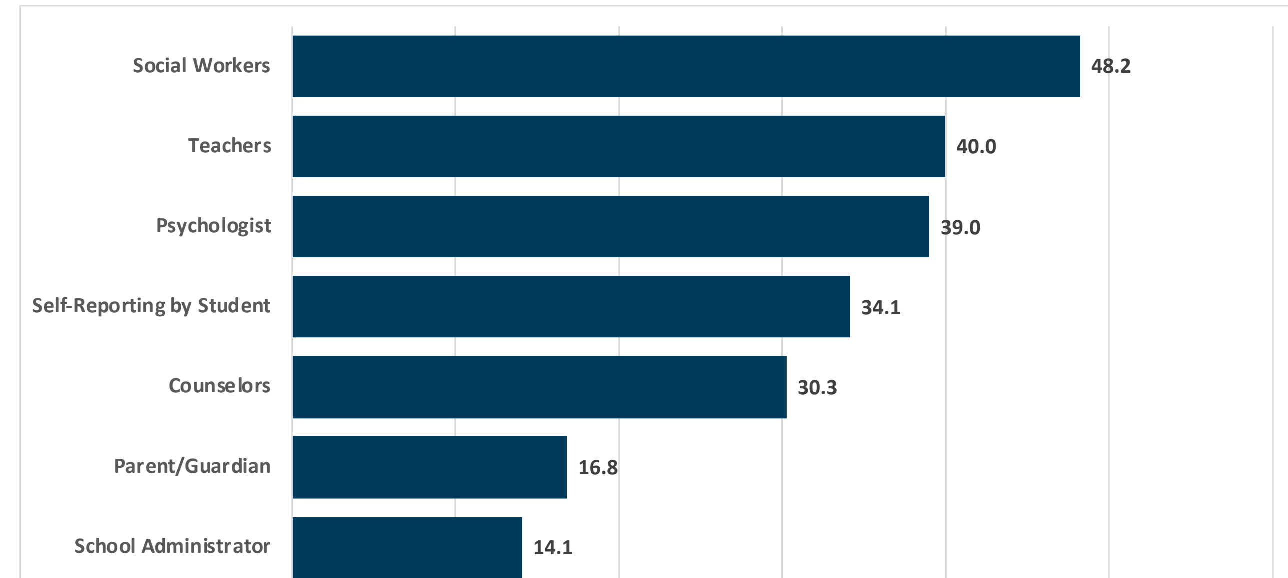
Figure 7. Most Widely Used Mental Health Screeners (in percent)



It is important to note that nearly half (47.2%) of those districts implementing screening use more than one screening tool. A small percentage (7.5%) of districts rely on five or more screening tools. The proportions of districts with multiple screening tools were not significantly different by implementation status.

Nearly half of the districts that indicated any screening activities also indicated that they rely on social workers (48.2%) to administer their screeners, followed by teachers (40%) and psychologists (39%) (Figure 8).

Figure 8. Personnel Administering Mental Health Screeners (in percent)



Consistent with the feedback form results, many school personnel expressed the need for increased mental health training. They said the lack of qualified mental health personnel meant that teachers and other school personnel are being tasked with managing student mental health now more than ever. However, many feel daunted and underprepared to address the serious and sensitive issue of students' mental health without having received professional education in this area. One participant said that a large part of her job now involves managing students' mental health even though she does not have the knowledge or skills to do so. She said that, for school personnel, it feels like they are trying to play catch-up with a problem that is already smacking them in the face. Many participants across listening sessions reiterated the need for training for all teachers and staff who interact with students — regardless of their involvement with the screening process — because mental health is such a prominent part of students' day-to-day experience and can have such a large impact on their ability to learn. Participants emphasized that training on how to recognize symptoms of mental health challenges — namely internalizing symptoms — is especially critical for school personnel who administer screeners for young children who cannot complete the screeners on their own. The training needs that were raised include the use of the tools, response to crises, vocabulary for discussing and normalizing needs, and help-seeking. Participants in the listening sessions emphasized that training is important for all staff who administer screeners so that they are being implemented in a consistent, reliable way.

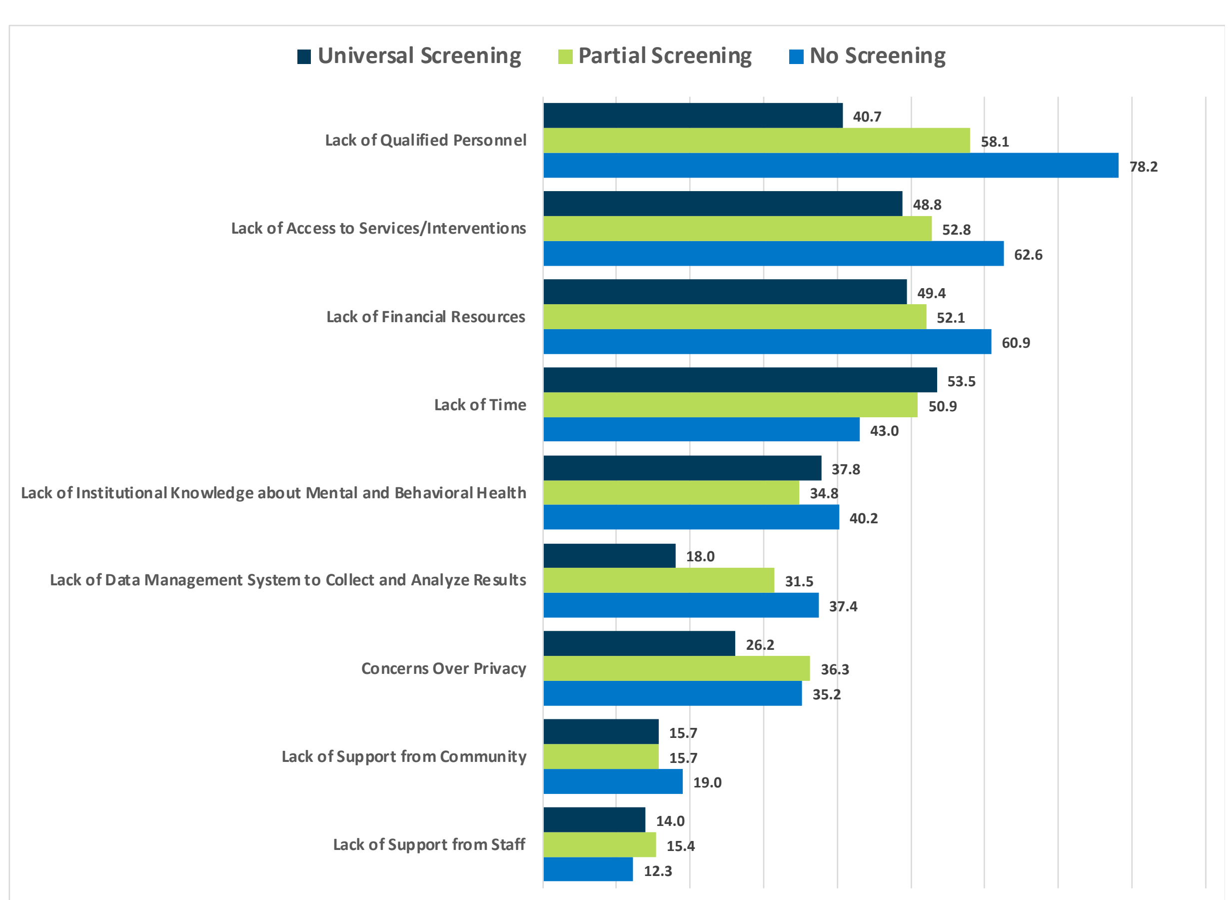
We also learned via the feedback form that implementing mental health screening can be challenging for school districts due to various factors, including personnel, access to services, budget limitations, and time constraints

(Figure 9). The specific challenges can vary depending on the district's current screening practices. About 80% of districts that have no screening activities identified a lack of qualified personnel as their most frequently mentioned barrier, which suggests a struggle to find or employ individuals with the necessary expertise to conduct mental health screenings. The second most common barrier for these districts was a lack of access to mental health services or interventions, with 62.6% reporting this as a challenge. Financial resources were also a significant challenge, with 60.9% of districts reporting a lack of financial resources as a barrier.

Among the districts reporting no current screening activities, 80% reported a lack of qualified personnel as a barrier to universal screening.

The biggest barrier for districts that were implementing universal screening was a lack of time, with 50.9% indicating this as a challenge. The second most common barrier for these districts was a lack of financial resources, with 49.4% reporting this issue, followed by lack of access to mental health services or interventions (48.8%).

Figure 9. Barriers and Challenges to Implementing Universal Mental and Behavioral Health Screenings in Schools by Current Screening Status (in percent)



Many Illinois schools are already implementing mental health screening to some extent, but variability in school resources; access to community mental health services; and school size, culture, and location have contributed to a significant amount of diversity in schools' screening practices. The results of the landscape scan show that schools fall along a broad spectrum of screening practices and readiness, and it highlighted the importance of meeting schools where they are to avoid causing undue strain.

The need for policy and procedural resources related to mental health screening

Any large initiative impacting a school system needs support from policies and procedures at all levels, as well as opportunities for educators, parents/guardians, and students to learn about changes and new practices. We heard three specific themes pertaining to the practice of screening at a school –communication to internal and external stakeholders about screening, confidentiality of screening results, and reliable screening follow-up – all of which point to a need for strong policies and procedures alongside of practice.

Regarding communication with stakeholders, listening session participants highly recommended increased parent communication and education campaigns to address mental health stigma about screening students. One school administrator said that some parents feel that schools are overstepping by screening students, saying that parents know there are mental health needs but that they do not want the schools to intrude in this area that they see as private to the family sphere. We heard that parents have objected to some of the questions included in the screeners, and many are wary of the potential for private information about their child to be shared without their knowledge. School personnel noted that there are a lot of misconceptions about what the screeners entail and how the data are used, so clarifying the details in communications outlined in school board policies about the screening process would likely reduce concerns. This includes communications and transparency from school districts about the issue of parental consent to participate in screening. A strong policy and written procedure for communicating with families and communities about the use of universal screening will not solve or allay the fears of every single stakeholder, but they may go a long way in helping to raise awareness of the purpose, benefits, and plans related to screening of students.

Along the same lines, communication beyond policies in the form of educational campaigns for families and communities may support the implementation of screening. Participants suggested student registration as an opportunity for parent/caregiver education on these topics. Several participants reported that parent and community education helped ease pushback because it made parents feel like screening practices were not happening behind their backs. In addition, we heard listening session participants note that pulling parents and community members into conversations about the screening process and plans would likely ameliorate some of the stigma because it would increase conversation about student mental health, provide opportunities for feedback, and increase trust overall.

School personnel, parents, and students cited confidentiality and privacy concerns about screening. Listening session participants emphasized that trust is a key component to the success and reliability of screening at all stages of the process. Students and families need to trust that the personal information they share in the screening process will be kept confidential. One school staff member pointed out that even a teacher talking about a concern over a student's mental health with another teacher might be viewed as a breach. Thus, many school personnel expressed the need for screening practices to be accompanied by specific policies pertaining to data confidentiality and privacy, and training about those policies. Consent to participate in screening as well as the opportunity for parents or students to opt-out of the process were raised by several listening session participants.

These listening session participants said that data sharing and storage of mental health screening results needs to be carefully considered to ensure that the storage system is secure and that only authorized personnel have access to the data. Additionally, school personnel said that it would be helpful to have clear plans in place so that

students and families know exactly what they are consenting to do when filling out a screening tool. One student said that if she had any doubt at all about whether or not her responses on a screening tool were going to be kept confidential, she would not be honest in her answers.

Finally, we learned about the need for a clear written policy about the plans for follow-up after screening. We heard participants cite that families need to know the procedure and plan for after the screening is administered to trust that it is worthwhile for them to share this information with schools. School personnel also expressed much care and consideration in thinking about how best to manage students' screening results so that they can respond with the appropriate services. Many schools said that analyses of screening results were helpful in evaluating the school's current mental health programming and identifying which students could benefit from additional support. We heard that properly trained individuals and a larger team are necessary to not only deal with individual follow-up on the day of the screening administration if concerns arise, but also follow-up may be needed on a systemwide level — and all of this should be outlined in a written plan.

In conclusion, ISBE learned a great deal from the landscape scan across these four themes, and we want to extend our gratitude and thanks to all of those individuals who participated – whether by filling out a feedback form or attending a virtual or in-person listening session. Information was shared and your concerns were heard. This feedback has greatly informed the recommendations that follow herein.

Universal Mental Health Screening Recommendations

Recommendation No. 1: Illinois should undertake a phased approach to universal mental health screening of all K-12 students enrolled in public school districts. Universal mental health screening of all K-12 students means mental health screening of every student in every grade enrolled in a school district each year.

- The landscape scan indicates that this is both feasible and valuable for documenting mental health needs among students and facilitating linkage to supports and services. ISBE should work with stakeholders to develop a strategy that includes a tool for measuring capacity and readiness to implement universal mental health screening of students. This strategy, informed by the landscape scan results and findings, should build upon existing efforts to understand district needs for resources, technology, training, and infrastructure supports. The strategy should include a framework for supporting districts in this phased approach to implement universal mental health screenings.

Rationale: ISBE's landscape scan pointed not only to a need for universal mental health screening of students in Illinois, but the importance of a careful, intentional, and supported implementation of this policy and practice change over time. Over 25% of Illinois school districts that responded to the landscape scan feedback form already conduct universal mental health or social-emotional learning screening for their students, and 71% of the districts have some form of wellness screening activities. However, these screening activities significantly vary by district size and geography. Districts that are not engaging in any screening practices at all cite lack of qualified personnel as the largest barrier. It is irresponsible to move toward universal screening without first developing a strategy that includes a tool for measuring capacity and readiness to implement universal mental health screening of students. Universal mental health screening of students is one piece of many concurrently occurring resilient school-related initiatives (Figure 10), and a phased approach allows for more time for these various projects to work together to build a strong infrastructure for student mental health at all levels to ensure the success of each component, as well as a better understanding of mental health service capacity needs statewide.

Figure 10: Resilient Illinois Schools – A Social Ecological Approach

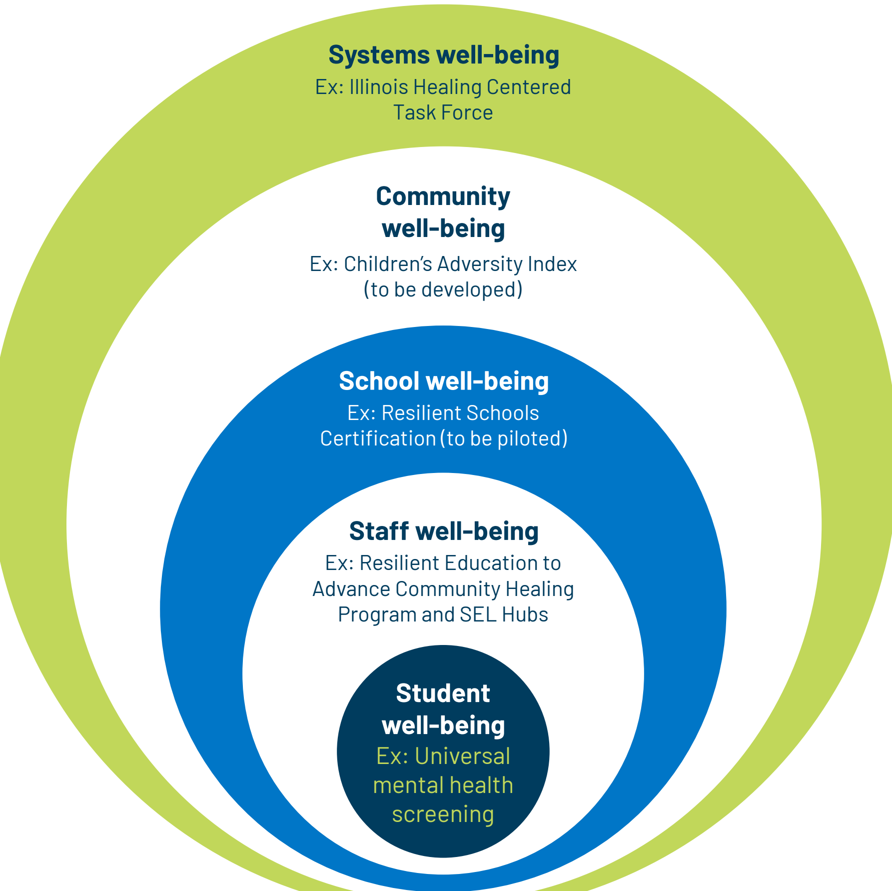
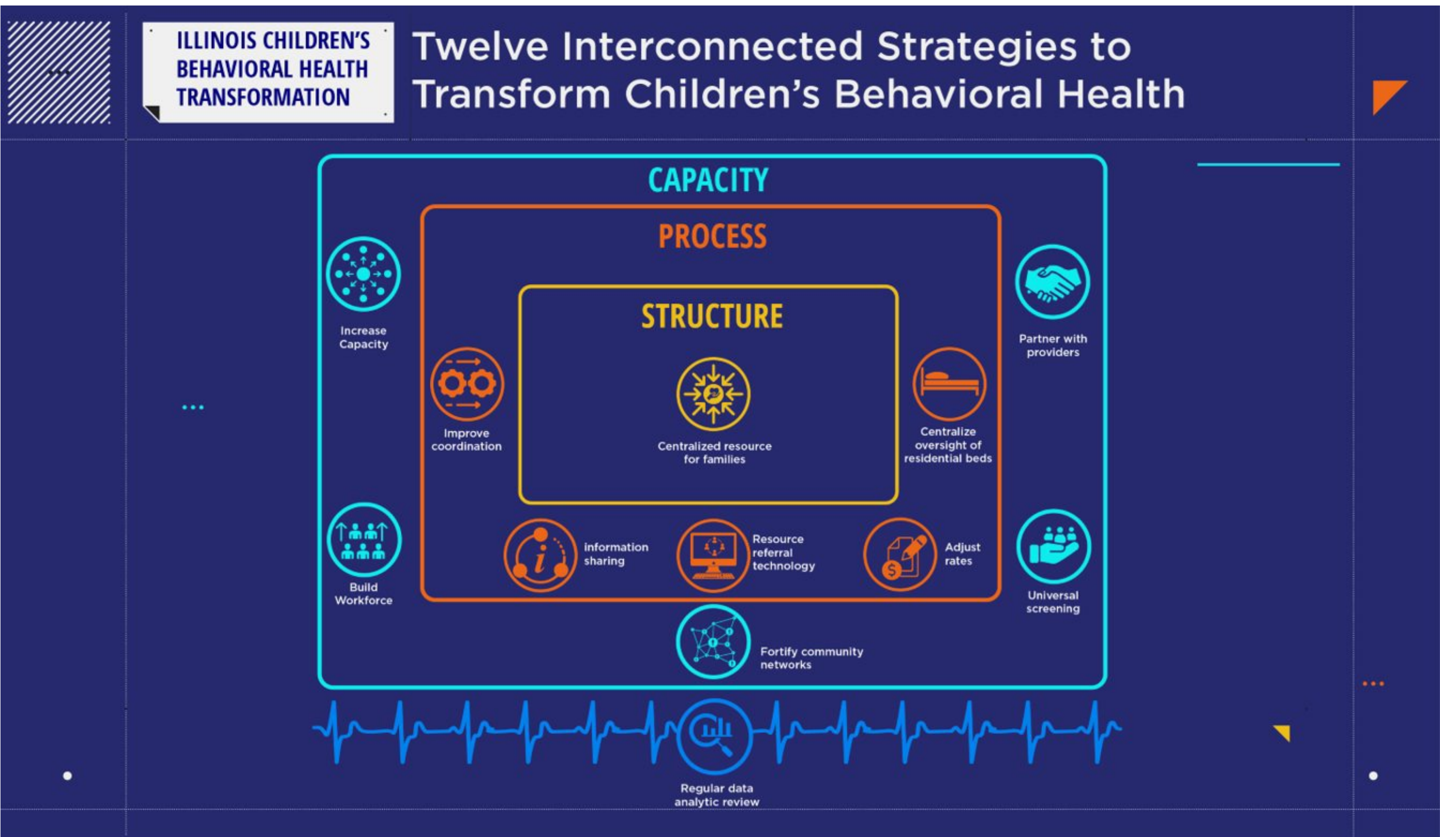


Figure 11: Interconnected Strategies to Transform Children's Behavioral Health in Illinois



As noted in Figure 11, universal mental health screening of students is also one piece of the entire Children's Behavioral Health Transformation Initiative. The Transformation Initiative continues to apply data to understanding gaps in service availability and strategically address that with capacity development for outpatient behavioral health programs. Universal mental health screening in schools is a key component of this understanding, but should be phased in over time to align with the other elements of the Transformation Initiative. It is important to identify and develop supportive resources for schools at the building, district, and community level to match needs that are indicated within screenings. Resources that complement and leverage existing partnerships are necessary for universal screening to be successful.

ISBE recognizes that successful implementation of this recommendation depends upon the following considerations.

Recommendation No. 2: ISBE, in consultation with relevant stakeholders, should compile and organize resources to support school districts in improving the mental health culture and climate in schools and reducing the stigma related to screening, referral, and participation in mental health services.

- ISBE, in consultation with relevant stakeholders that include families and students, should release a resource guide highlighting examples of free and low-cost evidence-based or evidence-informed trainings, stigma-reduction programs, resources for parent education about mental health, and information about the importance of peer-to-peer mental health support in schools.

Rationale: ISBE learned from our landscape scan listening session participants – particularly students – that stigma-reduction and mental health screeners need to be implemented concurrently to reduce the fear, hesitancy, and shame that often accompany asking for and receiving support related to mental health in schools. ISBE learned that screening practices may be more likely to be successful if introduced with strong support from training and communication and education campaigns for students, teachers, families, and communities.

Recommendation No. 3: ISBE, in consultation with relevant stakeholders, should release guidance about (1) mental health screening tools available for school districts to use with students and (2) associated training for school personnel.

- The process of developing guidance under this recommendation should include consultation with stakeholders who have expertise in administering mental health screening to students and providing training to school personnel about such administration. The guidance should be informed by evidence about universal mental health screening tools and the findings of the landscape scan.

Rationale: Screening practices vary widely across the state, and clarity is needed on which elements are the most important within a tool that is universally used. School districts need support in identifying best practices for training school personnel about mental health screening. A process overseen by ISBE should expand upon the evidence gathered in the landscape scan about the use of screening tools, which indicated that the use of such tools across the state is mixed. A process to develop guidance overseen by ISBE should recommend that tools used by school districts:

i. Be feasible for districts to administer.
ii. Specifically screen for relevant indicators and behaviors.
iii. Be developmentally and culturally appropriate, including, but not limited to:
    1. Age/grade.
    2. Special education.
    3. Language.
    4. Culture.

Recommendation No. 4: ISBE should oversee a process of model policy development with relevant stakeholders that supports school districts in implementing universal mental health screening of students.

- ISBE, in consultation with relevant stakeholders, should oversee a process of model policy development regarding universal mental health screening of all K-12 students enrolled in a school district, specifically model policy about communication, confidentiality, and screening follow-up and linkage to resources. This should include model policy about screening administration to every student in every grade enrolled in a school district each year, as well as model policy about offering the opportunity for students or parents to opt out of mental health screening.

Rationale: The landscape scan results indicate that students, parents, and school personnel are concerned about the policies and procedures that will guide universal mental health screening of students, specifically in the areas of communication, confidentiality, and follow-up procedures after screening.

In conclusion, the landscape scan documents a rigorous, comprehensive approach to gathering input and feedback from youth, parents, school personnel, and system stakeholders on the practice of universal mental health screening of students in schools. It illuminates key priorities and lessons learned from existing efforts, as well as some of the more nuanced intersections between social-emotional learning, school resource planning, community capacity, and school culture. Understanding these dynamics will be essential to any successful effort to enact universal in-school screening for mental and/or behavioral health service needs. Consequently, this landscape scan (and similar efforts to inform future innovations) should be consulted as the state embarks on an intentional strategy to develop a phased implementation plan, understand local capacity, and enhance resources and supports to schools to maximize the potential for in-school screening.

References

Castro-Ramirez, F., Al-Suwaidi, M., Garcia, P., Rankin, O., Ricard, J. R., & Nock, M. K. (2021). Racism and Poverty are Barriers to the Treatment of Youth Mental Health Concerns. Journal of Clinical Child & Adolescent Psychology, 50(4), 534-546. doi:10.1080/15374416.2021.1941058

Daruwala, I., Pan, J., Shramko, M., Salinas, V., Ramesh, K., Jiang, J., (2023, September). Study of learning renewal—Social emotional learning (SEL) programs for supporting pandemic recovery with the Illinois State Board of Education (ISBE) [PowerPoint slides]. American Institutes for Research.

Dowdy, E., Ritchey, K., & Kamphaus, R. W. (2010). School-based screening: A population-based approach to inform and monitor children's mental health needs. School Mental Health, 2, 166-176.

Dvorsky, M. R., Girio-Herrera, E., & Owens, J. S. (2013). School-based screening for mental health in early childhood. In Handbook of school mental health: Research, training, practice, and policy (pp. 297-310): Springer.

Glover, T. A., & Albers, C. A. (2007). Considerations for evaluating universal screening assessments. Journal of School Psychology, 45(2), 117-135.

Humphrey, N., & Wigelsworth, M. (2016). Making the case for universal school-based mental health screening. Emotional and Behavioral Difficulties, 21(1), 22-42. doi:10.1080/13632752.2015.1120051

Illinois Association of Regional Superintendents of Schools (IARSS) (2022). Educator Shortage Survey: Fall 2022 Administration for the 2022-2023 Academic Year. [https://iarss.org/wp-content/uploads/2023/01/IARSS-Educator-Shortage-AY23-230123.pdf]

Illinois State Board of Education (2023). Illinois Report Card State Snapshot 2022-2023. [https://www.illinoisreportcard.com/State]

Jones, S., Ethier, K., Hertz, M., DeGue, S., Le, V., Thornton, J., Lim, C., Dittus, P., Geda, S. (2022). Mental Health, Suicidality, and Connectedness Among High School Students During the COVID-19 Pandemic — Adolescent Behaviors and Experiences Survey, United States, January–June 2021 Supplement. US [Department of Health and Human Services/Centers for Disease Control and Prevention, 71:3, [https://www.cdc.gov/mmwr/volumes/71/su/pdfs/su7103a3-H.pdf]

McGaugh JL, McIntyre CK, Power AE. Amygdala modulation of memory consolidation: interaction with other brain systems. Neurobiology of Learning and Memory. 2002 Nov;78(3):539-52. doi: 10.1006/nlme.2002.4082. PMID: 12559833.

Mulfinger, N., Rüsch, N., Bayha, P., Müller, S., Böge, I., Sakar, V., & Krumm, S. (2019). Secrecy versus disclosure of mental illness among adolescents: I. The perspective of adolescents with mental illness. Journal of Mental Health, 28(3), 296-303. doi:10.1080/09638237.2018.1487535

Siceloff, E. R., Bradley, W. J., & Flory, K. (2017). Universal Behavioral/Emotional Health Screening in Schools: Overview and Feasibility. (1531-5479 (Print)).

Splett, J. W., Fowler, J., Weist, M. D., McDaniel, H., & Dvorsky, M. (2013). The critical role of school psychology in the school mental health movement. Psychology in the Schools, 50(3), 245-258.

Substance Abuse and Mental Health Services Administration: Ready, Set, Go, Review: Screening for Behavioral Health Risk in Schools. (2019). Office of the Chief Medical Officer, Substance Abuse and Mental Health Services Administration, Rockville, MD. [https://www.samhsa.gov/sites/default/files/ready_set_go_review_mh_screening_in_schools_508.pdf}

Appendix 1

PA 103-0546 — Sec. 2-3.196. Mental health screenings. On or before December 15, 2023, the State Board of Education, in consultation with the Children's Behavioral Health Transformation Officer, Children's Behavioral Health Transformation Team, and the Office of the Governor, shall file a report with the Governor and the General Assembly that includes recommendations for implementation of mental health screenings in schools for students enrolled in kindergarten through grade 12. This report must include a landscape scan of current district-wide screenings, recommendations for screening tools, training for staff, and linkage and referral for identified students.

Appendix 2

Illinois State Board of Education
Safe and Healthy Climate Center
June 2023
Mental and Behavioral Health Landscape Scan Feedback Form Preview

Pursuant to Recommendation 9 in the February 2023 Blueprint for Transformation: A Vision for Improved Behavioral Healthcare for Illinois Children report and in accordance with Senate Bill 724, ISBE is administering a one-time landscape scan of all school districts in Illinois regarding mental and behavioral health screening of students. This feedback form is an opportunity for districts or other public entities that provide school programming to public school students in Illinois to offer input about mental and behavioral health screening in schools. No personally identifiable information about individuals is collected in this form. Feedback from entries will be shared with Chapin Hall at the University of Chicago and summarized in a forthcoming implementation report.

Please feel free to email ISBE at mentalhealth@isbe.net with any questions.

Definitions

Mental health relates to thoughts and feelings and how those may impact our lives. Mental health issues also may comprise diagnosable mental illnesses or mental disorders, such as depression, generalized anxiety disorder, bipolar disorder, and post-traumatic stress disorder.

Behavioral health is related to behavior, and how the actions people take impact their health. Behavioral health issues may include substance use disorders, eating disorders, or conduct problems. Because behavioral health problems are often a reflection of an underlying mental health issue, addressing behavioral health issues often requires attention to mental health.

Screening is a preliminary evaluation that looks for possible signs of a problem that would require further evaluation and support. Screening tools are typically short in length and quick to administer and score, and do not result in a diagnosis. **Assessment**, on the other hand, is a more detailed examination that systematically evaluates the type and nature of a problem in order to identify appropriate treatment.

The purpose of this form is to understand the current practices your district/entity employs related to mental and behavioral health screening of students. Thank you for your participation in this landscape scan.

1. Does your district/entity currently have any student mental and behavioral health screening practices in place?

Check only one.

- Yes, we screen ALL students to identify mental and behavioral health needs. {skip to question 3}
- Yes, we screen SOME students for mental and behavioral health needs.
- No. {Skip to question 13}

2. What typically triggers the administration of a mental and behavioral health screening tool? Check all that apply.

a. Student request/concern about themselves
b. Parent/guardian observation/concern
c. Teacher observation/concern
d. Other school personnel observation/concern
e. Other:

Use of Screening Tool

Please answer questions as they apply to students who receive mental and behavioral health screenings in your district/entity.

3. In what grade level(s) do you typically administer mental and behavioral health screenings of students?

Check all that apply.

- Prekindergarten
- Kindergarten
- 1st Grade
- 2nd Grade
- 3rd Grade
- 4th Grade
- 5th Grade
- 6th Grade
- 7th Grade
- 8th Grade
- 9th Grade
- 10th Grade
- 11th Grade
- 12th Grade

4. Your district/entity may use a variety of tools to understand mental health, behavioral health, and related issues. Please indicate which of the following are in use in your district/entity.

Check all that apply.

- ASQ) Ask Suicide-Screening Questions
- (BERS) Behavioral and Emotional Rating Scale - Third Edition
- (BASC–3 BESS) BASC–3 Behavioral and Emotional Screening System
- (BIMAS-2 Standard) Behavior Intervention Monitoring Assessment System
- (BIMAS-2 Flex) Behavior Intervention Monitoring Assessment System
- (BSAD) Brief Screening for Adolescent Depression
- Columbia Suicide Severity Rating Scale
- (DESSA) Devereux Student Strengths Assessment
- Duke Health Profile
- (EBS) Emotional and Behavioral Screener

- (K-10) Kessler 10 Psychological Distress Scale
- Panorama Social-Emotional Learning Survey
- (PHQ-9) Patient Health Questionnaire-9
- (PKBS-2) Preschool and Kindergarten Behavior Scales
- (PSC) Pediatric Symptom Checklist
- (PSC) Pediatric Symptom Checklist - Abbreviated
- Rethink SEL Screener
- Satchel Pulse SEL Assessment
- (SAEBRS) Social, Academic & Emotional Behavior Risk Screener
- (SDQ) Strengths and Difficulties Questionnaire
- (SSIS) Social Skills Improvement System
- (SSIS-SEL) SEL Edition Social Skills Improvement System
- (SRSS) Student Risk Screening Scale
- (SRSS-IE) Student Risk Screening Scale - Internalizing and Externalizing
- (SSBD) Systemic Screening for Behavior Disorders
- (TABS) Temperament and Atypical Behavior Scale
- Terrace Metrics Screener System
- Other:

5. Does your district/entity administer mental and behavioral health screening tools to any student before the school year begins?

- Yes
- No

6. Are mental and behavioral health screening tool(s) administered to any student during the school year at your district/entity?

Check only one.

- No.
- Yes, once during school year.
- Yes, twice during school year.
- Yes, three times during the school year.
- Yes, quarterly during school year.
- Yes, administered as needed.
- Yes, other:

7. Who completes the mental and behavioral health screening tool(s)?

Check all that apply.

- Teacher
- Paraprofessional
- Nurse
- Counselor

- Social Worker
- Psychologist
- School Administrator
- District/Entity Staff
- Parent/Guardian
- Self-Report by Student
- External Partner/Vendor
- Other:

8. Who is responsible for reviewing the mental and behavioral health screening results?

Check all that apply.
- Teacher
- Paraprofessional
- Nurse
- Counselor
- Psychologist
- School Administrator
- District/Entity Staff
- Parent/Guardian
- External Partner/Vendor
- Other:

9. Does your district/entity have a plan in place to address student needs identified by a mental and behavioral health screening?

Check only one.
- Yes
- No

10. Does your district/entity have a team that specifically handles student needs identified by a mental and behavioral health screening?

Check only one.
- Yes
- No (skip to #12)

11. Please select all staff from the list below who make up your district/entity's team.

Check all that apply.
- Teacher
- Paraprofessional
- Nurse
- Counselor

- Social Worker
- Psychologist
- School Administrator
- District/Entity Staff
- External Partner/Vendor
- Other:

12. Please select all of the barriers experienced by your district/entity in obtaining services/interventions for students related to a mental and behavioral health screening:

- Not enough information about where to find services
- Not enough capacity/long waiting lists
- Specific types of services not available
- Services not available at the times that students/families need
- Families don't have transportation to access services
- Services not available in the language that student/family speaks
- Difficulty making referrals
- Available services are unaffordable to students/families
- No barriers

Comments, barriers, challenges

13. What do you believe are the barriers and challenges to implementing universal mental and behavioral health screenings in schools?

Check all that apply.

- Lack of qualified personnel
- Lack of financial resources
- Lack of institutional knowledge about mental and behavioral health
- Lack of support from staff
- Lack of support from community
- Concerns over privacy
- Lack of access to services/interventions
- Lack of time
- Lack of data management system to collect and analyze results
- Other:

14. Please use the space below to provide any additional comments you would like to share about the topic of mental and behavioral health screening of students in your district/entity.

Thank you for your participation. Please feel free to email ISBE at mentalhealth@isbe.net with any questions.

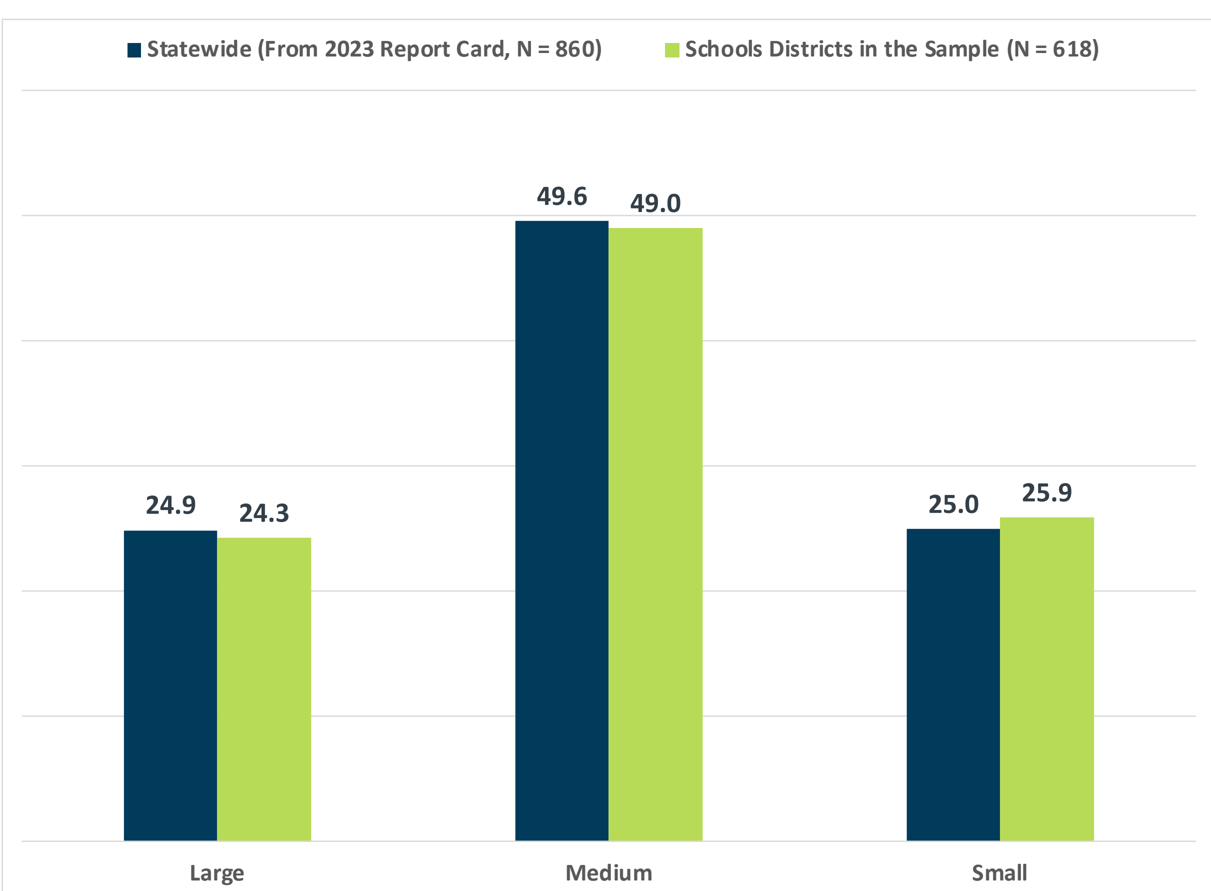
Appendix 3

Validation of Sample

Ensuring the representativeness of a survey sample is crucial for obtaining reliable and valid results that can be generalized to all school districts in the state. If certain school districts are systematically missing from the sample, it can introduce bias and compromise the external validity. The landscape survey sample was validated based on the district level data for SY2023 from ISBE state report card (https://www.isbe.net/ilreportcarddata). While 71% of the school districts (614 out of 865) participated in the landscape survey, they included 57.4% of the students enrolled in public schools in Illinois. Two notable omissions in the survey were two largest districts in the state, Chicago Public Schools and District U-46 that include 11 communities in 3 counties northwest of Chicago. The characteristics considered to gauge representativeness of the sample include district size, grades served in a given district, corresponding county, and racial composition. The characteristics of the sample mirrored all the districts in Illinois and no geographical concentration or omission was detected. The participating districts included higher percentage of white students compared to the percentage for the state as a whole, and black and Hispanic students were underrepresented.

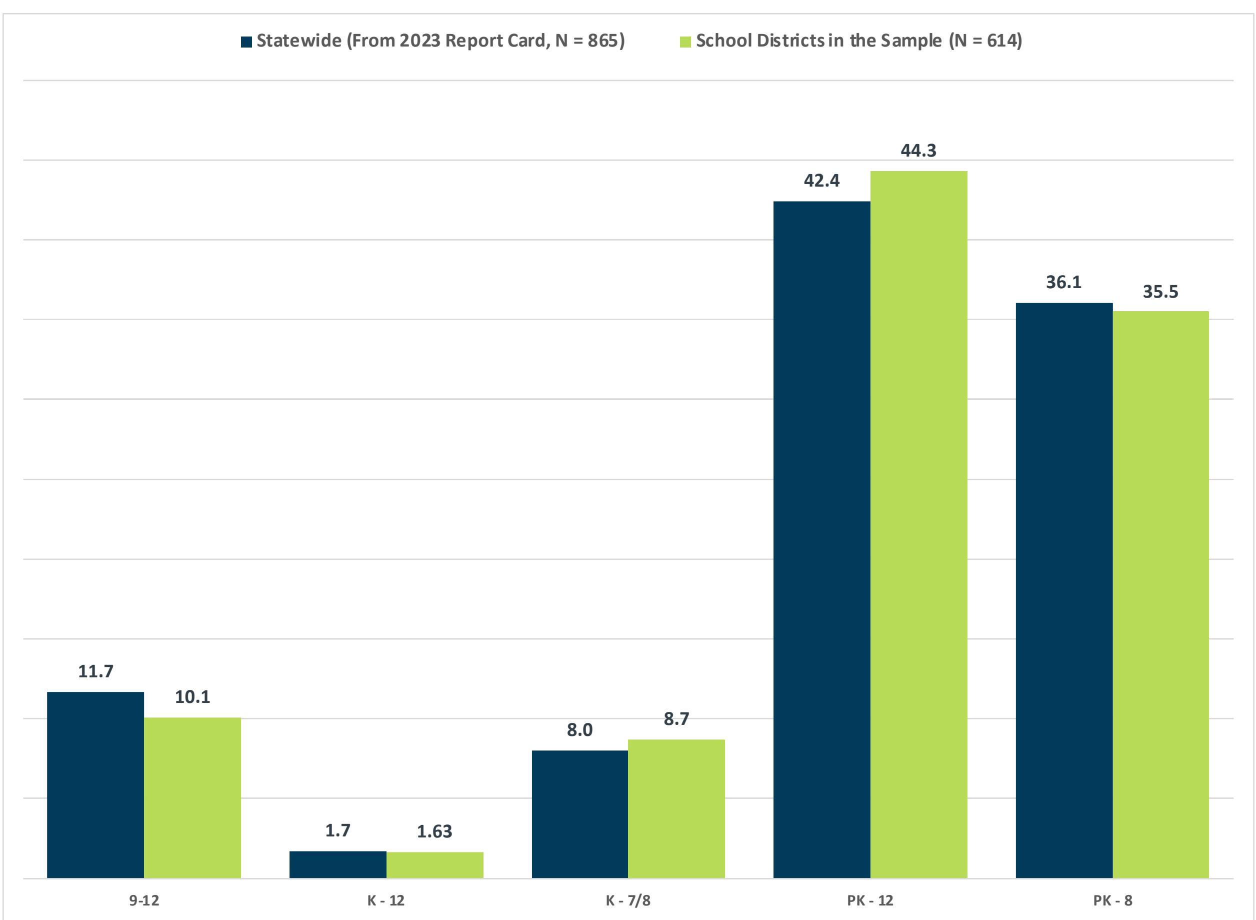
There was no significant difference by size of district between all the districts in the state and those districts that participated in the landscape survey (Figure 3-1).

Figure 3-1. Distribution by District Size (in percent)



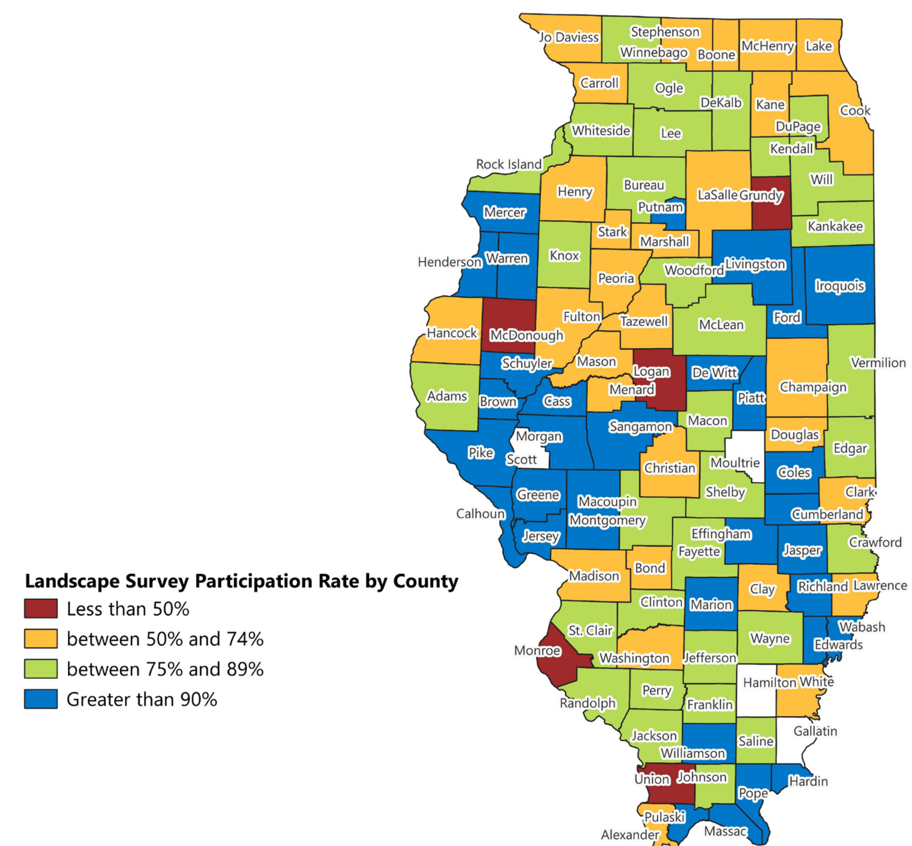
Distribution by grades served was also similar between the statewide distribution and the landscape survey sample (Figure 3-2). Approximately 80% of the school districts serve prekindergarten through 8th or 12th grade in the state, as was the case in the sample.

Figure 3-2. Comparison of Distribution by Grades Served (in percent)



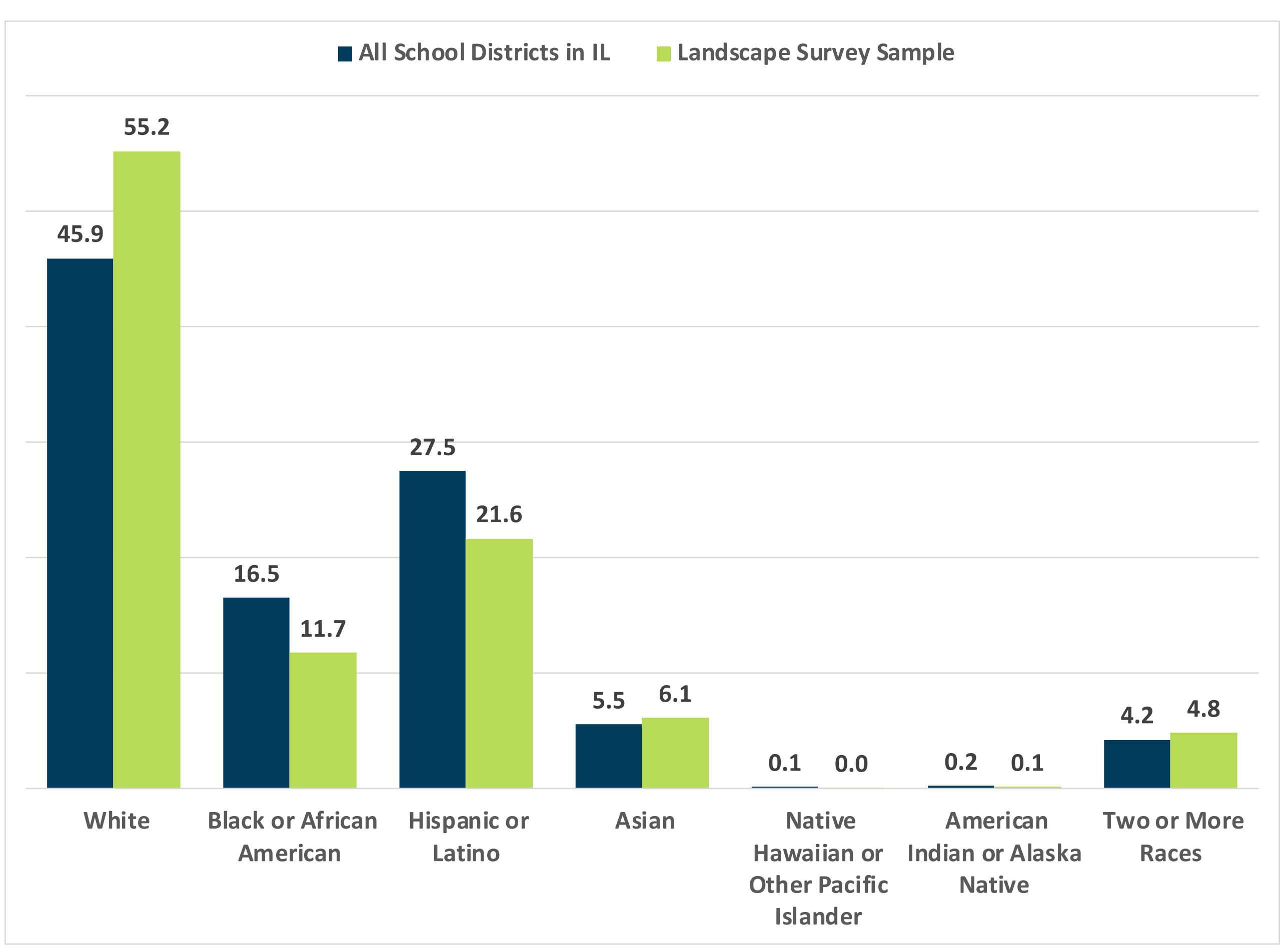
The landscape survey had widespread participation across the majority of counties, with some counties having exceptionally high participation rates and a few with lower rates. The geographical distribution of the districts that participated in the survey had representation from 98 out of 102 counties. In addition to 4 counties that did not have any school districts participating in the survey, only 5 additional counties had participation rates below 50%. Conversely, 32 counties had participation rate greater than 90% including 30 counties with all of their districts participating in the survey (Figure 3-3). Those counties with extremely high level of participation were found in central, southwestern, and southern parts of the state.

Figure 3-3. Landscape Participation Rate by County



The racial composition of the participating school districts indicates that white and Asian students, as well as students with two or more races, were overrepresented in the sample while Black and Hispanic students were underrepresented (Figure 3-4). This notable difference in racial composition between the landscape survey sample and the overall student population is largely a reflection of higher rates of participation among central, southwestern, and southern parts of the state, where the student population tend to be more homogeneous in terms of race. Conversely, the participation rates were relatively lower in the northern part of the state, where more diverse school districts are located.

Figure 3-4. Comparison of Racial Composition (in percent)



Appendix 4

Listening Session Guiding Questions/Prompts and Consent Information

School personnel guiding questions and prompts:

- What is your experience with mental and behavioral health screening in schools? Or, have you ever participated in a mental or behavioral health screen in the school context?
- Please share your general thoughts about screening students in Illinois public schools for mental and behavioral health issues.
- Think back over the years of your time working in education. Are there examples of when a practice of screening all/some students was or would have been helpful?
- Do you have any concerns about the practice of mental or behavioral health screening in schools? Are there examples of when practices of screening all/some students was not or would not have been beneficial for a particular reason?
- Please make any suggestions to ISBE of issues that should be considered when approaching the topic of mental and behavioral health screening of students.
- What are the three most important issues that need to be addressed to support your school/district administering screening?
- If your school/district uses any mental or behavioral health screening tools, please share any successes or challenges that may inform this landscape scan.
- Please share any positive outcomes that have resulted from screenings in your school/district, including in the realms of discipline, interpersonal relationships, or bullying.

Parents/caregivers guiding questions and prompts:

- What is your experience with mental and behavioral health screening in schools? Or, have you or your child ever participated in a mental or behavioral health screen in the school context?
- Please share your general thoughts about screening students in Illinois public schools for mental and behavioral health issues.
- Are there examples of when a practice of screening all/some students was or would have been helpful for your child?
- Do you have any concerns about the practice of mental or behavioral health screening in schools? Are there examples of when practices of screening all/some students was not or would not have been beneficial for a particular reason?
- Please make any suggestions to ISBE of issues that should be considered when approaching the topic of mental and behavioral health screening of students.
- If your school/district uses any mental or behavioral health screening tools, please share any successes or challenges that may inform this landscape scan.
- Please share any positive outcomes you have observed in your child that have resulted from screenings in your school/district, including in the realms of discipline, interpersonal relationships, or bullying.

Youth guiding questions and prompts:

- What is your experience with mental and behavioral health screening in schools? Or, have you ever participated in a mental or behavioral health screen in the school context?
- Please share your general thoughts about screening students in Illinois public schools for mental and behavioral health issues.
- In your experience as a student, are there examples of when a practice of screening all/some students was or would have been helpful?

- Do you have any concerns about the practice of mental or behavioral health screening in schools? Are there examples of when practices of screening all/some students was not or would not have been beneficial for a particular reason?
- Please make any suggestions to ISBE of issues that should be considered when approaching the topic of mental and behavioral health screening of students.
- If your school/district uses any mental or behavioral health screening tools, please share any successes or challenges that may inform this landscape scan.

Consent information (youth consent and assent were adapted from this language):

Informed Consent

You are invited to join a conversation about the possibility of screening for mental health concerns in schools. This conversation will help the Illinois State Board of Education (ISBE) to improve schools' ability to help young people who are dealing with mental health challenges. These efforts are based on recommendations from the Blueprint for Transformation: A Vision for Improved Behavioral Healthcare for Illinois Children.

Your participation in this study is voluntary. You may decide not to answer any question or to end your participation at any time with no punishment or consequence.

If you consent to participate in this study, you would participate in a virtual "listening session" (a group discussion with 5-10 other youth, ages 15-25) with researchers from Chapin Hall at the University of Chicago as part of the Illinois Children's Behavioral Health Transformation Initiative. Illinois State Board of Education staff will sit in to hear the feedback, but they will be listening only. The listening session will last about 90 minutes.

The conversation will not be recorded, but one of the researchers will take detailed notes. No names or identifying information will be written in the notes. You may choose how much or how little you want to speak during the session.

Your participation will help the State develop plans for in-school mental health screening; there is no risk to your participation in this discussion, except possibly feelings of distress that may come up in talking about mental health issues.

The information you share with us will be kept completely confidential except for if you disclose any abuse or neglect (which is legally required to be reported to the Illinois Department of Children & Family Services) or risk of harm. The researchers will do our best to keep all information you share confidential. We cannot guarantee that everyone in the group will keep the discussion private, but we will ask that everyone please not share these conversations outside of this group to keep them confidential. Reports that include information learned during the listening sessions will not include any identifying information.

If you have any questions about this study, please contact the project's Primary Contact, Louisa Silverman at lsilverman@chapinhall.org. If you have questions about your rights as a research participant, please contact the University of Chicago Institutional Review Board at irb@crownschool.uchicago.edu or 773-834-0402.

Verbal Consent

By verbally consenting to taking part in this listening session, you acknowledge that you understand and accept all of the information provided to you. Do you voluntarily give consent to participate in this listening session?