BLUEPRINT for TRANSFORMATION

A Vision for Improved Behavioral Healthcare for Illinois Children

February 2023

IDHS Illinois Department of Human Services

Illinois Department of DCFS Children & Family Services

Illinois Department of Juvenile Justice

HFS Illinois Department of Healthcare and Family Services

Illinois State Board of Education

IDPH Illinois Department of Public Health

Acknowledgements

This report presents an overview of the findings and recommendations of the Illinois Children's Behavioral Health Transformation Initiative as well as data analyzed by Chapin Hall at the University of Chicago for the purpose of understanding the children's behavioral health system.

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I. Executive Summary

In response to a nationwide youth mental health crisis, Governor JB Pritzker launched the Children's Behavioral Health Transformation Initiative ("Transformation Initiative") in March 2022 to evaluate and redesign the delivery of behavioral health services for children and adolescents in Illinois. The Transformation Initiative builds upon the substantial progress made by Illinois agencies to ensure that every young person experiencing mental or behavioral health problems can access needed services. By identifying and addressing current barriers to delivering efficient and effective care, the Transformation Initiative hopes to improve the State's ability to offer families a set of streamlined, accessible, and responsive solutions.

The Governor empowered the Transformation Initiative to analyze systemic problems and, in collaboration with the six child-serving State agencies, to develop creative, evidence-driven solutions in order to achieve five goals:

1. **Adjust capacity—**so that there are *enough* of the services we need
2. **Streamline processes**—so that services can be *easily accessed*
3. **Intervene earlier**—so that acute crises can be *prevented*
4. **Increase accountability—**so that there is *transparency* in service delivery
5. **Develop agility**—so that systems can be *responsive* to the changing needs of the youth population

To develop the recommendations in this report, the Transformation Initiative engaged hundreds of stakeholders, analyzed dozens of statutes and policies, analyzed administrative data, and researched best practices from states and counties across the country to arrive at a Blueprint for Transformation. Reporting to the Office of Governor JB Pritzker and with substantial support from the Illinois Departments of Children and Family Services (DCFS), Human Services (DHS), Healthcare and Family Services (HFS), Juvenile Justice (DJJ), Public Health (DPH), and the State Board of Education (ISBE), the Transformation Initiative has tested new strategies while developing recommendations for a better system.

Together, we envision a transformed children's behavioral health service system that provides clear, consistent, and comprehensive guidance to families seeking behavioral or mental health services for the children and youth in their care. The transformed system will be appropriately resourced to ensure that services are available to everyone who needs them without barriers to access; make good use of technology to facilitate efficient, equitable, and easy access to care; be informed and adjusted in accordance with parent leadership and representation of people with lived experience; deliver care together with provider agencies through collaborative and reliable partnerships; incorporate public health approaches to intervene early and prevent severe or acute problems; and achieve better outcomes for children and families.

The Transformation Initiative is proposing a plan that addresses both ends of the service continuum—streamlining and improving access to high-end services like residential treatment, while also broadening the reach of prevention and early detection. This requires accurate estimates of the numbers of youth in need of outpatient behavioral health services by community and adequate resources to provide high-end behavioral health care, like residential treatment, to those who are eligible. While the Transformation Initiative has made progress in this area (described below), developing accurate estimates has been challenging due to disconnected data systems and imprecise methodology. To understand the population of youth addressed by this report it is important to note that an estimated 2,215 youth require residential treatment each year, while more than 165,000 children ages 0-20 received a Medicaid-paid outpatient MH service in FY22[1]. To chart a course toward a transformed child and adolescent behavioral health system,

1. This number (165,000) is likely an underestimate of actual need, as it does not account for youth who are not covered by Medicaid or those who need mental health interventions they have not received.

I. EXECUTIVE SUMMARY

this report sets out twelve strategies to streamline processes, build capacity, and improve the State's ability to provide services earlier to prevent more serious problems. They are:

1. Create a **centralized resource for families** seeking services for children with significant and complex needs. This will involve building a more robust intake portal to allow families to more easily access information and help.
2. **Improve coordination** of service delivery, ensuring more seamless transitions and detecting elevated risk earlier.
3. **Centralize oversight of residential beds** to reduce duplication and enable the State to more effectively manage residential treatment resources.
4. Implement **resource referral technology** to enable families to more easily link to services in their communities.
5. Use **regular data analytic review** to inform provider capacity adjustments, allowing service availability to be adjusted with agility.
6. **Adjust rates,** including standardizing rates for similar services across State agencies, to ensure that providers are compensated consistently and that youth can receive the services they need to thrive.
7. **Increase capacity** to serve more children and families by expanding eligibility for current programs and developing new service types so that Illinois has a full continuum of care.
8. **Partner with providers** on a standard protocol to encourage consistent and transparent development of new programs to meet emerging needs.
9. Offer **universal screening** in education and pediatrics to ensure that mental and behavioral health problems are detected and addressed early.
10. Facilitate **information sharing** across State agencies to improve seamlessness and timeliness of interventions, leveraging previous efforts to integrate data and overcome barriers.
11. **Build workforce** using paraprofessionals and supporting other roles with incentives and creative approaches to credentialling.
12. Fortify **community networks** by investing in local communities and parent leadership.

A phased implementation of recommendations will prioritize the most impactful and feasible changes as well as those necessary to establish a foundation so that subsequent changes can be made. The Blueprint outlines the short-, medium-, and long-term goals for implementing these strategies. In the near term, steps are being taken to develop a robust Intake Portal for parents and families seeking access to residential interventions, to increase the State's ability to deliver comprehensive and flexible services and supports to stabilize youth, to improve the State's ability to manage residential treatment resources, and to leverage existing partnerships with advocacy and advisory groups. The next set of changes will involve the development and implementation of technological strategies to speed and improve access to outpatient mental health care and to develop programs that need to be expanded or added. In the long term, the Transformation Initiative aims to institutionalize data-guided capacity adjustments, expand the mental health workforce, and implement strategies to promote equity and trust among youth, families, and provider partners.

Each of these approaches is a starting point, from which specific shifts may include legislative, policy, process, and practice changes, ongoing data analysis, staffing and fiscal implications, and technological innovation. The Transformation Initiative will continue to leverage broad support for systemic change by raising awareness of these strategies and working in partnership with the systems, agencies, and individuals who can put them into action. This will culminate in an implementation plan that will be submitted to the Governor in October 2023 to guide ongoing transformation work.

II. Introduction

Illinois is on the cusp of transformation, built upon efforts by multiple State agencies to change the way they recognize and address the needs of children and families. Since 2018, the State has taken strategic steps to implement systemic reforms in conjunction with the N.B. Consent Decree[i], which requires the Illinois Department of Healthcare and Family Services to design and implement a model to provide class members[2] with medically necessary intensive home- and community-based services. Similarly, the Illinois Department of Children and Family Services has developed strategies to meet the behavioral health service needs of youth in State custody[3] in accordance with the B.H. Consent Decree[ii]. The Illinois Department of Human Services has developed strategies to promote the least restrictive placements of individuals with developmental disabilities and mental health service needs in accordance with Olmstead, Bogard, Ligas, Williams, and Colbert Consent Decrees. The Illinois Department of Juvenile Justice has also embarked on historic efforts to reduce the number of incarcerated youth while recognizing and addressing service needs resulting from trauma and other challenges.

It is against this backdrop of progress and intensive effort that the Transformation Initiative aims to build a fully functioning, comprehensive system of services and supports for children and adolescents that is fortified by community networks, parent leadership, state of the art technology, and interagency coordination. Illinois will build this system upon the foundation of existing structures, by knitting together the various functions and operations of multiple entities that have evolved on separate paths. This integration and coordination will provide services to youth that are more consistent, continuous, and comprehensive. With an unprecedented degree of interagency collaboration and the leadership of an administration committed to improving the mental health of children and adolescents, the State has undertaken an historic effort to understand, document, and reshape the ways in which children and families access care. This report describes the collective work toward a new vision for a coordinated children's mental health service system, providing context for the current crisis, analyses and findings related to the challenges we face, a set of recommendations for system transformation, and a clear plan for achieving these goals.

Together, we envision a transformed children's behavioral health service system that provides clear, consistent, and comprehensive guidance to families seeking behavioral or mental health services for the children and youth in their care. The transformed system will be appropriately resourced to ensure that services are available to everyone who needs them without barriers to access; make good use of technology to facilitate efficient, equitable, and easy access to care; be informed and adjusted in accordance with parent leadership and representation of people with lived experience; deliver care together with provider agencies through collaborative and reliable partnerships; will incorporate public health approaches to intervene early and prevent severe or acute problems; and will achieve better outcomes for children and families.

2. N.B. Class consists of all Medicaid-eligible children under the age of 21 in the State of Illinois who have been diagnosed with a mental or behavioral disorder; and for whom a licensed practitioner of the healing arts has recommended intensive home- and community-based services to correct or ameliorate their disorders.
3. B.H. Class consists of all persons who are in the custody of the Illinois Department of Children and Family Services and who have been placed somewhere other than with their parents.

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Background

System Overview

The Illinois public children's behavioral health system is comprised of the services and programs administered by:

- The Illinois Department of Healthcare and Family Services (HFS): This single state Medicaid agency administers and coordinates Medicaid benefits for nearly 1.5 million children, or an estimated 50% of the children in the state.
- The Department of Children and Family Services (DCFS): The child welfare agency provides child protection response to reports of abuse or neglect, placement for 22,000 youth in its custody, and in-home services to 4,000 families to prevent youth being separated from their parents or caregivers.
- The Department of Human Services (DHS) provides the State's residents with access to integrated services across the Divisions of Mental Health, Developmental Disabilities, and Substance Use Prevention and Recovery.
- The Department of Juvenile Justice (DJJ) houses and provides services to 145 youth in secure custody and 183 youth who are monitored and supported on Aftercare in communities throughout the state.
- The Illinois State Board of Education (ISBE) sets educational policies and guidelines for public and private schools and coordinates the efforts of over 850 school districts serving 2 million children in Illinois. ISBE oversees the distribution of federal Special Education funding to local districts, which can be used to support residential placement when required by a youth's Individualized Education Plan (IEP).
- The Illinois Department of Public Health (DPH) regulates inpatient care, including pediatric psychiatric hospital units, and provides education and outreach to promote awareness of mental and behavioral health concerns.

Each of these agencies has their own jurisdiction, mission, budget and potential constraints (for example, state and federal statutes, regulations, and mandates) that constitute Illinois' publicly funded children's mental health system. Together, they are intended to support the State's estimated 2.8 million children.

In addition to the State agencies, there are many entities across Illinois that provide navigational assistance, services, and infrastructure supports. While these efforts have produced targeted improvements, without a centralized access point or coordinated structures and processes, *what* families receive depends on *where* they start, and navigating different paths to services can be frustrating for parents who are already challenged by their children's distress. For example, families seeking high-end services or residential placement find there are five distinct ways to obtain support for residential interventions. Eligible youth may access these services through the Family Support Program (HFS) or the Developmental Disabilities Waiver (DHS Department of Developmental Disabilities). Youth who require residential placement in order to receive an education may be eligible for school district-supported placements, and youth in custody of the State may be placed in residential treatment settings by DCFS or DJJ (Figure 1).

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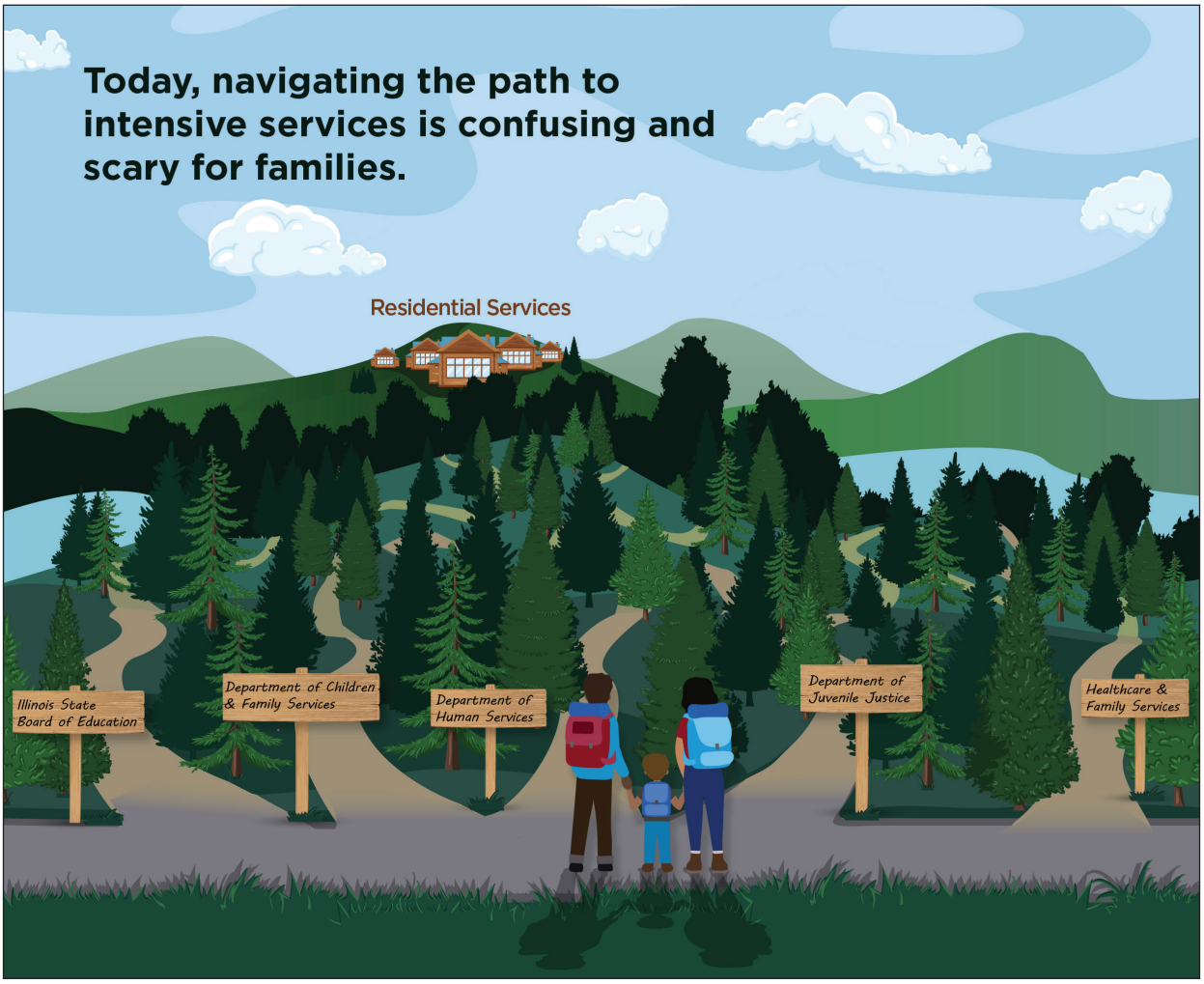
Figure 1. Current Pathways to Residential Treatment



Leveraging all of these efforts in the context of a single coordinated strategy can elevate the Illinois service delivery system and accomplish true transformation.

Increased demand and insufficient capacity

Like states across the country, Illinois is experiencing a youth mental health crisis. While Mental Health America's 2023 report ranks Illinois 13th-best overall based on a set of factors related to youth mental health and access to care, nearly 40% of young people in Illinois who experienced major depressive episodes were unable to receive mental health care.[iii] Nationwide, rates of mental health conditions among children and adolescents have increased. The Adolescent Behaviors and Experiences Study, conducted by the Centers for Disease Control and Prevention in 2021 to understand the impact of COVID-19 on youth mental health, documents that 44% of youth nationwide reported depressive symptoms that lasted for at least two weeks, and 20% of youth experienced suicidal ideation.[iv] And, according to the U.S. Surgeon General, nationally it takes an average of 11 years for a young person with an identified mental health service need to receive treatment.[v]

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In Illinois, these problems are compounded by a workforce shortage, an eroded continuum of care, misalignment in the geographic and clinical distribution of services, and, historically, fragmented processes across State agencies that have resulted in an inadequate array of supports and placements for youth with significant and complex behavioral and mental health needs. This has resulted in substantial wait times at several points in the service continuum, including in emergency rooms and psychiatric inpatient units. In some cases, parents have chosen to give custody of their children to the State in an attempt to secure residential placement or payment for psychiatric services. This practice, discouraged by the Child Relinquishment Prevention Act,[4] causes unnecessary family separation and does not address placement problems caused by insufficient capacity.

Further, there are significant racial/ethnic and income disparities in the prevalence rates of many illnesses and conditions, including depression.[vi] Specifically, the rate of having had four or more adverse childhood experiences (ACEs)[5], as well as the rate of several Social Determinants of Health[6], are higher among Black Illinois residents than for other groups.[vii] These experiences and circumstances affect brain development and change the way bodies respond to stress, which creates significant risk factors for a wide range of physical and mental health problems.[viii] This underscores the need for a refined strategy for estimating service need that accounts for the distribution of contributing factors (e.g., economic hardship, exposure to violence) to ensure that system transformation achieves equitable access to care.

Across the country, community and residential services are in short supply. In Illinois, progress is underway to address these shortages. Developed in accordance with the N.B. Consent Decree, the Pathways to Success program is anticipated to provide an expanded, comprehensive array of home- and community-based services for Medicaid-eligible children under 21 with intensive needs. While this development is expected to have significant positive impacts on the State's behavioral health ecosystem, Illinois must build capacity to deliver some services that will be necessary to ensure that youth mental health problems can be addressed *before* crises occur. These services include community-based prevention, evidence-based treatments for trauma and other problems, intensive in-home supports, intensive outpatient or day treatment, partial hospitalization programs for youth who may be able to receive acute intensive care outside of the hospital setting, and transitional residential programs for youth to sustain psychiatric stabilization after receiving acute inpatient care.

HFS continues to proceed with implementation of the NB Implementation Plan in close consultation with the Court-appointed Expert and a team of national experts as well as a subcommittee of the Medicaid Advisory Committee (MAC). Other steps taken by HFS as part of the NB Implementation Plan include:

- implementation of a statewide mental health assessment and treatment plan, known as the Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS) and a supporting web-based IM+CANS Portal to collect clinical data on youth receiving services; introduction of new behavioral health services[7] and new provider types[8] under the Medicaid State Plan across the continuum of care;

4. The Custody Relinquishment Prevention Act, 20 ILCS 540, requires DCFS, DHS, and other state agencies to enter into an interagency agreement to prevent children and youth from entering the custody or guardianship of DCFS solely in order to receive services for serious mental or emotional problems.
5. Adverse Childhood Experiences (ACEs) are potentially traumatic events that occur in childhood, including but not limited to violence, abuse, and growing up in a family with mental health or substance use problems.
6. Social determinants of health (SDOH) are the nonmedical factors that influence health outcomes, including the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.
7. New services include crisis stabilization; integrated assessment and treatment planning; Psychiatric Collaborative Care Model; Screening, Brief Intervention and Referral to Treatment (SBIRT); adaptive behavior supports including applied behavior analysis (ABA); and violence prevention community support teams.
8. New provider types include Behavioral Health Clinics, Licensed Clinical Professional Counselors and Licensed Marriage and Family Therapists, Board Certified Behavior Analysts, Registered Behavior Technicians, and Developmental Technicians.

- implementation of a Behavioral Health Decision Support Model designed to stratify youth into tiers of care coordination and service intensity based upon their individually assessed needs;
- launch of the Provider Assistance and Training Hub (PATH) within the University of Illinois;
- installation of Family Leadership Councils through each of the HFS-contracted Managed Care Organizations (MCOs); and
- execution of new contract deliverables for MCOs, outlining enhanced responsibilities for coordinating and standardizing children's mental health services and operational processes.

Fragmented system and tangled processes

The patchwork of strategies and programs to address youth behavioral health needs deployed by the State has evolved over time independently, such that eligibility and service availability vary by agency, program, and mandate. At the community level, this means that there is no single hub for access to behavioral health care. For youth with significant and complex challenges, this means there are multiple "front doors" through which families enter to receive assessment, eligibility determination, and needed services or placement.

Multiple state agencies operate programs that provide services to support children's behavioral health, but there is minimal systematic coordination and no holistic, developmentally informed approach to meeting youth needs. With no central point of entry to help families navigate, children and families must access services differently across agencies, meet agency-specific eligibility requirements, and maintain access to services with minimal supports. Subject matter experts repeatedly identified system fragmentation as a barrier to supporting the behavioral health of children and youth, highlighting that it presents both challenges to service access for children and families and challenges to service delivery for providers and state agencies.

Additionally, in the current siloed system, there is no systematic mechanism to communicate the array of services and resources available to families across state agencies. This highlights the need to provide community education on existing programs to increase the ease with which families can identify and access available services. It is critical that state agencies continually ensure that publicly available information on existing resources, services, and the method by which they can be accessed is accurate and up-to-date, easily accessible, and communicated in plain language. During interviews and focus group discussions, both parent and youth experts described challenges experienced accessing services and expressed a desire for more information about the mental health services and supports that are available and how to access them. As hospital social workers and others have observed, when families cannot locate services for youth, untreated challenges worsen over time.

There is also a need to increase awareness of resources among stakeholders engaged in supporting youth behavioral health. For example, hospital social workers expressed the need for greater communication and awareness of psychiatric resources among medical professionals. In addition, parents explained that even after they started receiving services, they did not fully understand the processes involved in service delivery and how they could most effectively engage in and support their child's treatment (e.g., questions to ask, services and supports available to them, parents' and child's rights, effective advocacy). Youth expressed that they do not know who to turn to for support with their behavioral and mental health challenges and have a difficult time identifying helpers they can trust who can empathize with and understand their experiences.

The fragmented system is further complicated by inconsistency in how terms are defined and utilized across child serving agencies and programs. Each program offers multiple categories of services, and services are not uniformly categorized across (or within) state agencies. For example, each state agency uses a slightly different definition for "crisis." Consequently, each state agency has similar yet separate and distinct crisis response systems, each with their own service definitions, operations, and payments. Similarly, services with the same name may refer to a different

array of interventions or have different requirements for eligibility and funding. For example, family peer support will be provided as a standalone service in the Pathways to Success program, whereas the Department of Human Services offers peer support as a Community Mental Health Non-Medicaid Enhanced Service. The lack of shared language makes it challenging to easily assess and compare service availability across state agencies. It may also cause unnecessary confusion among individuals seeking out services and may make it difficult to monitor for service duplication and gaps across state agencies.

Transitions heighten vulnerability—yet the current children's behavioral health system pays minimal systematic attention to the developmental significance of transition periods and the necessity of supports to promote success during these challenging periods. Whether because age-based requirements and eligibility periods vary across and within agencies, or because agencies wait too long to begin planning for anticipated changes, transitions between levels of care (following hospitalization) or between child- and adult-serving systems pose challenges in the context of agency silos. Even definitions of simple terms can have complex variations in meaning and implications. For example, the term "child" or "youth" can vary across state agencies. For purposes of Medicaid eligibility, the term "child" refers to an individual under 21, and for implementation of the Family Support Program HFS uses the term "youth" to refer to individuals under age 18 (IL.admincode.139.110). At DHS, "youth" are minors under 21 years of age (IL. admincode.310.2) and at DCFS, youth are at least 16 years but less than 18 years of age (IL.admincode.409.20). The ways in which terms are defined have implications for the services for which individuals are eligible; these issues are further clarified in Appendix E – Eligibility Crosswalk.

It is important to center youth, parents, and family members in this effort; youth and parents expressed the need for youth- and family-centered service delivery and the need to be more meaningfully included in service decisions and the development of treatment plans. Subject matter experts repeatedly highlighted the role of formal and informal relationships in supporting children's behavioral health, accessing and navigating service systems, and facilitating service delivery. Parents and youth who expressed the need to incorporate peer support into the behavioral health system also recognized the need for greater diversity and representation within the workforce. They explained that they need the support of clinicians and mentors who can understand and empathize with their experiences. Despite the importance placed on supportive relationships, they are rarely identified as components of successful service delivery or systematically assessed, monitored, or evaluated in relation to treatment outcomes.

Missed opportunities to intervene early

In the context of the current crisis, the emphasis on institutional and other high-end supports may overshadow efforts to support behavioral health promotion and prevention-focused efforts. In most cases, the onset of mental health problems is gradual. Many problems have signs and symptoms that develop over time; if recognized, they offer an opportunity to intervene early. Intervening early is more effective and less costly to children, families, and society than more intensive interventions to address severe problems and crises. Earlier interventions provided in children's natural community-based settings can alleviate the need for acute care. Approaches vary in intensity but are all intended to keep children and youth functioning within their home environments and prevent escalation of difficulties. It is important to understand what exists, or does not exist, in the current mental health care continuum that may lead to missed opportunities to intervene early.

Intervening early requires early detection of problems. Consistent with recommendations from the American Academy of Pediatrics[ix], mental health screening occurs in some places and contexts in Illinois. Screening occurs in mental health treatment programs as well as some schools, pediatric practices, childcare centers, home visiting programs, Federally Qualified Health Centers and other settings, and through websites such as Mental Health America. However, there is no coordinated effort to ensure universal screening in the context of school and pediatric settings, where almost all youth have regular touchpoints with professionals who could be trained to detect and identify mental health concerns early.

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The ability to distinguish early indicators of problems from typical development requires an understanding of the issues, challenges, and milestones that affect children and adolescents at various stages. Parents, providers, and stakeholders who have a developmental context for understanding problems will be better prepared to meaningfully interact with and support youth they regularly encounter. This depends upon the availability of developmentally informed supports, which can be delivered through warmlines, mobile response units, public awareness campaigns, community networks, and other resources that prepare adults to recognize and respond to potential child behavioral health challenges or behavior changes.

In the case of children exhibiting aggressive and oppositional behavior problems, early recognition (at ages 2–8 years old) allows effective treatment with parenting interventions such as the Chicago Parent Program,[9] a "behavioral parent training" model.[x] These models are effective for reducing problems and increasing parents' skills in behavior management and positive relationship development. When the early signs of behavior problems are missed or ignored, in some situations they grow and develop into harmful behaviors that lead to family disruption, school failure, justice interactions, and institutional levels of care.

Intervening earlier will require commitment to educating the array of stakeholders on the developmental needs of children, how the needs and capacities of children and adolescents change over time, and how community conditions and surrounding adults can support or hinder development. There will also need to be a coordinated effort to introduce screening for mental and behavioral health concerns into pediatric and education settings.

In summary, to achieve transformation Illinois must *adjust capacity, streamline and centralize processes,* and *intervene earlier* in the context of a system that operates with *accountability* and *agility.* This Blueprint addresses these three areas with a set of strategies, targets for improvement, and a clear plan for achieving sustainable change in our ability to meet the needs of young people who are struggling.

Response – Children's Behavioral Health Transformation Initiative

To respond to the current crisis, in March 2022 Governor Pritzker announced the Children's Behavioral Health Transformation Initiative (Transformation Initiative). The Transformation Initiative aimed to identify a set of strategies for improving the state's ability to respond to young people experiencing mental health challenges and improve the transparency and ease with which their families could seek services. Specifically, the Initiative was tasked with building a coordinated, interagency approach to ensure that young people with significant behavioral health needs receive the community and residential services that they need to thrive while providing parents, guardians, and family members with transparency and clarity in the process.

To accomplish these tasks, the Initiative included three components: *engagement* with key stakeholders, agency leadership, provider partners, and families and youth with lived experience; *analysis* of data, policies, documents, and best practices for improving children's behavioral health care nationwide; and *coordination* to lead, model, facilitate, and test strategies for overcoming siloed approaches to collaboratively serving youth. These activities were designed to culminate in a roadmap or "Blueprint" for transformation. In its first year, the Initiative accomplished key milestones in each of these areas.

The plan that follows represents the convergence of perspectives, accumulated experience working to overcome barriers and expedite services and placement for the highest-need youth, and rigorous and comprehensive analysis of data from both state agency administrative and publicly available sources in order to understand the scope and nature of children's mental health needs in Illinois and to develop strategies to effectively address them. The Transformation Initiative worked closely with a team of policy, research, and data analysts at Chapin Hall at the University of Chicago.

9. The Chicago Parent Program is a 12-session, evidence-based parenting program created for parents of young children (2–8 years old) and designed to meet the needs of a culturally and economically diverse audience.

II. INTRODUCTION

Chapin Hall is an independent policy research center that provides public and private decision-makers with rigorous research and achievable solutions to improve the lives of children, families, and communities. Data analytic procedures and findings are detailed in the appendices to this report.

ANALYTIC STRATEGIES

Quantitative Data Analysis and Linkage Chapin Hall combined data from DCFS (on youth who are in state custody and require residential intervention), HFS (on youth who receive residential interventions through the Family Support Program and the DD Waiver), and ISBE (on youth who receive residential interventions through local school districts) to estimate current extent of specific obstacles to effective behavioral health care for adolescents in Illinois. These analyses have identified discrete subgroups of youth with specific programmatic needs and policy implications and are detailed in Appendix B.

Qualitative Data Analysis Chapin Hall staff conducted interviews and focus groups with a range of stakeholders (n=720) to understand the perspectives and experiences of Illinois children and families as they attempt to obtain behavioral health care. This included interviews with subject matter experts, including senior agency leadership, program staff, hospital social workers, provider partners, advocates, parents, and youth who shared their in-depth knowledge of the current system. Detailed documentation of engagement throughout the initiative is included in Appendix F.

Best Practice Research To understand successful practices in children's behavioral health, Chapin Hall staff examined promising practices from across the country. During this review, the Chapin Hall team gathered information through interviews with executive leadership from state agencies and service providers to learn more about their programs. During these interviews, the team discussed with leadership the strengths of their programs, current challenges, planned future modifications, costs, and considerations for implementation in Illinois.

Policy Review To understand how to improve coordination and service delivery across the five key state agencies who support children's behavioral health, Chapin Hall staff explored the agency-specific policies and procedures that guide the provision of behavioral health services throughout the state, as well as legislation and policy that outline requirements for cross-agency collaboration. This included enacted and proposed legislation, administrative code, funding requirements, provider manuals, annual service reports, current consent decrees, evaluation and assessment requirements, and interagency agreements, among others. The team then focused analysis on policies that guide access to and the provision of educational services and school-based supports; policies that guide access to services for individuals who have a developmental disability via the Prioritization of Urgency of Needs (PUNS) database; and policies that guide the monitoring and oversight of residential treatment providers. In addition, we explored how state agencies support individuals and their families across the transition to adulthood, a critical period of development when many must shift from child to adult service systems.

Business Process Maps Chapin Hall used policy and practice documents to visualize the paths to commonly accessed services, including the (1) psychiatric hospitalization via the Mobile Crisis Response program; (2) transition from institutional to community-based care; (3) residential treatment services (via the Department of Human Services Developmental Disabilities Waiver, the Family Support Program, and ISBE); (4) access to special education services; and (5) transitions from the child service system to the adult service system. Business process maps illuminated various entry points through which individuals access services and how agency-based program eligibility requirements create multiple avenues to service provision. Process maps also illuminated factors beyond initial program eligibility criteria that may limit or influence access to services and illustrate the ways in which agency-based institutional requirements drive service provision.

III. System Transformation Plan

Approach

Rigorous analysis of data, policies, practices, and perspectives has provided insight into a complex system that will require both *technical* and *adaptive* shifts. *Technical challenges* are problems that have concrete, logistic solutions, such as tools, assessments, IT systems, or capacity adjustments. *Adaptive challenges* require all system partners to change the way they *think* about their roles, their approaches, and the way they do their work. While technical challenges require resources, adaptive change requires deep engagement, coordinated effort, and a shared commitment to a changed vision for the future.

The recommendations outlined here guide both technical and adaptive changes to promote system improvement. These recommendations have been developed according to a set of principles:

Leverage existing strengths. The current children's behavioral health service system has evolved over decades, and many solutions have been implemented to incorporate best practices and iterate care in the context of existing constraints. While a re-envisioned system requires changes to longstanding structures and processes, it will also build upon the foundation of successful programs and robust infrastructure that the Transformation Initiative has worked to identify and understand.

Use data analytics to inform changes. Historically, state agency silos have created barriers to linking and analyzing data on the needs of children and adolescents that have limited our ability to accurately estimate how much and what kinds of services are needed. With strong support from all participating agencies, the Transformation Initiative has been able to overcome many of these barriers and produce an analysis that provides guidance for capacity adjustments. It is essential that the state leverage data to understand needs; applying a race equity lens to analytic work allows us to detect disparities and formulate strategies to address them by focusing on underlying issues.

Replicate best practices tested in Illinois or other jurisdictions. A thorough investigation of approaches to serving children and adolescents with mental health needs identified many examples across the country of practices that could be scaled or replicated to meet Illinois needs. Our examination of these approaches has included in-depth conversations with the developers of these approaches as well as the program staff who have implemented them to understand the factors that can facilitate or impede success.

Incorporate family and stakeholder input in plans for change. Any effort to improve or enhance behavioral health care must consider that parents, caregivers, and youth experience tremendous challenges in accessing existing programs and have invaluable insights on the processes that must be modified.

Test strategies before bringing to scale. While the necessary changes recommended here are broad and far-reaching, in some cases it will be important to test strategies on a smaller scale to ensure that approaches are stable and well supported by existing systems and roles. The selection of specific locations, programs, or providers for pilot implementations should also be guided by data identifying the most feasible targets with the greatest potential for immediate impact.

Utilize technology to improve efficiency. The human service sector lags behind other fields in the adoption and implementation of technology for the purpose of improving efficiency, precision, and access to services and supports. This report identifies numerous opportunities to leverage technological solutions to expedite and improve service access.

Leverage public-private partnerships. Behavioral health care in Illinois is characterized by a high degree of collaboration with private providers. While state agencies monitor and facilitate access to almost all types of behavioral health care, in most cases actual services are provided by private social service agencies, hospitals, and publicly funded community mental health centers. Addressing capacity shortfalls and improving service availability will require robust partnerships and approaches that ensure the sustainability of private provider agencies.

Enhance information sharing to enable more seamless, and earlier, intervention. Historically, the inability to share information between system partners has been one of the biggest barriers to providing continuity of care as well as prevention. The Transformation Initiative has been able to test strategies that promote information sharing conducive to interagency collaboration. Information sharing can also support earlier identification of elevated risk that can facilitate more successful attempts at early intervention.

Commit to a public health approach to prevention. Underlying all of these ideas is a core strategy that prioritizes the early identification and recognition of the need for behavioral health care among all children as a strategy to improve equitable access to behavioral health care. Over time, this approach will reduce the number of children needing acute care and allow more efficient and equitable provision of services.

It is important to note that there are many robust efforts underway to build and improve approaches that are related to children's behavioral health care. This plan was developed with awareness of and alignment with these efforts, which are envisioned as important components and supports for successful transformation. However, the Transformation Initiative did not conduct rigorous analysis of developments in the following areas:

- early childhood
- substance use prevention and recovery
- adult mental health
- telehealth
- pediatric consultation

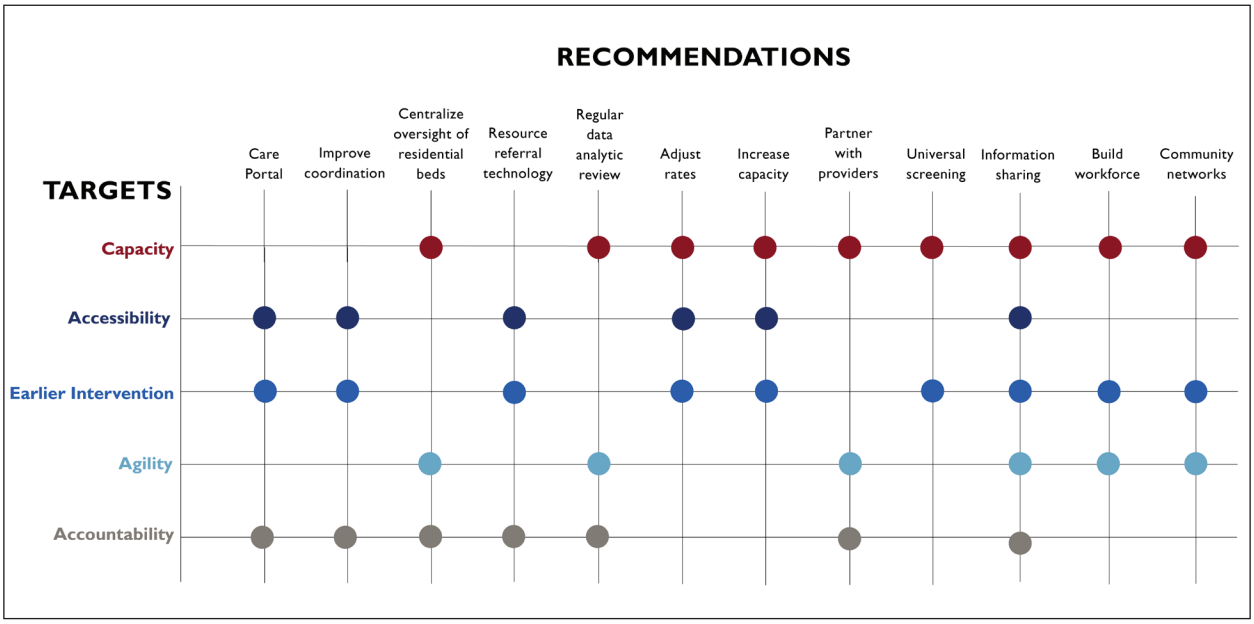
Implementation planning will proceed in collaboration with initiative in these areas to ensure that shared goals are met for access to needed mental health care across the lifespan.

Targets for System Improvement

When asked what they want to see in an improved behavioral health service system, most stakeholders identify the importance of having *enough* of what people need, delivering services *early* to prevent more serious crises, and making services *easier* for people to access. While these three issues (capacity, accessibility, and earlier intervention) are all primary targets of our system transformation efforts, there are two additional targets to ensure that Illinois can provide services in a timely and responsive manner regardless of changes in the needs of Illinois youth: we also aim to improve a*ccountability* and *agility. Accountability* refers to transparency and responsibility among provider partners and state agencies to ensure that services are delivered as promised and outcomes of recovery and healing can be achieved by youth with the help of these services. *Agility* refers to our ability to pivot when changes in service offerings, eligibility, location, or intensity are required to meet the changing needs of the population.

To achieve these five targets will require a set of interconnected activities as well as a set of structural changes to support the implementation of recommendations. Multiple strategies are needed to ensure that each target can be met; each strategy has a role to play in achieving multiple targets. The relationship between the 12 core strategies and five targets for system transformation is displayed in Figure 2.

Figure 2. Relationship between Core Strategies and Targets for System Transformation



Recommendations

Overview

Meeting the current system challenges requires an array of strategies that address identified targets. While there are 12 key strategies to pursue (see Figure 3), there are many more granular changes to policy, procedure, and practice that will be necessary to ensure these strategies can be implemented successfully and effectively for improving service delivery to young people. This section provides a description of the strategies that should be undertaken, noting implementation considerations for each strategy. A subsequent phase of this work will focus on the development of detailed implementation plans that identify phases, data elements, IT, staffing, and training considerations.

Figure 3. Overview of the 12 Key Recommended Strategies

RECOMMENDATIONS – OVERVIEW		
Centralize and Streamline	Adjust Capacity	Intervene Earlier
1. Develop Care Portal as centralized resource for families seeking services for children with significant and complex needs. 2. Improve coordination of service delivery 3. Centralize oversight of residential beds. 4. Implement resource referral technology.	5. Conduct regular data analytic review to inform capacity adjustments. 6. Adjust rates, including standardizing rates for similar services. 7. Increase capacity by expanding eligibility and developing new service types. 8. Partner with providers in a standard protocol.	9. Offer universal screening in education and pediatrics. 10. Facilitate information sharing across agencies. 11. Build workforce using paraprofessionals and other roles. 12. Fortify community networks by investing in local communities and parent leadership.
Structural Changes: Centralized Hub, Coordinated Advisory Groups, Interagency Coordination, Data Analytic Support		

Centralize & Streamline

The first four recommendations are intended to make it easier for families to access services for young people with mental health concerns. These strategies will improve access to services, increase efficiency, reduce duplication, and promote transparency. They are driven by an understanding of the challenges families face in obtaining services, the multiple policies and programmatic requirements, and the importance of a developmental perspective that can fortify families, especially during vulnerable transitions.

1. *Develop a **Care Portal** as centralized resource for families seeking services for children with significant and complex needs.* Families need to know where to obtain information, referrals, and guidance for obtaining services for children and adolescents experiencing mental health problems. In a transformed system, this information will be readily available through numerous channels, and many people in positions to help (e.g., school personnel, case managers, and pediatricians) will be equipped with tools and technology that can maximize their ability to link families with services. Families whose children have complex needs for behavioral health services that include residential treatment need an easy-to-use entry point; to that end, the Transformation Initiative is recommending the development of a Care Portal that can simplify and streamline the process of obtaining care.

   In collaboration with the six child-serving agencies, the Transformation Initiative developed and tested a portal prototype from June through December of 2022. This proof-of-concept demonstrated the feasibility of a technological approach to promoting interagency collaboration as well as the permissibility of information sharing (with appropriate consents) for the purpose of expediting placements for youth with the greatest needs. The group collaboratively worked to identify appropriate interventions and obtain placements and services for 114 of the most challenging cases, resolving 46 (40%) of these through January 10, 2023. While the pilot portal was only tested with a small subgroup of informed stakeholders (approximately 40 legislators, hospital social workers, agency staff, and advocates), Figure 4 provides a description of the sources of these cases, and Figure 5 provides details on the current living arrangements of youth for whom residential placements were sought.

Figure 4. Referral Sources of the Most Challenging Cases

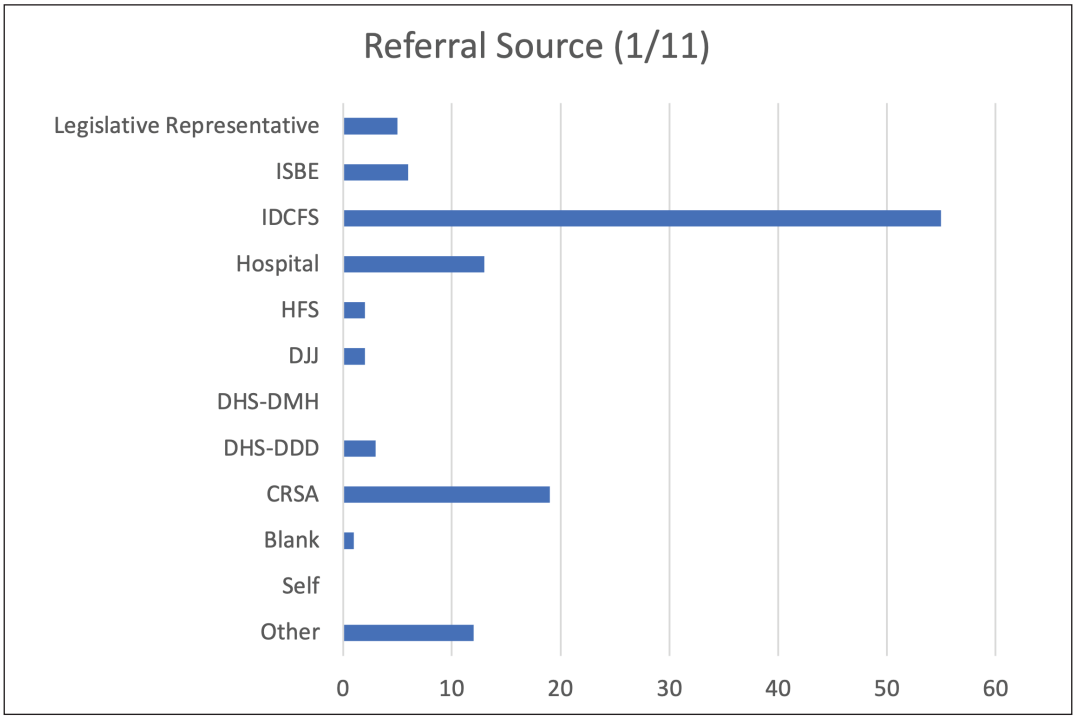
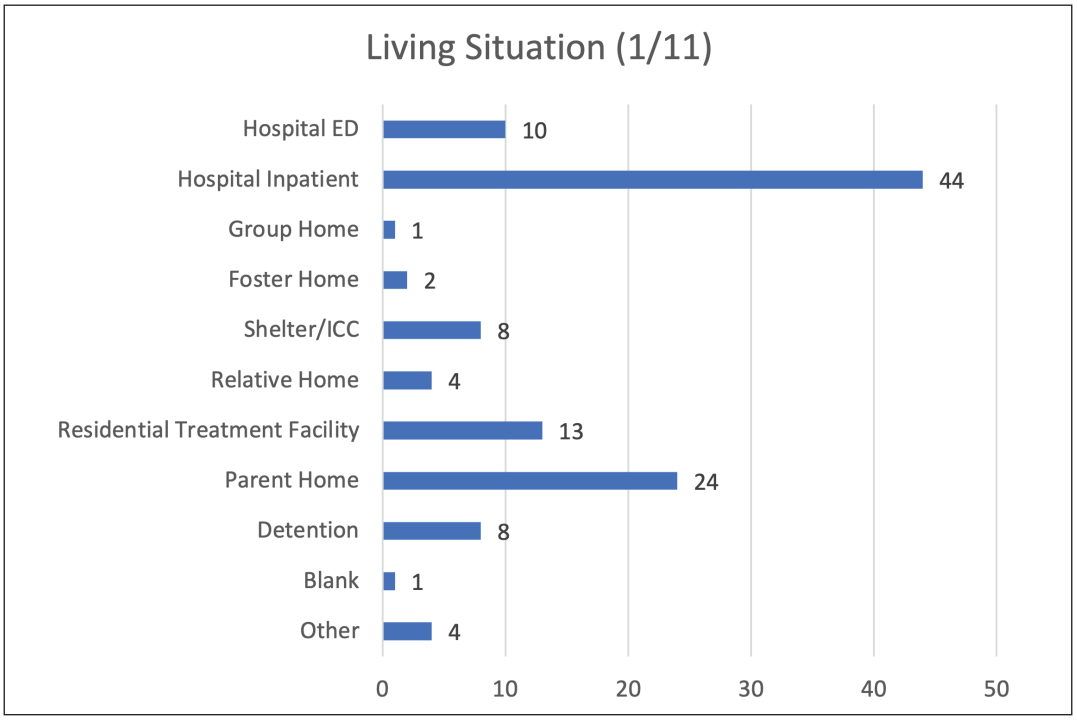
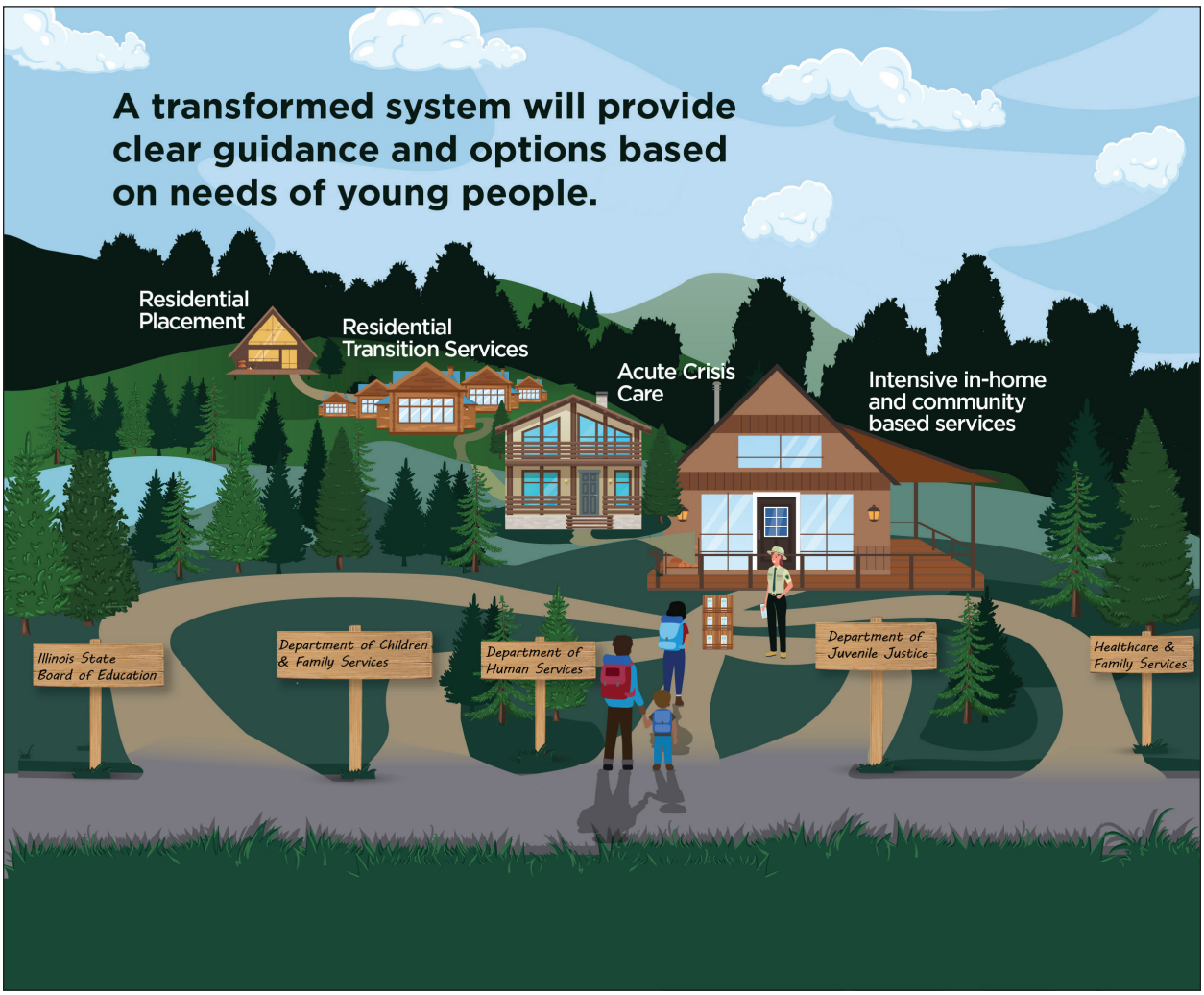


Figure 5. Current Living Arrangements of Youth Needing Residential Placements



Based on this pilot, a more robust Care Portal for children and families seeking behavioral health services can provide coordinated, cross-agency support to help families identify and access services to address their specific needs (see Figure 6). Depending on the level of need, the Care Portal can link families to Resource Navigators, existing warm/hotlines for informal assistance, and specialized guidance to begin the process of accessing care. This "front door" creates a new option for families to augment agency-specific paths, streamlining the user experience to direct families to the programs and services most equipped to meet their treatment needs with the most appropriate level and type of care. The approach can reduce the administrative burden on families by minimizing documentation requirements and submission of information at multiple points, promote information sharing (Recommendation 10) to enhance collaboration, and provide a data source for accountability and ongoing monitoring of the state's capacity to deliver needed services (see Recommendation 5).

Figure 6. A Transformed System Will Provide Clear Guidance and Options Based on Needs of Young People



A public-facing Care Portal will demystify the process of seeking residential treatment and allow concerned, involved adults (for example, parents, guardians, family members, teachers) to enter information and obtain a list of programs and services for which a youth might be eligible. Several state and local jurisdictions have intake forms or portals that allow them to triage cases based on need; consultation with these jurisdictions on their implementation of single point of access systems, centralized referral systems, intake portals, and referral forms has informed the Transformation Initiative's work on planning for an Illinois portal. Examples included:

- Idaho, where the infant and early childhood mental health consultation program is housed in the Department of Public Health.
- Washington and Massachusetts, who each use a partner organization to operate the referral system. Washington funds their program with Medicaid dollars.
- New York, where the Single Point of Access referral form is used by families to understand and access available services.
- New Jersey, whose System of Care also has a centralized system for accessing children's mental health services through their hotline.

- Sacramento County, CA, who staffs an Intake form that triages cases, expedites referrals, and tracks service needs.
- Colorado, where the state operates a user-friendly website that directs families to a variety of resources.

Locally, the National Alliance on Mental Illness (NAMI) Chicago staffs a robust resource "hotline" for the Chicago Metropolitan Area. In a 2021 report, NAMI Chicago reported more than 26,000 calls to their resource hotline from 2018 to 2021. While there was a significant increase in calls during 2020, these data show NAMI is a trusted resource for those with mental health needs. Callers requested services around mental health treatment, emotional support, resources for a mental health crisis, and information about basic needs like food and housing. Similarly, as part of the Illinois Mental Health Collaborative and in partnership with the DHS Division of Mental Health, Beacon Health operates a warmline that provides informal support and assistance with Certified Recovery Support Specialists. Both examples can be leveraged in partnership with a robust Care Portal to ensure that children at all levels of need receive necessary services.

Families seeking residential placements will still likely require assistance from *resource navigators,* who can help families understand and identify mental health resources and the processes for obtaining them. Resource navigators are critical to helping families navigate a complex mental health system and understand what they qualify for based on their insurance, the specific needs of their child and what resources might address those needs, as well as which supplemental resources, programs, and services that might alleviate the need for acute care or complement existing supports. The Community Residential Services Authority (CRSA) has traditionally provided navigational assistance and service linkage for families seeking residential care and could be relied upon to provide navigational assistance in the context of the Care Portal. CRSA has already been an active partner in implementing and testing the pilot portal with the Transformation Initiative.

The pilot implementation of the Transformation Initiative's Interagency Intake Portal, paired with information collected from other states using intake portals, provides a foundation on which to build. The Transformation Initiative has already implemented several key steps necessary for successful implementation on a large scale. These include negotiating interagency data sharing agreements and consent forms; developing an eligibility crosswalk to document the correspondence of child and family characteristics with available services (see Appendix E); developing basic processes for using the portal to expedite service delivery; testing with a diverse group of stakeholders, including legislators, hospital social workers, and the CRSA; and the development of metrics and indicators to monitor the timeliness and quality of interagency collaborative work in the service of expediting the provision of residential services. Further, data that has already accumulated on nearly 114 cases served by the pilot portal provide clear evidence of the barriers and opportunities to better serve families seeking care for significant and complex child and adolescent behavioral health care needs.

Plans for future development of a more robust system will include the following four key functions:

1. Match eligibility based on youth and family characteristics to provide information on available services.
2. Allow for information sharing between state agencies necessary to expedite service referrals where appropriate.
3. Display key metrics on service delivery using de-identified data from cases served through the portal on a "dashboard".
4. Provide regular reports to key system users that prompt needed and timely action on specific cases.

To implement this recommendation, **the Transformation Initiative recommends:**

- Partnering with existing hot/warmlines to understand patterns of inquiry and staff lower need cases;
- Finalizing technological specifications and identifying procurement or in-house development of a public-facing Care Portal;
- Developing a tiered approach to triaging Portal submissions and addressing service needs, which may require support from Resource Navigators, State agency Intake Coordinators and/or Clinical Specialists;
- Transitioning the Community Residential Services Authority to primarily focus on resource navigation assistance for families seeking residential services;
- Establishing staff roles at partner state agencies necessary to support Portal requests; and
- Working with key stakeholders to refine functionality and to ensure that metrics and indicators capture system performance for ongoing monitoring.

2. ***Improve coordination*** *of service delivery, ensuring more seamless transitions and earlier detection of elevated risk.* The effective delivery of services to children and youth with mental health needs depends upon our ability to assess, link, and manage service delivery. Whether youth are in state custody (as wards of DCFS or DJJ) or in their parents' care, an entity tasked with managing service delivery needs easy access to information about child needs and functioning as well as current information about local available service capacity. These tasks have been challenging for organizations with care coordination responsibilities (for example, MCOs and Independent Service Coordination agencies) because of system silos, barriers to information sharing, and the absence of a centralized technological platform to track and manage information about available mental health services.

   The N.B. implementation plan developed by HFS includes contractual requirements for MCOs to provide enhanced care coordination to Class Members through Care Coordination and Support Organizations (CCSOs). These organizations are tasked with coordinating all behavioral health services and supports for NB Class Members to ensure that assessment, linkage, and service delivery are streamlined for these youth. Similarly, the Independent Service Coordination (ISCs) providers arrange care for children with developmental disabilities who are eligible for residential and home-based services through the Developmental Disabilities Waiver, and Intact Family Services providers and Intensive Placement Stabilization providers offer intensive in-home services to stabilize youth in the homes of family or foster families, respectively. In conjunction with recommendations to implement **resource referral technology** and improve **information sharing,** the Transformation Initiative proposes a number of steps to achieve more responsive, timely, and comprehensive coordination for behavioral health care in all of these contexts.

   Some of these recommendations pertain to coordination between systems at key transition points, where youth may be most vulnerable to experiencing a deterioration in functioning. For example, the *transition from childhood to adult services* is complicated by misalignment in age-based eligibility requirements across agencies and programs, the availability of services in both the child and adult services systems, and service funding. The Children's Residential, Children's Support, and Adults with Developmental Disabilities Waivers operated by the Department of Human Services Division of Developmental Disabilities (DHS-DDD) allow for a four-year overlap in service availability to support the transition from child to adult services.[10] However, this transition does not always occur easily, particularly for youth in custody of DCFS.

10. "Waivers" refer to Medicaid Waivers, introduced under the Omnibus Budget Reconciliation Act of 1981, which offer states flexibility in implementing statutory requirements concerning eligibility and benefit provisions of a state's Medicaid program.

In some cases, changes in statute have preceded any assessment of the State's or providers' ability to implement new requirements. For example, modifications outlined in Public Act (P.A.) 101-0461 expanded eligibility for the Department of Healthcare and Family Services Family Support Program (FSP) to allow young adults to retain eligibility for services through age 26. The implications of extended eligibility for FSP services must be considered in the context of existing age requirements that restrict access to the residential supports that these programs provide. More specifically, although FSP will offer extended eligibility through age 26, some of the facilities in which program services are provided (for example, child group homes, childcare institutions, independent living programs) do not serve individuals in the extended age range. This results in a gap in service access for young adults requiring residential care, as young adults should not be placed in adult facilities that may not meet their developmental and behavioral health needs. In conjunction with recommendations to **centralize oversight of residential beds** and **increase capacity** with the addition of residential placements for transition-age youth, enhanced coordination across systems can help to address these issues.

There is also the need to better coordinate transitions to residential placements or community homes for youth *after receiving crisis care*. Youth deemed ready for discharge from the hospital are sometimes transferred to a pediatric ICU, a medical floor, or an emergency room because no transition placements or supports are available and their parent or caregiver is unable to take them home. In addition to transition placements, stakeholders consistently expressed the need to enhance cross-agency communication and collaboration to support youth as they transition from the hospital to the community. This can be accomplished by streamlining the documentation required for post-discharge program and service approval, as the lengthy paperwork process creates congestion in emergency departments and can contribute to longer hospital stays. At the same time, efforts to coordinate care must also address **workforce** shortages and increase the number of service providers and clinicians available to facilitate service delivery and reduce the long waitlists for services that currently exist.

To implement this recommendation, **the Transformation Initiative recommends:**

- MCOs should be granted access to information on child functioning that includes but is not limited to the Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS) through the existing IM+CANS Portal;
- Using data analysis in partnership with technical assistance from the Office of Medicaid Innovation and other academic partners, HFS should work to develop a set of early indicators of elevated risk for behavioral health crises for youth who do not meet criteria for inclusion in the N.B. Class;
- HFS should develop processes by which these risk indicators can trigger intensive intervention focused on expediting services and stabilizing youth. The Behavioral Health Decision Support Model, along with additional information sharing between child-serving systems, should be utilized to identify youth who need more intensive intervention;
- HFS should implement the requirements the agency has developed for managed care including family presentations, enhanced care coordination for N.B. Class Members, equity in the provision of appropriate care for all members, and quality outcomes for youth;
- HFS should continue to develop monitoring processes and quality standards for MCOs that include guidelines for referral types by identified needs and support for the achievement of positive youth outcomes;
- HFS and DHS-DDD should conduct a cross-system analysis to identify barriers DD Waiver customers experience in accessing medically necessary Medicaid state plan services. These services may include Behavior Intervention and Therapy services beyond the monthly Comprehensive Home-Based Services (CHBS) budget requirements, or Counseling or Psychotherapy services (or a combination). The outcome

of this analysis should be made publicly available for stakeholder feedback. Where needed, the Medicaid state plan, state administrative rules, and the DD Waivers should be amended to reduce such barriers to access;

- The DHS Division of Mental Health (DHS-DMH) should consider amending administrative rule on Medicaid Community Mental Health Services Programs (59 Ill. Adm. Code 132) to explicitly allow Community Mental Health Centers to provide mental health services to children and youth whose primary diagnosis is a developmental disability;
- DCFS and DHS should continue to work together on streamlining transitions for youth with developmental disabilities who will continue to require residential placement after exiting foster care.

3. ***Centralize oversight of residential beds*** *to reduce duplication and enable the State to manage residential treatment resources more effectively.* Young people in need of residential treatment can receive it though one of five state agencies, each with its own eligibility criteria, process for accessing care, and network of contracted providers. No one state agency oversees capacity and quality for all residential programs serving youth. Because the *purchase* of residential care is handled separately by each of the five state agencies, without centralized oversight to monitor the capacity, vacancy, occupancy, and staffing of these programs, most purchasers find it difficult to manage the supply of beds across the entire system. DCFS is currently responsible for the oversight and licensing of all childcare facilities in the state, which includes these residential treatment facilities. Other state agencies assume that the residential programs comply with the regulatory requirements set forth in their licensing and accreditation requirements monitored by DCFS. Separate purchasing and varied monitoring strategies across State agencies means that the landscape of providers lacks the consistency and predictability that the system needs in order to improve. To thoughtfully redesign this component, the Transformation Initiative considered the *monitoring* and the *purchase* of care separately.

   Monitoring. Critical Incidents are a key indicator of client safety at residential facilities. Under the current decentralized monitoring and oversight process, each agency may only be aware of critical incidents that involved the youth they placed. Thus, they aren't aware of the total number of critical incidents occurring at each facility or why the incidents occurred. By creating a system that allows each agency to share information about the critical incidents that were reported to them, the State and placing agencies will have a more accurate understanding of client safety and quality of care.

   The Transformation Initiative reviewed residential oversight and monitoring activities conducted by four of the core state agencies (ISBE, DCFS, HFS, DHS-DDD) that place youth in residential services. Based on a review of documents, interviews with agency staff, and research on best practices (described in Appendix D), this review concluded that although all state agencies provide some degree of oversight and monitoring of children in their care and the services they receive, they primarily rely on DCFS to conduct oversight and monitoring of facilities. While DCFS can and does share information with other agencies, there is no mechanism by which other agencies can share information with DCFS. All agencies ensure that the services received align with agency-specific mandates, consent decrees, and federal requirements, and some have established monitoring processes using outside contractors.

   Centralizing communication of monitoring results will be essential to understanding the quality of each facility. For example, ISBE focuses on monitoring the educational services provided to the youth they place in each facility, but youth placed by DHS, HFS, and DCFS are receiving the same services, and it is important for these agencies to be made aware if there are problems with the education provided. Similarly, HFS has plans underway to implement a monitoring and oversight process that focuses on the quality of the mental health

treatment at each facility where the agency places youth. Sharing these results would allow the other agencies to determine if a specific facility is meeting all the treatment needs of their youth.

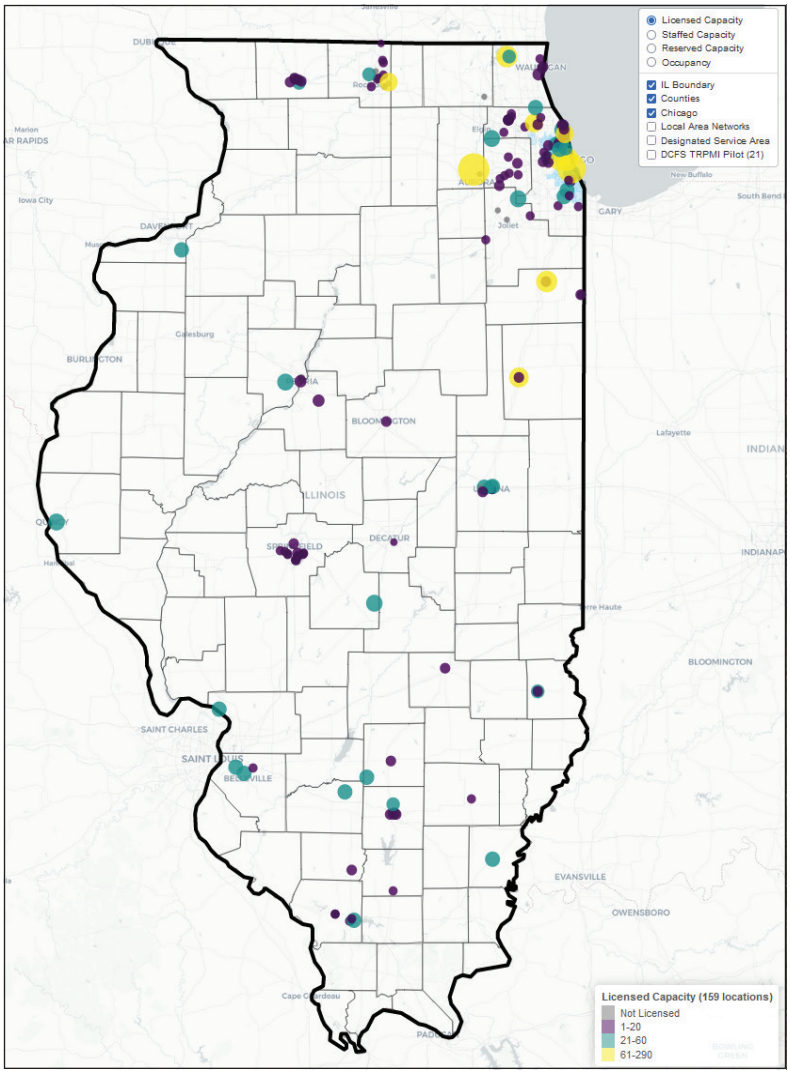
Purchase. Centralizing purchasing can improve the State's ability to expedite placement in available beds, removing some of the barriers that result in long waits. It is important to note that HFS doesn't *contract* with residential providers per se (these providers enroll in Medicaid and contract with MCOs) and youth placed through the education system are in beds purchased by their school districts (not ISBE). These procedural variations, as well as differences in the criteria for approval of residential placements among agencies, will need to be resolved as part of a strategy to centralize the purchase of care. Once implemented, this strategy is also likely to reduce duplicative processes across agencies and the burden on both the agencies and the residential centers.

While DCFS licenses each facility for a set number of beds, a residential provider might not have the staff required to utilize all of the beds that it is licensed to operate at a given time. A survey of licensed residential facilities in Illinois (described in Appendix A) suggests that staffed capacity for residential treatment is approximately 72%.[11] Limited staffing is a significant challenge with wide-ranging implications; staff shortages at agencies that serve youth with externalizing behaviors put both workers and youth at risk. Thus, a centralized system to capture the staffed capacity of each residential provider will provide more accurate representations of facility capacity which can be tracked by funders and families, providing a near "real-time" capacity status of the State's residential network.

To test an approach to centralizing information for the purpose of more agile and responsive management of bed capacity, the Transformation Initiative linked survey results on staffed and occupied capacity at residential providers with DCFS data on licensed beds. The Transformation Initiative mapped these results in a single interface that allows users to view the available beds by provider across the state. The resulting interactive map allows users to see the point-in-time number of contracted beds from each state agency, as well as to select views showing licensed capacity or staffed capacity. Figure 7 displays an example of the map. Additional interactive features, such as the option to overlay Local Area Network or Designated Service Area boundaries, allow for a more tailored view. The map serves as a proof of concept for a regularly updated resource that could be made available if providers were required to regularly update and report capacity. Survey results are described in detail in Appendix A.

11. Facility capacity ranges from 3 to 103 beds per facility, while staffed capacity ranges from 0 to 66 beds.

Figure 7. Example Map of Available Beds, by Provider



While the oversight of licensing and quality may be distinct from purchasing and contract oversight, centralizing each of these functions will allow the State to operate a more efficient system with fewer barriers to providing equitable access to quality residential care to young people who need it. Any determination of the appropriate home for centralized oversight of these dual functions should consider each agency's capacity to monitor (licensing, regulatory compliance, and compliance) separately from each agency's capacity oversee the purchase of residential care. As demonstrated with the interactive map, centralized purchasing would allow the management of all residential capacity as a single system, as well as support recommendations to **standardize rates** across funders. Centralizing monitoring, while maintaining current practices to comply with federal regulations and consent decrees, will promote transparency and allow agencies to engage providers with consistent understanding of the strengths and challenges of residential treatment environments. State agency leaders should work together in conjunction with the Transformation Initiative on a strategy to parse and distribute these functions in order to maximize efficiency, federal claiming, and the seamless access to residential care for young people who need it.

To implement this recommendation, **the Transformation Initiative recommends:**

- Considering the most appropriate State agency home for monitoring and purchasing of residential treatment beds separately to increase accountability, equity, and access for all youth who need residential treatment;
- Convening leaders of the child-serving State agencies to consider proposals for centralized oversight;
- Immediately requiring all providers of residential interventions to regularly submit information on staffed capacity and available capacity for *all types of clients* to DCFS, using the current technological solution. Eventually require this information to be submitted to the oversight entity;
- Establishing a standardized residential admissions application that streamlines the clinical and administrative information families and funders must supply in order for residential treatment facilities to make admissions determinations;
- Developing language to clarify expectations and requirements for residential providers that serve youth, in conjunction with a centralized contract management strategy;
- Piloting strategies for centralizing purchase of care with a small group of providers, developing necessary interagency agreements to allow the purchase of beds from a single state agency;
- Developing a means to share information about Critical Incidents across agencies to help inform funders and families about the quality of care at all residential treatment providers.

4. *Implement* ***resource referral technology.*** Illinois does not utilize a single, consistent approach to linking people seeking services to community-based outpatient care. However, an array of software platforms have evolved over the last decade to assist health care organizations and systems to identify and refer patients to social service organizations. While primarily focused on building and maintaining resource directories and managing referrals, these systems also incorporate features that can assist case management, screening, provider capacity management, and quality monitoring, among other functions.[xi] The success of several of the strategies outlined in this report (for example, **universal mental health screenings**) depends upon the use of a single, centralized system that can link families with service providers in their local community and facilitate their access to these services by providing essential information about eligibility, required documentation, hours and locations, and other service features that can enhance accessibility. Previous research documents the feasibility of resource referral technology for implementation within state systems, and linkage with the Electronic Health Record (EHR).[xii]

   Conversations among the child-serving state agencies are underway to select a resource referral platform that would be (1) available to case managers, service providers, teachers, pediatricians, MCOs, and others who might be in a position to recognize a mental health concern and provide information about available services; (2) populated with an up-to-date database of service provider offerings; (3) able to facilitate communication between families and service providers; and (4) able to allow service providers to accept referrals sent by case managers or others. There are numerous examples of systems currently in use in Illinois, but none are operated consistently, updated comprehensively, or intended for use with all Illinois residents regardless of geography, eligibility, or agency affiliation (for example, Iris, 211, SPIDER). Although these systems share common features they deploy different strategies and functionality.

   The Transformation Initiative recommends that the state invest in a unified and coordinated strategy for leveraging technology to expedite linkage to outpatient services. Whether that is a deliberate network of existing technological tools or the adoption of a single comprehensive platform, it will be important to work across agencies to ensure that the license for the tool makes it available to anyone in a position to provide

linkage and referral, that it contains information on all service providers available to families regardless of whether they hold state contracts, that it be flexible enough to connect with existing systems (for example, EHR, school systems, provider networks), and that it utilize precise geographic and clinical matching to offer services that will be accessible to the children and families who need them.

To implement this recommendation, **the Transformation Initiative recommends**:

- Selecting and procuring a tool that can leverage Medicaid funds to implement a coordinated strategy for improving resource referral accuracy and efficiency with input from all affected state agencies;
- Working with an experienced vendor to identify specific functionality and specifications for the tool;
- Engaging a team of representatives from multiple agencies, providers, roles, and individuals with lived experience to inform specific functionality and the implementation of the tool.

Adjust Capacity

The next four strategies are designed to ensure that capacity adjustments are informed by data analysis, evidence of effectiveness, and broad stakeholder input *and* that new programs can be developed in a predictable and consistent manner, guided by best practice principles and lessons learned from pilots, both in Illinois and other jurisdictions.

5. *Use **regular data analytic review** to inform provider capacity adjustments, allowing service availability to be adjusted with agility.* Illinois will be able to improve its behavioral health system only if we can accurately and precisely understand the needs of Illinois children and adolescents. To that end, estimates of needed capacity for service types can and should be based on analyses that delineate subgroups of youth in need of care paired with data on the existing availability of services. The Transformation Initiative conducted two analyses (described in Appendix B and Appendix C) to begin to understand the numbers of outpatient openings or residential beds needed to appropriately serve all children who have mental or behavioral health service needs. Moving forward, in order for the state to respond with agility to the changing need for youth services, it must ensure data linkage across agencies, employ data analytic strategies to understand population needs and contrast these with existing capacity, and leverage available and new data sources on both population needs and provider supply. The Transformation Initiative undertook two examples to establish the baseline capacity to meet youth's needs. For residential placements, data from ISBE, HFS, DHS, and DCFS were analyzed to identify the types of clinical needs of youth being referred for residential placement. This latent class analysis (described in detail in Appendix B) also detected subgroups of youth who have been deemed eligible for residential care but could be served in community-based settings. For example, among DCFS youth, approximately 34% of youth in the queue for residential care do not have clinical characteristics indicating need for residential treatment. These youth appear to be in the queue because they have a history of either juvenile detention (8%) or foster care placement instability (26%), neither of which is a sufficient qualification for institutional placement or residential treatment. This finding calls upon the State to develop the other types of services (Recommendation 7, **Increase Capacity)** that can alleviate the need for residential placements for these groups and make additional services available to youth who cannot be served in less restrictive settings.

   The second data analysis to guide capacity adjustments is a gap analysis of adjusted estimates of outpatient behavioral health needs and available community capacity. *Spatial gap analysis* is a type of geospatial analysis that compares the location of service providers to the location of clients in need of those services. This type of analysis can be completed at various geographical levels (counties, zip codes, census tracts) but must have some measure of the difference between supply (total services that can be accessed) and demand (total services needed). For this analysis, the spatial gap analysis was completed at the county level because system planning within state agencies in Illinois is often conducted at the county or region level.

To estimate the demand for services, we adjusted traditional estimates based on two factors documented in the research literature as being associated with elevated mental health service needs: economic hardship and exposure to violence.[xiii, xiv] As these factors are disproportionately represented across racial/ethnic groups, accounting for their contribution in estimates of need is essential for developing equitable access to services. Thus, the Transformation Initiative created a composite county-level behavioral health need prevalence rate based on these and other demographic factors.

The resulting map (see Appendix C), estimates that more than 200,000 youth ages 3 to 17 live in counties with a high demand for behavioral health services and low access to those services. Of these youth, we estimate that nearly 80,000 will need behavioral health services, a behavioral health prevalence rate of nearly 40%. These youth must travel nearly twice as far to reach behavioral health services as the average resident of Illinois. The adjustments developed for this analysis can help to ensure that the capacity to deliver services is developed in accordance with clinical *and* geographic needs. A detailed description of the methodology and additional maps can be found in Appendix C.

To implement this recommendation, **the Transformation Initiative recommends:**

- Developing specific numbers of slots/beds within service types to be adjusted/added for residential treatment and community-based outpatient services;
- Utilizing gap analysis to inform State agency funding opportunities (NOFOs) to prioritize the areas in greatest need of services, in partnership with local networks and community mental health agencies that can promote the implementation of trauma-informed, evidence-based care;
- Conducting spatial gap analyses specific to special populations, such as Spanish language residents or youth in need of specific services;
- Incorporating adjustments for economic hardship and exposure to violence in future efforts to estimate service needs and require regular re-assessment of geographic gaps between needs and services; and
- Examining equity and access disparities among youth seeking services.

6. ***Adjust rates,*** *including standardizing rates for similar services across State agencies, to ensure that providers are consistently compensated and that youth can receive the services they need to thrive.* Fiscal levers drive many of the patterns of care delivery as well as the discrepancies between what policy dictates and what families experience. While this project did not conduct a rate study of optimal rates for residential and outpatient services, key stakeholders and the Transformation Initiative have identified opportunities to adjust rates in a few ways. Building upon the DHS Guidehouse study of rates for care for adults with developmental disabilities, the work of the Purchased Care Review Board (ISBE) and the HFS infrastructure for setting and adjusting Medicaid reimbursement rates as well as plans to leverage federal Medicaid Waiver opportunities (for example, 1115 Waiver), the State should embark on a strategy to standardize rates for similar services across state agencies, activate rate changes that have already been approved or required in statute, and identify additional areas in which insufficient reimbursement or payment is driving capacity shortfalls. The state must do this in a thoughtful manner, cognizant of budgetary constraints, and look to a phased-in approach over years.

Support for providers is central to transforming the children's behavioral health system. Adjusting rates for residential service providers to ensure that they have the resources and capacity to serve children with varying levels of need should be considered as part of this transformation. Specifically, Medicaid rate adjustments to ensure staffing and resources needs are met should be explored. One option for adjusting rates is a tiered system using traditional providers and what are known as "risk providers." Risk providers are entities that have

been selected and equipped with the resources required to care for children with high mental health needs; this model has been used in Nebraska to overcome difficulties in placing high-need youth. Eligibility criteria can include staff credentials or other staffing requirements and low staff-to-client ratios. Rate increases could be used to recruit and retain more staff or specialized types of staff and ensure that facilities will have funds to sustain themselves as they take on more complex cases.

To implement this recommendation, **the Transformation Initiative recommends**:

- Developing standardized rates for combinations of clinical needs and program offerings in the residential care context across agencies, maximizing financial participation from the federal Medicaid program and coordinating reimbursement with child welfare under Title IV-E;
- Working collaboratively with providers of psychiatric care to ensure that all needed services can be reimbursed through Medicaid. Examples may include rates for reimbursement for psychiatric consultation with parent without youth present, rates for interprofessional consultation with pediatric behavioral health specialists to bill under interprofessional consultation codes, and rates for intensive outpatient and day treatment programs for flexible number of hours appropriate to youth needs and developmental stage.

7. ***Increase capacity*** *to serve more children and families by expanding eligibility for current programs and developing new service types so that Illinois has a full continuum of care.*

The American Academy of Child and Adolescent Psychiatry describes a "continuum of care" as the complete range of programs and services provided for children and adolescents with mental illnesses.[xv] Figure 8 describes the services that typically comprise a continuum of care for child and adolescent mental health.

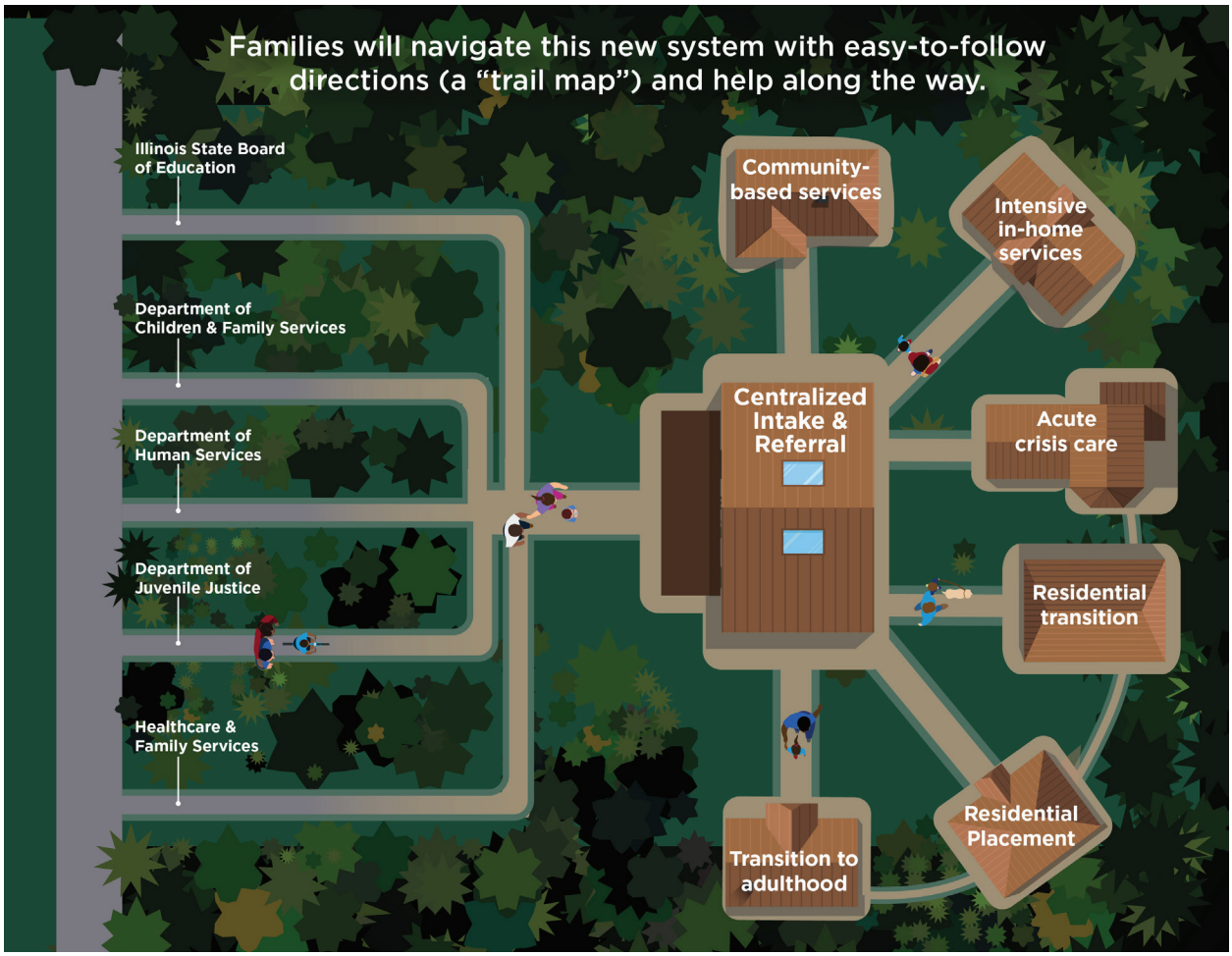
Figure 8. Continuum of Care

Continuum of Care

- **Outpatient counseling:** Visits are typically 30-60 minutes and may be "evidence-based" by following a specific model that has research evidence documenting effectiveness
- **Intensive case management:** Coordination of psychiatric, financial, legal, and medical services to help the child or adolescent live successfully at home and in the community.
- **Home-based treatment services:** A team of specially trained staff go into a home and develop a treatment program to help the child and family.
- **Family support services:** Services to help families care for their child such as parent training or parent support groups.
- **Day treatment program:** This intensive treatment program provides psychiatric treatment with special education. The child usually attends five days per week.
- **Partial hospitalization (day hospital):** This provides all the treatment services of a psychiatric hospital, but the patients go home each evening.
- **Emergency/crisis services:** 24-hour-per-day services for emergencies such as hospital emergency rooms or mobile crisis teams.
- **Respite care services:** Provides a safe (non-treatment) setting for youth to stay away from home briefly.
- **Therapeutic group home or community residence:** This therapeutic program usually includes 6 to 10 youth per home, and may be linked with a day treatment program or specialized educational program.
- **Crisis residence:** This setting provides short-term (usually fewer than 15 days) crisis intervention and treatment. Patients receive 24-hour-per-day supervision.
- **Residential treatment facility:** Patients receive intensive and comprehensive psychiatric treatment in a campus-like setting on a longer-term basis.
- **Inpatient hospitalization:** Comprehensive psychiatric treatment in a hospital unit specifically designed for children or adolescents.

To simplify family access to appropriate, effective services for youth, Illinois needs to make structural shifts in the availability of services across the continuum so that it spans the array of supports needed to address all types and severities of problems.

Figure 9. New System for Supporting Families in Illinois



Relying on a combination of funding streams and structures, much of Illinois' behavioral health service continuum is established within the context of the Illinois Medicaid Program. While some of these services are already in place, others are in place but need additional capacity, and others are not yet established in Illinois. Some services are not uniformly available to all children and youth who need them, and program eligibility requirements leave some youth without options.

Consistent with federal court decisions such as Olmstead,[12] programs such as the HFS Family Support Program and the Developmental Disabilities Waiver offer both community-based and residential supports, although evaluations, assessments, and other criteria may be needed to demonstrate the need for treatment in institutional settings. The Children's Residential Waiver is currently only accessible to children who are in crisis, narrowly defined as children who are at risk of experiencing abuse, neglect, and homelessness, and both the Children's Support and Residential Waivers are dependent upon the availability of state funding support. Therefore, the number of children who receive waiver services may not reflect the range of children who could benefit from waiver supports; expanding access to children's waivers may help more youth obtain needed services and supports in adulthood.

12. Olmstead v L.C., 1999

III. SYSTEM TRANSFORMATION PLAN

The fragmented system and the lack of shared language across state agencies makes it difficult to concisely describe the existing service array. To inform system improvements, the Transformation Initiative considered which are in place but difficult to access, either because of eligibility requirements or insufficient reimbursement; which services are available without adequate capacity; and which services the State currently lacks. Table 1 provides examples of programs and services in these categories.

Table 1. Characteristics of Programs that Improve Access, Increase Capacity, or Develop Capacity

IMPROVE ACCESS	INCREASE CAPACITY	DEVELOP CAPACITY
Crisis assessment and response	Psychiatric inpatient care	Transitional post-acute residential care
Specialized services for youth with developmental disabilities	Residential treatment for youth with severe behavior problems	In-home behavioral health supports
School-based services	Outpatient psychiatric care	Therapeutic foster care (for child welfare-involved youth)
Partial hospitalization/Intensive outpatient/day treatment	Wraparound services/intensive case management	Respite care
Family therapy	Outpatient evidence-based interventions	

The N.B. Consent Decree and Implementation Plan, as well as subject matter experts, recognize the need to expand the array of available services and intervention modalities to accommodate diverse needs, learning preferences, communication styles, and treatment orientations. To that end, HFS has begun to implement additional home and community-based services as well as to establish training, coaching, mentoring, and other supports for providers willing to offer these services. This includes two levels of enhanced care coordination: High-Fidelity Wraparound and Intensive Care Coordination, to be provided with fidelity to the nationally recognized Wraparound model.

To effectively navigate the current child and adolescent mental health crisis, the most immediate and essential adjustments or additions to the service array are to (1) expand "wraparound"-style services to serve and stabilize more youth (beyond those in the N.B. Class); (2) develop transitional residential placements for youth moving from acute care psychiatric settings to residential treatment or for transition-age youth moving from child to adult systems; (3) develop and train in-home behavioral health supports; and (4) expand the availability of respite care. Once these needs have been addressed, it will be easier to understand what adjustments are needed to the supply of inpatient psychiatric treatment.

Wraparound. Wraparound services refer to a philosophy of care and correlated services that center youth, providing a comprehensive, holistic, youth- and family-driven way of responding when children or youth experience serious mental health or behavioral challenges with support from a team of professionals and natural supports.[xvi] There is now strong evidence that, when wraparound is done well (that is, with "fidelity"), young people with complex needs are more likely to be able to stay in their homes and communities, or, should a crisis occur, to be in out-of-home placements only for short periods of time. Young people receiving wraparound tend to have better outcomes than similar young people who don't receive wraparound across different areas of their lives, including mental health and functioning in their homes, schools, and communities. This can result in substantial cost savings by minimizing the time that young people spend in out-of-home facilities like residential treatment centers or psychiatric hospitals, which can cost between $1,000 and $3,000 per day.[xvii]

While these services will be available to Medicaid-eligible youth who are NB Class Members through Pathways to Success, the state currently deploys several wraparound-style strategies for service delivery which could be expanded to serve all youth who need them. The most prominent examples are the Comprehensive Community Based Youth Services (CCBYS) program operated by DHS and the pending expansion of High-Fidelity Wraparound proposed by DCFS in an amendment to the Family First Preventive Services Act (FFPSA) prevention plan[13].

The CCBYS program is operated through the DHS Division of Family & Community Services. It is designed to offer 24/7 crisis availability to youth ages 11–17 and their families. The target population consists of youth who have run away or been locked out of their home or other institutions and are at risk of involvement with either the child welfare or the juvenile justice system. The focus of the intervention is on ensuring safety and reunifying youth with their families and providing supports and referrals to move them toward placement stability.

Since 2018, DCFS has contracted with community service agencies to offer High Fidelity Wraparound for both intact families as well as children in care. Over the past four years, the program has witnessed a year-by-year incremental increase in program capacity. Preliminary positive outcomes have also been observed in the number of families remaining intact as well as the number of children returning home from DCFS care. Beginning in January 2023, DCFS plans to expand High-Fidelity Wraparound and provide provider partners with training, certification, and fidelity monitoring based on the recommendations of the National Wraparound Implementation Center.

Transitional housing. In the context of the current mental health crisis, youth identified as being in need of and clinically appropriate for residential treatment often wait for months for a bed to become available. These youth are faced with extended inpatient hospital stays beyond medical necessity or a return home without adequate psychiatric care, threatening a tenuous stability achieved in the hospital. For this reason, it is necessary to consider the development of transitional housing units to provide 24/7 care, supervision, and mental health treatment following an inpatient hospital stay and prior to admission into residential treatment. Few examples of transitional housing exist in the state, and those that do are frequently unable to manage multiple referrals for youth requiring a high degree of supervision or staff-to-client ratio.

Programs that do provide transitional residential supports are limited in their reach and are reserved for select populations (such as programs for youth in DCFS care). Similarly, CCBYS supports youth who are at risk of custody relinquishment and have been authorized as being clinically ready to be discharged from the hospital. The program provides an array of stabilization supports and services to children and families, but currently operates with limited funding and resources and does not have the capacity to meet the need for emergency housing/transitional living arrangements. In addition, many programs will not serve children who display aggressive behaviors or who have experienced multiple hospitalizations, citing the need for more supports or supervision to serve these youth.

In-home behavioral health supports. DCFS, HFS, and DHS-DDD all offer intensive in-home supports to families, and expansion of these programs within HFS is underway as part of the N.B. Implementation Plan. DCFS offers Intact Family Services to stabilize families and prevent separation using in-home supports and care coordination. Through its Support Services Teams (SST), DHS-DDD provides interdisciplinary technical assistance and training to people with developmental disabilities in medical or behavioral situations that challenge their ability to live and thrive in the community. In addition to enhanced care coordination with

13. Beginning in January 2023, IL DCFS plans to expand High Fidelity Wraparound to additional counties, with 4 new contracts in addition to the existing 4 contracts that will serve 760 youth across 51 counties. CCBYS provides short-term wraparound services to 5,621 youth each year but could be expanded to provide emergency housing and meet the needs of an additional 1,000 youth over a 2-year expansion.

fidelity to wraparound, HFS is also developing Intensive Home-based Services, Family Peer Support, Therapeutic Mentoring and Respite, as well Individual and Therapeutic Support Services that provide services and supports that Medicaid does not otherwise cover. These services are designed to offer parents in-home services and supports to help them identify, understand, and address the behavioral health concerns of their children:

- Intensive Home-Based (IHB) Services are individualized, time-limited, and focused services provided directly to children and their caregivers in home and community settings. The IHB service is provided to children and their caregivers to promote healthy family functioning, improve the family's ability to provide support for youth, and prevent the child's admission into an inpatient hospital or other out-of-home setting. This is achieved through the delivery of two components: Intensive Home-Based Clinical (IHBC) and Intensive Home-Based Support (IHBS).
- Family Peer Support is a structured, strengths-based, individualized service provided to a parent, legal guardian, or primary caregiver of a youth with behavioral health needs. The service is designed to enhance the caregiver's capacity to understand the youth's behavioral health needs, support the youth in the home and community, and advocate for services and supports for the youth and family. The service will be delivered by Family Peer Supporters who have individual lived experience or experience as a caregiver for a child with special needs, preferably behavioral health needs, and who have completed required Family Peer Support Training.
- Therapeutic Mentoring is a strengths-building service provided on an individual basis to children who require support in recognizing, displaying, and using prosocial behavior in home and community settings. This service allows trained mentors to spend quality time in the community with the child, modeling positive ways of interacting with other children and adults in a variety of social situations. Children work with their Therapeutic Mentors to gain and practice valuable skills that will help them develop positive relationships and build their confidence. Therapeutic Mentors must attend and complete required training for Therapeutic Mentoring.

In addition, Illinois should strengthen the availability of *mobile response* and *in-home behavioral health aides* to support the families of youth experiencing behavioral health challenges. While Illinois has a Mobile Crisis Response system that provides assessment and stabilization services to youth experiencing psychiatric crises (MCR/SASS), this service has evolved since its joint development by HFS, DHS, and DCFS in response to the Children's Mental Health Act of 2003. Today the SASS infrastructure represents the State's most comprehensive statewide behavioral health safety net system for children. In addition, CCBYS and DHS-DDD have systems in place for responding to crises, particularly when these crises threaten the stable living arrangements of young people. Working to streamline the definition, funding, and implementation of Mobile Crisis Response services would ensure that these are available to all children and parents experiencing difficulties, including difficulties with child behavior, substance use, and mental health. In other states, mobile response is deployed to assist parents in situations below the crisis threshold, which may be effective for increasing parents' awareness and linking families with services to avert more serious crises.

In addition to needing help identifying and understanding mental health concerns of children, parents may also need help supporting young people who require a high degree of supervision and assistance. Similar to in-school aides (paraprofessionals providing 1:1 attention to a single youth in a classroom) or personal attendants, some states have used *Behavioral Health Aides* (BHAs) to provide help in the home context. Consultation with states who use in-home aides suggests that this approach fills a critical gap in community-based service delivery. State leaders emphasized key considerations for implementation, including funding, recruitment and retention, educational requirements, and scope of practice.

The most robust state programs leverage funding from federal grants, Medicaid reimbursement, and state budgets. State leaders also encouraged intentional conversations around the Medicaid rate for Behavioral Health Aides (BHAs), as states without appropriated funds were not able to offer wages high enough to attract or advancement opportunities to retain BHAs. Illinois will also need to consider what certification and educational requirements will be necessary. Some states use lower levels of educational attainment (associates or bachelor's degree) as a qualifier for these paraprofessional roles, and others require only certification.

Respite is a time-limited, face-to-face service that provides scheduled relief to help prevent stressful situations, including avoiding a crisis or escalation within the home. This support service can be provided in home, school, or community settings and allows caregivers a period of rest from their caregiver responsibilities. A trained mental health professional or other designated individual is responsible for the child during the respite period. While some respite services are provided in Illinois and may be introduced for N.B. Class Members as part of the Implementation Plan, it does not appear that families have adequate access to these services. DHS offers respite for youth and adults with developmental disabilities but expanding the availability of respite to the families of youth experiencing behavioral health challenges may help to avoid family separation.

To support implementation of new services, HFS has built the Provider Access and Training Hub (PATH) to provide the training, coaching, mentoring, and learning collaborative structure. PATH is offered by HFS through a partnership with the University of Illinois System, Office of Medicaid Innovation (OMI), and the University of Illinois at Urbana-Champaign School of Social Work. PATH trained all of the community mental health centers and providers upon the rollout of the Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS), demonstrating the capacity to train and coach all providers in preparation of the of all of the Pathways to Success program. Through its partnership with the University of Illinois, HFS has established an infrastructure that can be used to expand the delivery of service training and provider infrastructure development as the Departments continue to expand service options.

To implement this recommendation, **the Transformation Initiative recommends:**

- Amending legislative language to expand eligibility, duration, and service types for CCBYS to include emergency housing for youth;
- Identifying the youth who can access Pathways to Success or DCFS High Fidelity Wraparound (or both) and adjust budget to deliver CCBYS for any youth needing wraparound who are not eligible for either of these services;
- Funding services to youth who are seeking care through the state's PUNS list;
- Developing estimates for the numbers and locations of youth needing transitional placements and collaborating with providers leveraging facilities and capital grants to stand up several transitional programs that can provide holistic support for youth transitioning from acute settings;
- Streamline definitions, funding and implementation of crisis services;
- Developing estimates on the number of families that could be served with broader application of mobile response based on regional needs, expected response time, expertise level of staff, and program availability; and
- Developing a plan to create, fund, train, and monitor BHAs.

8. ***Partner with providers*** *in a standard protocol to encourage consistent and transparent development of new programs to meet emerging needs.* Each child-serving state agency has its own mission and constraints (for example, state and federal statutes, regulations, mandates, and consent decrees); together they make up the tapestry of programs and services of the public children's mental health service system. While DCFS relies on

a network of private social service agencies to deliver many of the services and supports needed by children and adolescents with mental health concerns, much of the community-based behavioral health service array is comprised of Medicaid-enrolled providers.

Private providers deliver crisis stabilization services, outpatient behavioral health, in-home parenting supports, and an array of other supports. Any effort to expand or refine service delivery will happen in partnership with this group of providers, many of whom bring substantial experience, knowledge, and specialization to the work of stabilizing, treating, and supporting young people and their families.

To fortify and enhance collaborative relationships with private providers, it will be necessary to develop a consistent approach to working together on (1) provider enrollment, (2) the inception of new service types and programs, and (3) the development of new approaches to expanding capacity and caseloads. It is essential that providers can trust that they will receive a manageable mix of service referrals, streamlined regulations and operations, and timely reimbursement for services. It is also essential that state agencies can trust that providers will serve every youth in need who is appropriate for their care. To do this, we recommend exploring strategies in use in other jurisdictions and other fields, such as case-mix approaches to balancing assignment, risk adjustment, and ongoing monitoring of quality in addition to compliance. As described in Recommendation #3, the Transformation Initiative worked extensively with state agency representatives to understand the level and type of monitoring activities that sustain ongoing relationships with providers.

Over the last ten months, while some programs have shut down, numerous other provider agencies have stepped forward to partner with the State to meet the current challenge by augmenting capacity for residential and other types of care. In the context of the Transformation Initiative, these providers have been directed to (1) apply for capital grants to support facility modifications, (2) meet with an interagency team to understand needed services and programs, (3) develop proposals for service delivery, including volume, scope, and scale, and (4) recieve technical assistance for implementation of new programs. It is essential that these activities continue and expand in a consistent and standardized way.

As the state continues to introduce new service providers into the Illinois Medicaid program, technical assistance and support is necessary to help those organizations understand regulations and engage with HFS's MCOs and the full array of services that they can provide. In addition to assisting grant-based entities making the leap into the Medicaid service array, identifying other atypical provider types and finding ways to support them will also benefit Illinois' children and families. For example, opportunities stemming from the introduction of peer services across various parts of the Medicaid program introduce the possibility of a developing family-run organization (FRO) culture that is aligned with the introduction of High-Fidelity Wraparound services such as those found in the new Pathways to Success program.

It will also be necessary to rebuild trusting relationships with providers operating in a system under stress. In the context of DCFS residential placements, traditional approaches to case assignment have emphasized matching provider programming and supervision with the level of risk and needs of youth. This results in some providers being designated as specializing in serving high-risk youth, while others may serve youth with more moderate problems. As reliance on residential placements has diminished as the field increasingly prioritizes treatment in the *least restrictive environment*, the youth receiving residential interventions may have higher concentrations of acuity than in the past. In light of these shifts, and recognizing the difficulty in identifying and sustaining appropriate residential treatment environments, it may be helpful to revisit previous efforts to "risk adjust" cases paired with a new "case-mix" approach to making residential referrals.

In the context of child welfare, risk adjustment has been attempted in conjunction with "performance-based contracting" to ensure that assessments of provider quality and outcomes are adjusted for the severity of

the youth they serve. These approaches involve developing statistical models to predict high-risk events and using these models to understand the level of risk carried by a provider. However, there has been little effort to apply these models to the management of a single residential treatment program's "risk load." Borrowing from models used in the health insurance context (in which plans aim to have a balance of risk levels rather than a concentration of risk in a single plan), Illinois might consider case-mix approaches to case assignment that would cap or balance the distribution of cases placed with each provider. This would address provider concerns about excessive risk while promoting the safety and security of program treatment environments. There is some evidence to suggest that a case-mix classification system can promote stability and equitability in the allocation of limited resources for vulnerable populations.[xviii]

To implement this recommendation, **the Transformation Initiative recommends:**

- Developing a standard approach to providing technical assistance to individuals and entities seeking to become providers across the State's service array to ensure a best practice approach to implementation that is informed by evidence of effectiveness, implementation science, and data analyses on population needs;
- Testing strategies with a small number (1-3) of providers to identify a clear process for capacity building;
- Exploring strategies for case mix approaches for more equitable and manageable referrals;
- Revisiting risk adjustment strategies for ensuring that providers are assigned appropriate cases;
- Finalizing a protocol for engaging new providers in discussions around planned expansion or development, to include Requests for Proposals (RFPs) that require articulation of:
  - identification of target population,
  - identification of resource needs, and
  - a clear outline of service types and scope, proposed staffing structure, and models of care

Intervene Earlier

The third set of strategies are designed to ensure that it will be possible to move upstream of problems and detect, identify, and assess child and adolescent behavioral health challenges early enough and with enough precision to inform timely and appropriate intervention. These strategies will allow us to proceed with system transformation that is trauma-informed, youth-centered, and evidence-based.

9. ***Universal screening*** *in education and pediatrics.* In order to ensure that problems are detected early, it is necessary to implement screening within the contexts that all youth are seen: schools and pediatricians' offices. For decades, hearing and vision screenings have been required in schools in order to detect problems that could interfere with children's ability to learn. Mental health problems also threaten school success, and yet efforts to screen for mental health problems in schools have been sporadic at best. There are examples of mental health screening infrastructure and progress in Illinois, but these instances depend on culture change that destigmatizes the detection of problems and supports the screening and information sharing required to effectively address them.

   Similarly, there have been successful efforts to engage pediatricians in universal screening, such as the developmental screenings that inform referrals to the State's Early Intervention program.[14] Although some pediatric offices utilize the Pediatric Symptom Checklist – 17 (PSC-17) to identify behavioral and

14. This program provides families with in-home services to address developmental delays as soon as they are detected.

psychological challenges, this is not universal practice. HFS has engaged in the planning and implementation of behavioral health screening activities within primary care settings consistent with the N.B. Implementation Plan. It has also convened a workgroup in collaboration with the Illinois Chapter of the American Academy of Pediatrics (ICAAP) to identify behavioral health screening tools appropriate for individuals ages 0–21, to develop a training process for pediatricians utilizing the tools, and to establish a clear process for pediatricians to refer youth for additional behavioral health services (in conjunction with Recommendation 4, **Resource Referral Technology).**

We can look to examples of in-school screening for vision and hearing and pediatric developmental screening for lessons learned about the factors that can facilitate and impede success in the education context. Previous efforts to implement universal mental health screening have failed because of several concerns about the implementation of universal screening in schools. These concerns include (1) the tools that will be used, (2) confidentiality and privacy of information collected, (3) the processes for communicating information, and (4) the ability to act upon identified problems. Fortunately, there are numerous examples of Illinois school districts that have overcome these challenges and there are existing toolkits and technical assistance to drive change in districts that still need to implement screening.

Despite the fact that some Illinois school districts have implemented universal screening, current practices are inconsistent. Screening results are generally not shared between technological systems, so some children receive multiple screenings that can be duplicative or contradictory. Selected screening instruments may not have been vetted for validity and reliability. Most importantly, Illinois will need to implement a **resource referral tool** (Recommendation 4) to ensure there is a consistent plan in place for how to get care for children when concerns are identified.

A comprehensive landscape scan of school mental health screening efforts should precede planning efforts; a preliminary review of school districts that have deployed universal screening yields some key guidance. Districts that have successfully implemented universal screening have involved all stakeholders in planning, have data systems that facilitate information sharing, have internal teams of mental health professionals that can guide responses to identified problems, use free or inexpensive brief screening tools, have support from school leadership and communities, and give parents the ability to "opt out" of screening if they choose.

In pediatric settings, implementing mental health screening will require supporting pediatricians in identifying mental health problems. To that end, this year the Pritzker administration announced a $2.5 million federally funded program that, through partnership with DPH, HFS, DHS, the University of Illinois Chicago's (UIC) DocAssist Program, and ICAAP, increases the volume of consultation services provided across the state, provides mental health education and training opportunities to physicians and health care professionals, and strengthens the network of mental health resources and referrals accessible to providers and their patients.

To implement this recommendation, **the Transformation Initiative recommends:**

- Partnering with ISBE to conduct a landscape scan of screening activities underway in all Illinois school districts to inform a long-term plan to expand screening toolkits, education, technical assistance and support to districts across the state
- Identifying a list of acceptable screening tools;
- Identifying training needs and resources;
- Consulting with technical assistants and utilize existing toolkits to promote culture change to support universal screening;

- Promoting the availability of resources including toolkits, screening tools, training, and consultation (such as DocAssist) to primary care and education settings to enhance the feasibility of screening activities;
- Implementing primary care behavioral health screening guidance to Medicaid-funded pediatricians consistent with N.B. Implementation Plan;
- Identifying optimal pilot districts for universal in-school screening.

10. ***Information sharing*** *to improve seamlessness and timeliness of interventions.* As noted, there are six State agencies in Illinois that are involved in delivering children's behavioral health care. Each agency has idiosyncratic policies and procedures regarding who can access supports, how children can access supports, and when children can access supports. Information about children as well as service eligibility policies are not systematically shared across systems, which leaves confused and frustrated parents to navigate these hurdles on their own. Even if children are identified with mental health concerns at an early stage, families report difficulties finding an open door to services; from their perspective, the system seems to put forth more robust efforts only once situations become acute crises. Barriers to information sharing between state agencies push families to resort to emergency room visits or crisis hotline calls as the surest way to receive emergency mental health services, a far distance from early interventions.

    Without integrated data across the six state agencies, it is difficult for state agencies to monitor service provision to children receiving behavioral supports, and, consequently, to adequately plan for future service needs. Not knowing how many children are identified as needing care and when and where they receive it can result in inadequate, duplicative, uncoordinated, or undesirable combinations of services. Longitudinal, integrated data across the agencies would allow the state to forecast future service needs.

    In addition to a timely understanding of mental health service availability, Illinois requires a resource that supports planning, administering, and evaluating the youth behavioral health system. Despite years of planning for integrated data infrastructure, Illinois does not have a fully integrated data and information system to address the current youth mental health crisis. For this project, the Transformation Initiative combined data from DCFS, HFS, DHS, and ISBE to estimate the current extent of specific obstacles to effective behavioral health care for children and adolescents in Illinois. However, one-time data collection linkage and analysis will not be sufficient for the proactive planning needed to meet the current challenge. Ongoing analysis can ensure that changes are implemented effectively and sustained. This depends on having a data system that can support real-time monitoring and evaluation of our ability to meet the service needs of young people.

    With ongoing capacity to consult child-level data across agencies, improved interagency coordination can be driven by information in addition to policy. A data system that is consistently providing information can alert leadership to when the number of youth hospitalized beyond medical necessity is spiking, or when early indicators of need are changing. Similarly, the needs of children awaiting care can be better understood with information from across state agencies. Monitoring the population of youth can also provide information to improve the appropriate and effective utilization of FSP, DD waiver, and DCFS supports, and other mechanisms for service delivery.

    Therefore, Illinois should develop the capacity to measure, on a real time basis, the number of children and adolescents at risk of restrictive psychiatric care. Data analyses can identify risk factors. An integrated system can allow each agency to contribute to and monitor estimates of the prevalence of risk so that communities are

aware of what resources may be needed to provide sufficient mental health services to prevent restrictive care or provide the proper level of care needed to maximize the well-being of children and families.

Illinois needs a centralized solution to combine data across agencies and maintain a dashboard that is accessible to state and local leaders and public health departments. A dashboard can provide indicators of the need and availability of services and the relative gap between them. While the raw data are available, the capacity to build the database and analyze the data is not. With input from the relevant agencies, the State should develop the database and capacity to analyze the data for programmatic and policy purposes with the highest level of data security. Data elements include but are not limited to:

- DCFS placement services provided to foster children and characteristics of those children and their families
- ISBE youth with IEPs, particularly those with BH needs
- HFS Medicaid claims of youth in outpatient and inpatient care with MH diagnoses and services
- Service receipt through FSP and the DD Waiver

As described in the analytic appendices for this report, estimates of mental health service needs should continue and be adjusted for demographics, economic hardship, and exposure to violence. Improved and timely local measures can be developed from both Census and Illinois state administrative data and provide information that can be used by local service providers in addition to state leadership to target services.

To implement this recommendation, **the Transformation Initiative recommends:**

- Building on the foundation of information sharing developed for the interagency intake portal by ensuring that interagency agreements are in place to protect the privacy of individuals and promote continuity of care;
- Maximizing federal financial participation by leveraging Medicaid resources to support the development or enhancement of a shared data repository;
- Making additional information available to care coordination entities; and
- Using data to estimate needed capacity.

11. ***Build workforce*** *with paraprofessionals and incentives.* As many providers and system partners have noted, capacity to serve youth with mental health needs in communities (as well as in higher-end care such as residential) is limited by a workforce shortage. In the 1990's, grant-based funding for community mental health services allowed staff resources to be dedicated to educating, training, and supervising interns and junior clinical staff to develop new clinicians over time. When the Illinois community mental health system began to financially transition from a grant-based system to a fee-for-service model (beginning in 2005) it introduced a substantial shift in the capacity of the system to train the next generation of mental health clinicians. The results of this shift were not generally recognized or anticipated at the time, but it is likely that the current funding structure (with reimbursement only for clinical care) makes it difficult to support the necessary supervision and development of new clinicians to maintain a prepared and available workforce.

    Community mental health providers will need financial support to restore the mental health workforce. While trauma and other stressors experienced by clients make community mental health a challenging setting in which to work, it also has the greatest opportunity to provide evidence-based interventions that, applied early, can prevent the need for institutional care and keep children living with families in their communities. Until recent adjustments, the Illinois Medicaid payment rates were so low that the community mental health

and other public providers could not pay staff wage levels that retained clinicians who serve families living in poverty. Moreover, until recently the Medicaid rates for family therapy, which is an evidence-based treatment modality and a specialized clinical skill, were lower than those for individual therapy, which may have disincentivize agencies from providing needed care.[15]

Ensuring a stable workforce that can provide equitable access to resources among all families will mean undertaking an analysis of provider cost structures that must be supported for a healthy and robust service delivery system. Given the system's reliance on Medicaid funding, HFS should actively review provider reimbursement rates to ensure effective and efficient treatment for children and families.

In Illinois there are several workgroups and research studies examining systemic approaches to addressing workforce shortages.[16] Even before the COVID-19 pandemic, these working groups were focused on building more appealing and affordable pathways to careers in case management and clinical care. Since the pandemic, it has become even more difficult to attract and retain qualified staff. Programs under consideration by working groups and research teams include tuition assistance for mental health-related educational programs, loan repayment or loan forgiveness programs for clinicians and other mental health professionals, special incentives for those who serve rural areas or special populations, and pipeline programs and partnerships between universities, state agencies, and providers. Some of this work highlights the potential for creating paraprofessional roles to assist in the delivery of services in the absence of more highly trained staff. In 2021, the Paraprofessional Workforce Workgroup produced a set of specific recommendations to HFS for formalizing these roles and deploying paraprofessionals to intervene with children and families with youth at-risk for behavioral or emotional difficulties.[xix]

Addressing workforce shortages will require attention not only to the number of clinicians but the number of trained, high-quality clinicians and other professionals who can provide evidence-based interventions to a diverse range of children. Many stakeholders have highlighted the need for a more diverse mental health workforce, with professionals who are culturally and demographically aligned with clients. Thus, Illinois should implement strategies to improve both the diversity and quality of providers through mechanisms such as specific types of training (for example, cultural competency, diversity, evidence-based interventions) as well as changes to hiring and compensation.

Another strategy for diversifying the workforce is to broaden our conceptualization of expertise to include lived experience, deep knowledge of the challenges in navigating systems, and peer support. This is consistent with approaches that rely on community members or community-based programs as informal mental health providers. Consultation with Communities United[17] suggests a need and desire for mental health services that are community driven and more informal. Through recent "Healing Through Justice" funding awards, Communities United will be able to sustain and possibly expand its informal mental health work. By augmenting the workforce with paraprofessionals who may not have the educational attainment of more highly trained clinicians but can obtain certification and training to perform many of the roles the Initiative recommends (for example, in-home behavioral health aides, resource navigators, peer supports), Illinois can deepen support for this and similar programs in other communities across the state.

Peer supports can serve as resource navigators and as trusted allies for parents as they identify and pursue services for youth. Peer support can also be integrated into mobile response implementation, which works

15. As of 7/1/2022, the family therapy rate has been raised to parity with the individual therapy rate.
16. Illinois Behavioral Health Workforce Education Center Task Force, the Illinois Chapter of the National Association of Social Workers, the Illinois Partners for Human Services
17. Communities United is a survivor-led, intergenerational racial justice organization developing grassroots leadership for social change.

on the scene with families to develop next steps and provide emotional support. Illinois should consider this option when building out a more robust continuum of services for families.

Several initiatives are already underway to address workforce challenges:

- Senate Bill 3617 ("Ensuring a More Qualified, Competent & Diverse Behavioral Health Workforce Act") directs DHS-DMH to award 3-year grants or contracts to community mental health centers (CMHCs) to establish or enhance training and supervision of interns and providers in training who are pursuing independent licensure as Licensed Clinical Social Workers (LCSW), Licensed Clinical Practitioner of Care (LCPC), or Licensed Marital Family Therapy (LMFT) clinicians.
- Public Act 102-0699 established significant rate increases for Medicaid-funded community mental health and substance use disorder services, a total annual fiscal impact estimated to be $160 million, to modernize rates and help rebuild the community behavioral health workforce.
- HFS has set aside $84 million in American Rescue Plan Act (ARPA) enhanced home and community-based services spending to support behavioral health workforce and new service development.
- The Illinois Behavioral Health Workforce Education Center Act commits $6 million to organize a broad consortium of stakeholders to implement strategies in every region of the state, which includes efforts to collect and analyze workforce data and grow and advance the peer and parent-peer workforce.
- The HFS-funded Provider Assistance and Training Hub (PATH) provides free training and coaching to behavioral health providers on a variety of topics (clinical interviewing, assessment, treatment planning, crisis de-escalation and safety planning, care coordination, etc.). On average, approximately 9,200 PATH trainings are completed annually.
- Department of Human Services Division of Mental Health Certified Recovery Support Specialist Success – Community College Tracks allows the DHS Division of Mental Health to utilize state marijuana tax funds to implement and evaluate community college programs for the Certified Recovery Support Specialist credential (200 per year).
- Health Resources Services Administration (HRSA) Behavioral Health Workforce Education and Training Program's 4-year grants to support the education and training of 25 students per year entering the behavioral health workforce.
- Jane Addams College of Social Work is piloting a 3-year project to recruit, enroll, and support 8–10 diverse Masters of Social Work (MSW) students (with a focus on Black and Brown men and Spanish-speaking women) by providing tuition waivers, stipends, and mentoring support.
- Community Behavioral Healthcare Association's Ensuring & Enhancing the Children's Community Mental Health Workforce project is piloting and evaluating an initiative to restore the capacity of community mental health organizations to serve as training institutions for mental health interns and early career staff from diverse mental health disciplines.

To implement this recommendation, **the Transformation Initiative recommends:**

- Consulting with the Paraprofessionals Workforce Workgroup and other workgroups on next steps for implementing strategies and recommendations;
- Developing paraprofessional roles with associated training requirements;
- Broadening resources available for peer support roles;

- Considering partnerships with state and community college systems to develop state-funded feeder programs that waive costs in exchange for commitment of a set number of years in state workforce, similar to models in medicine, teaching, and other fields; and
- Developing incentives to diversify the mental health workforce by attracting and retaining diverse staff.

12. *Fortify **community networks** by investing in local communities and parent leadership.* In 1984, the Child & Adolescent Service System Program (CASSP) laid out a conceptual framework to guide children's mental health service system development.[xx] These principles require that care be child-centered, family-focused, community-based, multisystem, culturally competent, and in the least restrictive environment. The principles have been used as the basis for Systems of Care (SOC), a service delivery approach that builds partnerships to create a broad, integrated process for meeting families' multiple needs. When implemented with fidelity, this approach can reduce home placement disruptions, mental health symptoms and suicide, and caregiver burden, while improving school attendance and performance. While Illinois has fully embraced these principles in the N.B. Implementation Plan and the development of the Pathways to Success program, there are areas where implementation of these principles can be strengthened.

    Children's mental health systems of care are best implemented in smaller regions where individual relationships between child-serving system leaders, provider partners, and community members can be developed and nurtured. Similarly, the groundwork for supporting parent and youth leadership and voice is best initiated at the local level.

    In Illinois, each state agency uses unique geographic boundaries as the basis of governance and resource distribution. While originally organized into local area networks (LANs), these networks are now implemented inconsistently. As a result, some well-resourced areas have robust LANs to manage local needs, and others are virtually nonexistent. The erosion of the LANs has left the State without a cohesive strategy to coordinate and resource community-level leadership and has allowed siloed care to proliferate. The HFS Designated Service Areas (DSA), developed based on population size and service utilization, offer an opportunity to rebuild and fortify community networks. These regions have been newly redesigned; each will have at least one "Care Coordination and Support Organization" (CCSO) to lead local efforts. The CCSOs are community mental health agencies that have staff specially trained in Wraparound, facilitating child and family teams, updating the IM+CANS with the team, overseeing the implementation of the plan of care, and ensuring that the child and family receive all recommended services. In addition, CCSOs act as localized, accountable hubs with responsibilities for coordinating with all the various state and local agencies and providers who are involved in the child and family's treatment, ensuring that everyone involved is working from the same plan of care to help the family reach their goals. CCSOs also must understand and coordinate local resources to help families access services and supports that they can rely on after they have graduated from Pathways services, helping to sustain their progress toward their goals.

    In addition, CCSOs are responsible for providing mobile crisis response (MCR), leadership for all Medicaid-eligible individuals in their DSA, and leadership for the Family Support Program and Specialized Family Support Program. For these reasons, the DSA geographies and the associated CCSOs are now the most logical locations and partners to focus efforts to develop and strengthen local systems of care.

    To fortify this network, it will be necessary to invest in staffing needed to coordinate and convene all the child serving system partners in that geography and support their collaboration with parent leaders, community, and each other. The network of DSAs can be structured with hubs and satellites to promote shared expertise in the context of Learning Collaboratives.

To implement this recommendation, **the Transformation Initiative recommends**:

- Considering adding a full-time role for local resource coordination to each CCSO staffing plan;
- Funding a parent leadership position within each DSA to ensure partnership with community in implementing network functions. Parent leaders should be hired through an independent family-run organization, which can share responsibility for initial and ongoing training;
- Develop a Learning Collaborative strategy to provide opportunities for DSAs/CCSOs to learn from each other on best practices to service implementation, needs assessment, and other key functions;
- Provide DSAs access to **resource referral technology** to ensure effective linkage to services for families.

Structural Changes

Structure and oversight. To continue the momentum of these efforts and oversee continued systems change will require a centralized hub for child and adolescent mental health system transformation. This hub should drive change across the state agencies, provider organizations, and local networks. This section outlines the key functions of a hub. The Transformation Initiative proposes to centralize some key functions, while distributing others according to agency strengths, infrastructure, and resources.

In addition to overseeing the coordination of distributed components, staff at a centralized hub will continue to drive work in data linkage and analysis, coordinate technological development, facilitate provider agency efforts to build and scale new programs, liaise with advocacy organizations, and vet policy proposals concerning children's mental health to ensure alignment. The centralized hub will have core participation by a team of inter-agency representatives empowered to make decisions and act to drive policy and system change, as well as to link the three distributed components of the restructured system, each of which leverages a technological application to promote streamlined and centralized access. The three components are:

- Child and Family Interface: A **Care Portal** will be available for children and families who need information and assistance seeking residential treatment or treatment alternatives. The Portal will be staffed with a team of Intake and Clinical Specialists who will monitor information entered into the Portal and ensure that families are routed to the most timely and appropriate services. This work will be assisted by a team of Family Navigators—navigators who have experience as part of the state system, as family members with lived experience, or both.
- Provider Interface: The central channel by which providers will interact with the child and adolescent mental health system will vary depending on the type of services they provide. Providers of community services may collaborate with CCSOs at the local level and with **resource referral technology** as part of a network. Providers of residential services may collaborate through a **centralized oversight** interface.
- Community Interface: Community networks, outpatient providers, and other system partners will work with the children's mental health service system using a **resource referral tool.** This tool will track capacity for outpatient services and promote clear communication with families for all case management and care coordination entities, including MCOs, DCFS case management, FSP coordinators, DD Waiver ISCs, and school districts.

Coordination of advisory groups. The Illinois Children's Mental Health Partnership (ICMHP) recently completed a strategic plan (5/22) that broadly addresses many of the problems identified in the children's mental health system. There is also legislation that went into effect in January 2023 that newly defines the leadership and membership of ICMHP. ICMHP can serve in an important advisory capacity for the centralized Hub, as the Transformation Initiative

team works to develop more specific plans to transform the Illinois child mental health system. ICMHP leadership and its executive committee should meet together with the hub until the plan has been fully implemented.

Vetting of legislative proposals. The hub can also serve as a knowledge bank to respond to, inform, and review legislative proposals to ensure continued alignment with system goals and minimize confusion introduced by conflicting statutes. The Transformation Initiative has piloted this function, providing feedback in cases where the potential of proposed legislation for improving children's mental health service delivery can be maximized by "connecting the dots" between related initiatives or requirements.

Development of strategic communication to raise awareness. A large part of the Transformation Initiative's work has been to promote a shared understanding of common assets, challenges, barriers, and solutions among a diverse array of stakeholders. Going forward, it will be important to continue to engage with system partners, including judges, probation officers, teachers, pediatricians, emergency room and other hospital staff, and others to ensure that they are supported in their roles, informed about the goals of transformation, and able to make decisions that help rather than hinder progress. This will require a coordinated communication strategy that leverages the work of the six state agencies to build public awareness and communicate overarching strategy through accessible modalities.

Ensure the installation of functional parent leadership. Consistent with CASSP principles, children's mental health systems of care should be family driven and youth guided. These values are at the core of the development of a sustainable mental health system that will function to effectively and efficiently meet the needs of children and families experiencing all levels of social emotional difficulties. Family voice and experience is essential to the development, implementation, and evaluation of the children's mental health service system. The Transformation Initiative is an opportunity to ensure that family leadership is a key driver and address the shortcomings of early efforts to host and support an independent family run organization.[18]

Engagement with parent leaders produced a set of specific recommendations to ensure sustained involvement of family leadership and diverse representation in system planning and transformation. These parents recommended that parent leadership originate from an "independent" family-run organization. They stressed that the independent nature of the family voice and leadership ensures that families and youth are able to provide honest feedback to hold providers and child-serving agencies accountable for the quality of services provided.[19] In some states, nearly every county has an independent, family-run organization operating in its geography. In Illinois, parent leadership could be nested within the six ISBE Social-Emotional Learning (SEL) Hubs, or within the HFS DSAs in collaboration with CCSO agencies. Funding for these positions should include salaries, benefits, office and meeting expenses, off-site training for parents, technology, and stipends. In addition, there should be an administrative allowance for the hiring "home" organization. The hub will engage regularly with parent leadership to ensure that ongoing system codesign will be a reality.

Oversee and review ongoing data analysis. The Transformation Initiative will continue to collaborate with the Chapin Hall team to develop precise capacity estimates and continue to refine strategies for data linkage to ensure that projections can be nimbly adjusted as needs change. The Transformation Initiative will focus on developing the State's capacity to conduct data analyses internally, so that these functions can become an integrated component of system management.

18. Illinois Federation of Families (IFF), a chapter of the National Federation of Families, was initiated in the early 1990's in the first round of System of Care grants through SAMHSA, which required family voice and leadership. Currently Illinois is one of only 8 states in the U.S. that does not have an active chapter of the Federation of Families, although there is currently one small independent family-run organization, and the Youth & Family Peer Support Alliance (established as part of a SAMHSA grant in Champaign County) continues to operate out of Rantoul, IL.
19. Community Organizing and Family Issues (COFI) was recommended as the hiring and administrative "home" for these parent leaders.

III. SYSTEM TRANSFORMATION PLAN

Oversight and Strategic Implementation

In partnering with Chapin Hall, the Transformation Initiative Blueprint for System Transformation is informed by rigorous research as well as strategic implementation guidance. Successful implementation of systemic change requires attention to a variety of areas. Specifically:

Strategic Implementation Supports

Leadership, governance, and strategy: What is the oversight and administrative structure? What are the goals? Who is responsible? Who leads?

Fiscal and policy alignment: What legislative and policy changes are needed to support the new vision? What rate adjustments are needed and how will they be accomplished?

Data analytics and evidence use: What analyses will inform estimates? What data and data linkage will we need to analyze the data? What best practice examples will be replicated?

Practice and implementation support: What is the communication strategy? Who needs to be trained? What materials will be used for education, awareness, and training?

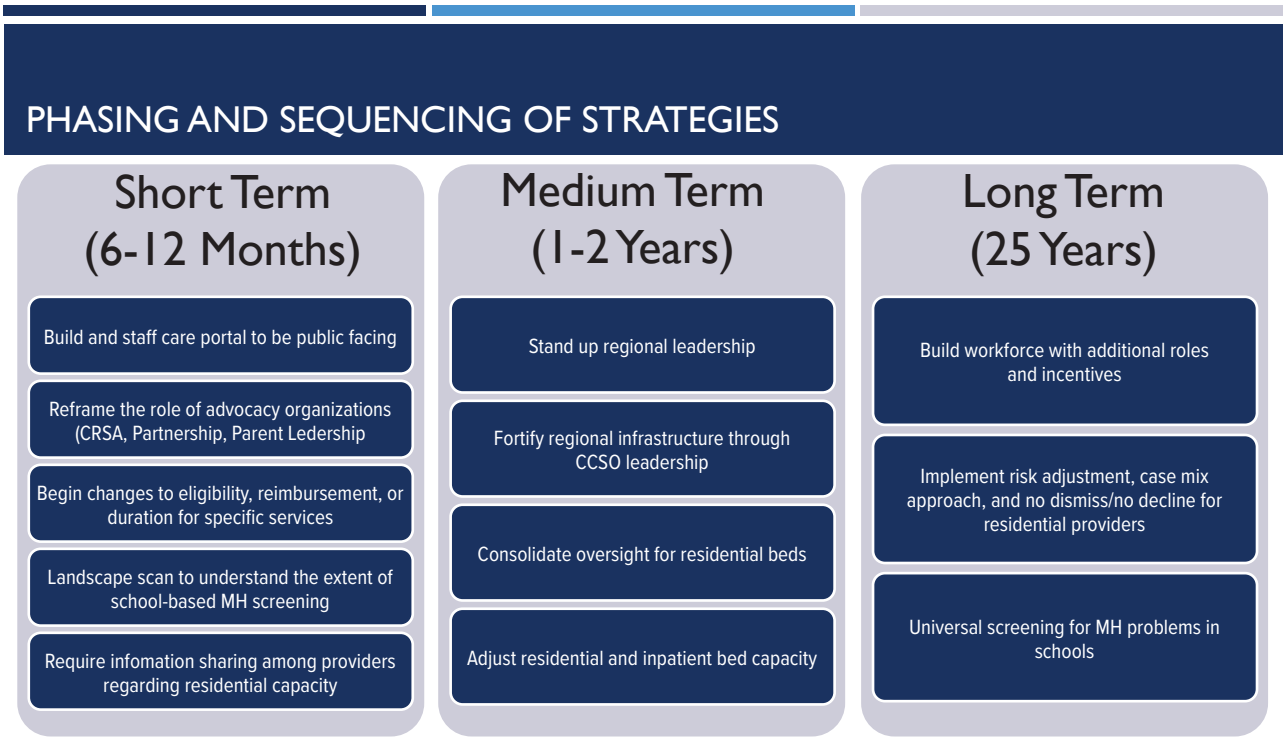
Continuous quality improvement: What IT systems, metrics, and indicators should be installed to ensure quality implementation and positive outcomes for children and families?

Broad engagement. Consistent with an implementation science approach to system transformation,[20] initial drafts of the Transformation Initiative's recommendations were vetted with subject matter experts for relevance and feasibility, reviewed by state agency teams to identify legislative and fiscal implications, and cross-walked with previous planning efforts to ensure that all of the voices and perspectives have been captured in recommendations for change.[21] In order to ensure that the Illinois children's mental and behavioral health system is aware of and responsive to the needs of children and families, it is critical that those most impacted by public policy are closely involved in the development of the system. Mental health provider and family voices should be included in every stage of design, planning, and implementation to achieve equitable, efficient, and effective results for the Illinois child and adolescent behavioral health care system. This broad engagement will continue; individuals with lived experience will be included at all levels of implementation planning.

Phased implementation. A phased implementation of recommendations will prioritize the most impactful and feasible changes, as well as those necessary to establish a foundation so that subsequent changes can be made. Figure 10 displays some of the short-, medium-, and long-term goals for the implementation of key strategies. To ensure that initial changes can be made, a subset of recommendations were identified as requiring immediate legislative and budgetary adjustments.

20. Implementation science, developed by the National Implementation Research Network (NIRN) is an approach to ensuring that changes result in meaningfully different experiences for service recipients and for maximizing the potential for positive outcomes.
21. The Transformation Initiative's recommendations were reconciled with the Plan developed by the Partnership for Children's Mental Health (2022) as well as the Report of the Whole Child Task Force (2019)

Figure 10. Phasing and Sequencing of Strategies.



Appendix A – Residential Provider Survey

The capacity of a residential provider is constrained by licensed capacity and staffed capacity. Because DCFS licenses residential facilities in Illinois, a licensed facility has a maximum licensed capacity determined by DCFS. In principle, a residential facility cannot provide more beds than it is licensed to provide at any time. Pertinent to policy considerations, a residential provider might not be able to staff all of the beds that it is licensed to provide at a given time. The staffed capacity of a residential provider more accurately represents the capability of a facility to provide beds to youth in need of residential placements. To measure staffed capacity, Chapin Hall administered a survey of licensed residential facilities in Illinois.

According to survey responses, mean facility capacity is 16 beds, while staffed capacity is 12 beds, implying that the average facility is operating at about 75% capacity. Survey responses show that facility total capacity ranges from 3 to 103 beds, while staffed capacity ranges from 0 to 66 beds.

Open-ended provider comments give more context to statewide needs pertaining to staffed capacity. Respondents emphasize that limited staffing is a significant challenge with wide ranging implications. Staff shortages at agencies that serve youth with externalizing behavior needs put both workers and youth at risk. Providers also point to financial challenges, which may both contribute to and result from staffing shortages.

Table A-1 summarizes residential capacity in Illinois based on survey data and administrative data. All survey results and administrative data were first aggregated to the address level (sometimes there is more than one provider at an address) and then summary statistics were calculated.

Table A-1. Summary Statistics of Survey Responses to the Illinois Residential Provider Survey Conducted by Chapin Hall

Survey Question / Variable	Mean	SD	Sum
Total Illinois licensed capacity according to admin data	21.805	36.448	3467
Licensed capacity among respondents according to admin data	17.418	21.216	1167
Please provide information about the capacity of each of the facilities you supervise… When we say **total capacity**, we mean the number of clients you could serve at one time, *if you were fully staffed*.	15.955	21.88	1069
Please provide information about the capacity of each of the facilities you supervise… When we say **staffed capacity**, we mean the number of clients *from all state agencies* you *could serve given current staffing levels*.	11.716	14.985	785
For each of the facilities that you supervise, please enter the **number of clients you serve that are from out-of-state**.	0.299	2.008	20
In the facilities you supervise, you probably have beds *occupied* by clients placed by state agencies. **Right now, how many beds are occupied by clients placed by the following agencies?** …DCFS	6.94	11.901	465
…DJJ	0.03	0.171	2
…ISBE	0.642	2.301	43
…DDD/DHS	1.91	5.712	128

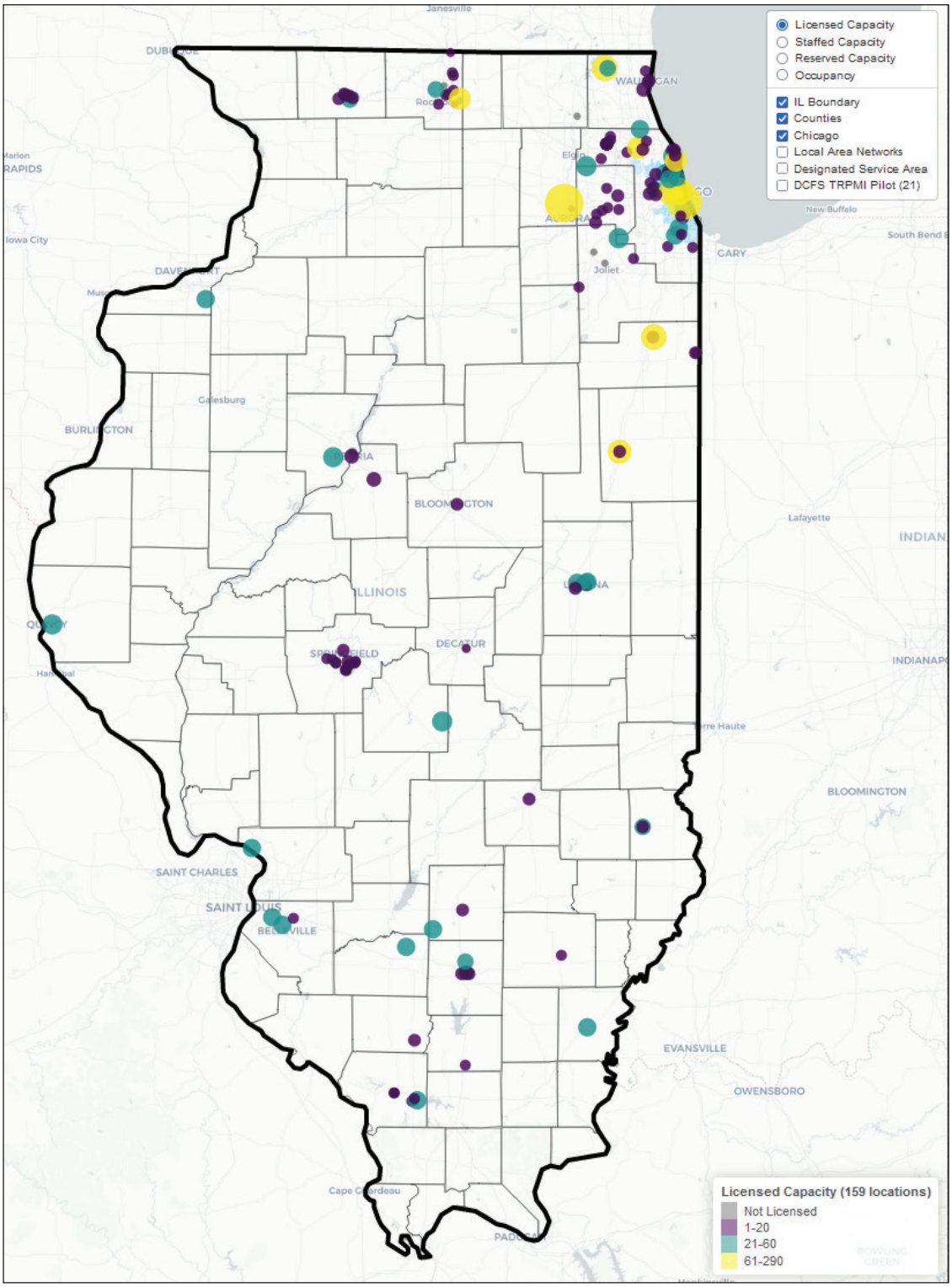
APPENDIX A – RESIDENTIAL PROVIDER SURVEY

Survey Question / Variable	Mean	SD	Sum
...HFS/FSP	0.448	1.52	30
...HFS Interim Relief	0	0	0
...Paid for by private payor	0.149	0.803	10
Total Occupancy	10.119	13.754	678
In the facilities you supervise, you may also have beds *reserved* for clients placed by state agencies. **Right now, how many beds are <u>reserved for</u> clients placed by the following agencies**? If you don't reserve beds, just enter zero. ...DCFS	6.403	13.026	429
...DJJ	0.179	1.043	12
...ISBE	0.597	4.645	40
...DDD/DHS	0.657	5.375	44
...HFS/FSP	0.03	0.244	2
...HFS Interim Relief	0	0	0
...Paid for by private payor	0.119	0.686	8
Total reserved capacity	7.985	14.864	535
When your program(s) is/are fully staffed, can you serve youth with the following needs?[a][1] Please answer for each need and facility. Choose all that apply. ...youth with developmental disabilities	0.478	0.503	32
...youth with aggressive behavior	0.463	0.502	31
...youth with anxiety/depression	0.522	0.503	35
...youth with sexually aggressive behavior	0.09	0.288	6
...youth transitioning to adulthood	0.463	0.502	31

[a] The mean will be between 0 and 1 for these items because the responses are binary (True or False).

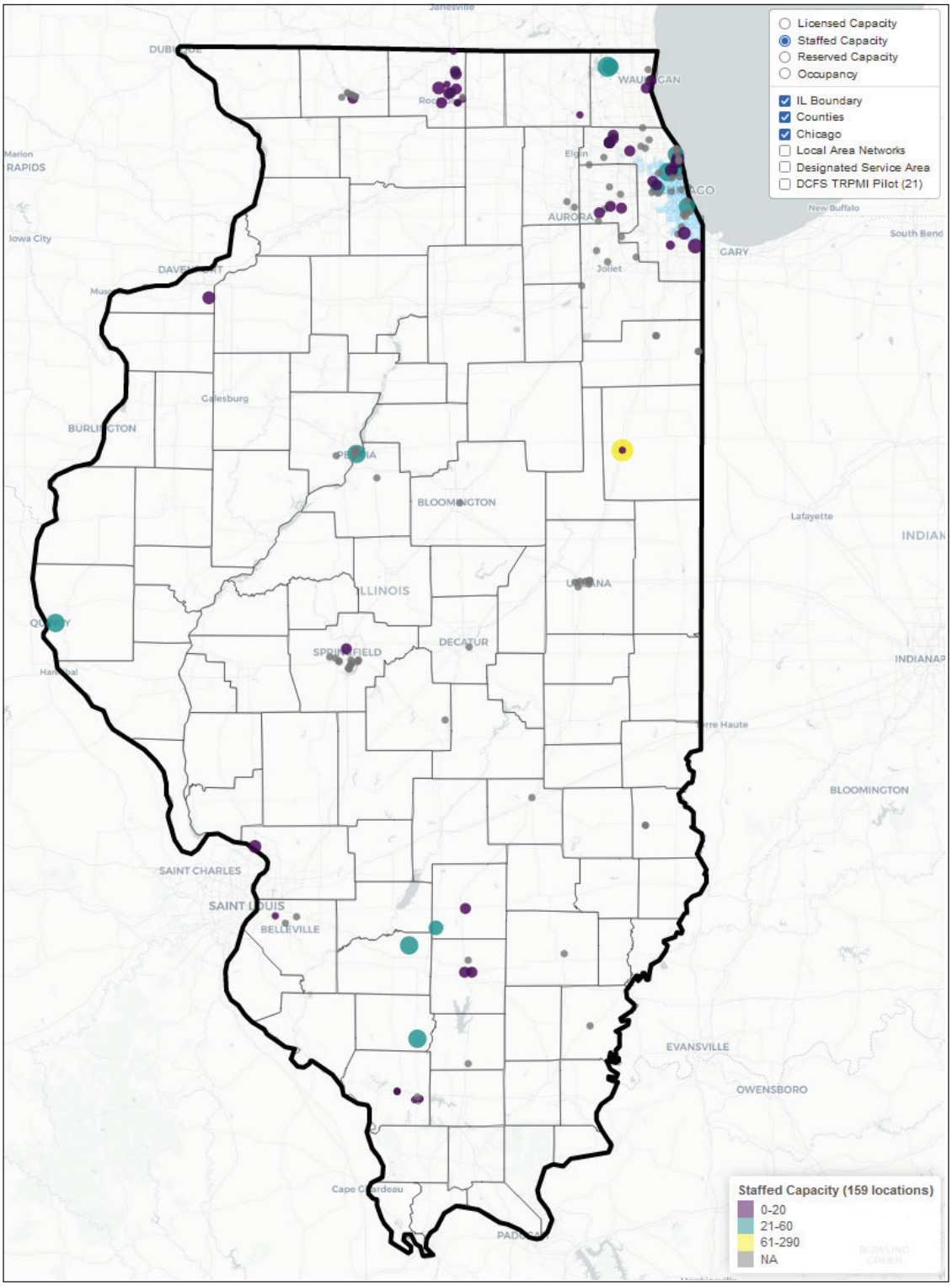
APPENDIX A – RESIDENTIAL PROVIDER SURVEY

Image 1. Licensed Bed Capacity of Illinois Residential Providers Based on DCFS Administrative Data



APPENDIX A – RESIDENTIAL PROVIDER SURVEY

Image 2. Staffed Capacity of Illinois Residential Providers Based on the Provider Survey



APPENDIX A – RESIDENTIAL PROVIDER SURVEY

Image 3. Licensed Capacity of Cook County Area Residential Providers Based on DCFS Administrative Data

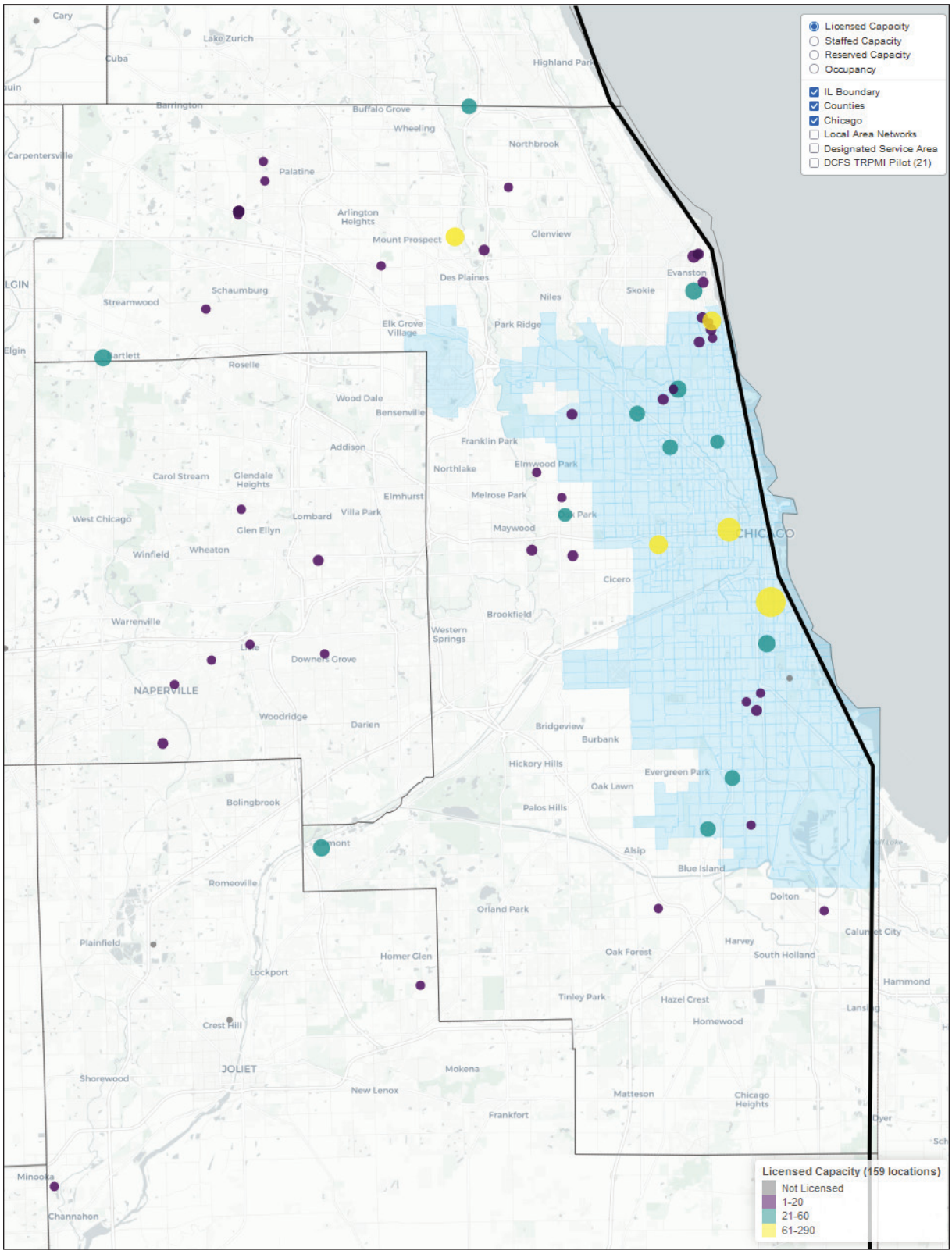
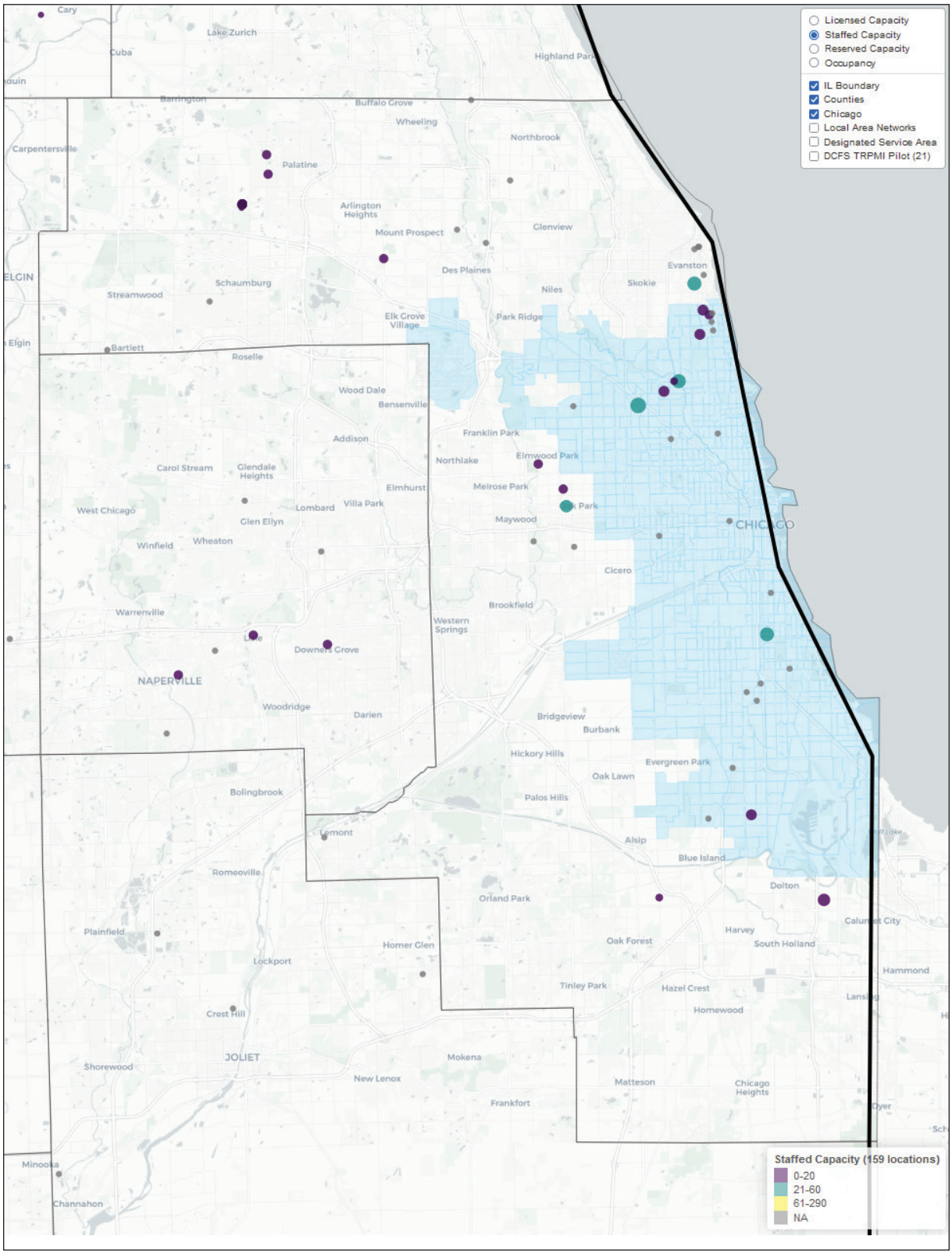


Image 4. Staffed Capacity of Cook County Area Residential Providers Based on the Provider Survey



Appendix B – Residential Service Needs

Chapin Hall worked with the Illinois Department of Children and Family Services (DCFS), the Illinois State Board of Education (ISBE) and the Department of Human and Family Services (HFS) to obtain data on youth who need residential treatment programs. Using these data, Chapin Hall conducted two Latent Class Analyses (LCA), with the goal of better understanding the distinct needs and subgroups of the residential treatment population in Illinois. LCA is a statistical method that identifies unobserved subgroups, called latent classes, within a population based on a chosen set of indicators.[xxi] The first LCA was conducted on a sample of DCFS youth requiring residential placement. The second LCA was conducted on a sample of Illinois K–12 Students with Individualized Education Programs (IEP) who were eligible for residential placement. Chapin Hall also analyzed data on youth who spent time in residential programs funded by HFS through the Family Support Program (FSP) or Department of Health Services (DHS)-administered residential programs. Chapin Hall did not conduct an LCA on these HFS/DHS youth due to data limitations. However, descriptive statistics on this population are presented, along with detailed findings of the analyses, below.

DCFS Youth Latent Class Analysis

Sample and Data Sources

DCFS maintains a database of youth who have been determined to need alternative placements based on youth's receipt of Clinical Intervention for Placement Preservation (CIPP). CIPP is a facilitator-guided, multidisciplinary team decision-making process that convenes for youth facing disruption of current placement or requiring a higher level of care. CIPP makes recommendations for the most appropriate level of care, including residential care. Chapin Hall used the CIPP database to identify all youth whose alternative placement need was in a residential care setting, based on having a CIPP conducted between July 1, 2020 and June 30, 2022. Chapin Hall also used the DCFS Psychiatric Hospital Tracking (PHT) database to identify all youth who were discharged from a psychiatric hospital into a residential care setting within this 2-year timeframe.

Combining the CIPP database and the PHT database resulted in 1,379 unique youth who experienced a CIPP intervention or were discharged from a psychiatric hospital into a residential care setting (or both). Chapin Hall then linked each youth to their available Child and Adolescent Needs and Strengths (CANS) assessment, which is administered to youth in DCFS care to assess their service needs. The Illinois DCFS CANS consists of 94 youth items and 45 caregiver items. Each CANS item is rated on a 0 to 3 scale. A rating of a "2" or a "3" is considered "actionable" and requires an intervention to address the need. Only CANS conducted within a minimum of 90 days from the youth's CIPP date or psychiatric hospital discharge date were used. Youth who did not have a CANS available within 90 days were excluded from the final sample. The final sample included 846 DCFS youth who were identified as requiring residential placement between July 1, 2020, and June 30, 2022.

LCA Model

Chapin Hall used DCFS administrative data from the Child and Youth Centered Information System (CYCIS) and the Statewide Automated Child Welfare Information System (SACWIS) to define a set of indicators, also known as dimensions, for the LCA model. The following dimensions were used in the LCA model:

- Gender
- Age (over/under 16)
- Placement instability (2 or more prior)

- Hospitalization history (1 or more prior)
- Detention history (1 or more prior)
- Developmental disability
- Emotional/behavioral issues
- Risk behaviors
- Danger to others
- Danger to self

Placement instability, hospitalization history, and detention history were respectively defined as having two or more such DCFS placements,[1] at least one prior hospitalization[2,3], and at least one placement in a detention setting[4] prior to the point of being identified for residential care. CANS assessment data were used to create the developmental disability,[5] emotional/behavioral issues,[6] risk behaviors,[7] danger to others,[8] and danger to self[9] dimensions.

Model Building and Selection

Table B-1. Fit Indices of LCA Models with 1 to 7 classes for DCFS Sample (***N*** = 846)

Model	Log-Likelihood (LL)	Akaike Information Criteria (AIC)	Bayesian Information Criteria (BIC)
1 Class	-4971.33	9962.66	10010.07
2 Class	-4688.13	9418.27	9517.82
3 Class	-4565.87	9195.75	9347.44
4 Class	-4529.15	9144.29	9348.14
5 Class	-4497.95	9103.90	9359.89
6 Class	-4472.07	9074.13	9382.27
7 Class	-4452.03	9056.07	9416.35

Chapin Hall followed conventional approaches to constructing the LCA model. LCA models were estimated by adding one class at a time, starting with the one-class model. Random starts were used to ensure that a global solution, rather than a local solution, was found for each model. Table B-1 presents three different fit indices commonly used in LCA model selection: Log-Likelihood (LL), Akaike Information Criteria (AIC), and Bayesian Information Criteria (BIC). In addition to the above fit indices, researchers also must consider how the selected models relate to another, and each model's general interpretability before selecting a solution.[xxii] Taking these considerations into context, Chapin Hall selected the 5-class model, the results of which are presented below.

1. Unbridged placement data is used. Placement at the time of CIPP/Hospital Discharge is excluded.
2. "HFM" (Medical Hospitalizations), "HFP" (Mental Health/Psychiatric Hospitalization), "HHF" (Hospital/Health Facility) Placement Codes.
3. For youth in PHT, the hospitalization spell at the time of discharge to residential care is excluded.
4. "DET" (Detention Facility/Jail) Placement code.
5. Cans34: Developmental/Intellectual has score of 2 or 3.
6. Two or more of the following CANS score a 2 or 3: Cans14: Adjustment to Trauma, Cans48: Psychosis, Cans49: Attention Deficit/Impulse Control, Cans50: Depression, Cans51: Anxiety, Cans52: Oppositional Behavior, Cans53: Conduct, Cans54: Substance Abuse, Cans56: Eating Disturbances, Cans57: Affect Dysregulation, Cans60: Anger Control.
7. One or more of the following CANS score a 2 or 3: Cans61: Suicide Risk, Cans62: Self-Mutilation, Cans63: Other Self Harm, Cans64: Danger to Others, Cans65: Sexual Aggression, Cans66: Runaway, Cans67: Delinquency, Cans68: Judgement, Cans69: Fire Setting, Cans70: Social Behavior.
8. Cans64: Danger to Others has score of 2 or 3.
9. One or more of the following CANS score a 2 or 3: Cans61: Suicide Risk, Cans62: Self-Mutilation, Cans63: Other Self Harm.

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Results

Figure B-1. 5-Class LCA Model of DCFS Youth (***n*** = 846)

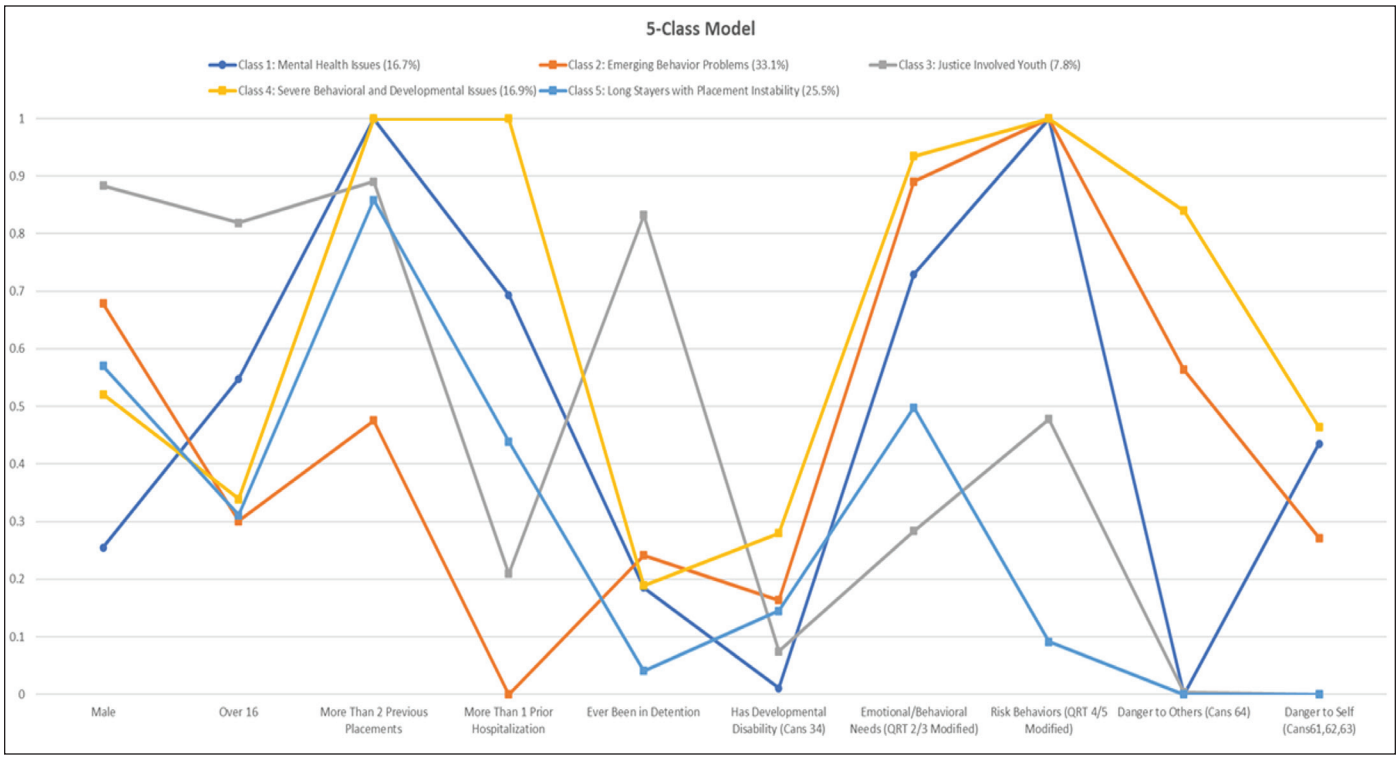

Figure B-1 shows the results of the 5-class LCA model for the 846 youth. Each line represents 1 of the 5 classes. The y-axis represents the predicted probability of a youth in each class exhibiting each respective dimension. For example, a youth in Class 1 has a 25% chance of being male. The 5 classes are differentiated from one another by their predicted probabilities on each dimension. These predicted probabilities are then used to assign each youth in the sample to a specific class. Note that the y-axis predicted probabilities from the LCA model may differ from the actual percentage of youth in each class exhibiting a certain dimension once they are assigned. We present descriptive statistics and discuss each class in further detail below.

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Class 1: Mental Health Issues (n = 141; 16.7 % of DCFS sample)

Table B-1. Descriptive Statistics for Class 1: Mental Health Issues

N	141
Mean Age (SD)	15.49 (2.19)
Male (n, %)	32 (22.7%)
White (n, %)	73 (51.77%)
Black (n, %)	64 (45.39%)
Mean Time in Care, days (SD)	1304.36 (1111.02)
Mean Total Placement Count, (n, (SD))	19.05 (14.69)
Youth with Prior Hospitalization (n, %)	126 (89.36%)
Mean Hospitalization Count (SD)	4.72 (3.81)
Youth Ever in Detention (n, %)	23 (16.31%)
Youth with Emotional/Behavioral Needs - QRT 2/3 (n, %)	103 (73.05%)
Youth with Risk Behaviors - QRT 4/5 (n, %)	141 (100%)
Youth with Developmental Disability - Cans34 (n, %)	0 (0%)
Danger to Others - Cans64 (n, %)	0 (0%)
Danger to Self - Cans61,62,63 (n, %)	63 (44.68%)
QRTP Algorithm Recommends QRTP Placement (n, %)	43 (30.5%)

Table B-1 shows descriptive statistics for class 1, also called the "Mental Health Issues" class, comprising 16.7% of the DCFS sample. Youth in this class were more likely to be female, experience placement instability, and have prior hospitalizations. Youth also had a high rates of emotional/behavioral needs and risk behaviors. Table B-2 shows the top ten most frequently actionable CANS items for these youth (score of 2 or 3), revealing a high likelihood of trauma due to physical abuse (40%) and sexual abuse (50%). Youth in this class are also likely to need acute psychiatric care to address depression, anxiety, and risk behaviors. Retroactively applying the Qualified Residential Treatment Program (QRTP) decision support criteria (under Illinois' implementation of the Family First Prevention Services Act) to these youth's CANS assessments reveals that 30% would have been recommended for residential placement.

Table B-2. Top Ten CANS Items for Class 1: Mental Health Issues

CANS Number	CANS Item	Percentage of Actionable Responses (CANS score of 2 or 3)
cans4	Neglect	56%
cans14	Adjustment to Trauma	56%
cans66	Runaway	56%
cans1	Sexual Abuse	49%
cans24	Coping and Savoring Skills	48%
cans50	Depression	48%
cans61	Suicide Risk	44%
cans29	Relationship Permanence	42%
cans60	Anger Control	41%
cans2	Physical Abuse	40%

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Class 2: Emerging Behavior Problems (n = 280; 33 % of DCFS sample)

Table B-3. Descriptive Statistics for Class 2: Emerging Behavior Problems

N	280
Mean Age (SD)	14.56 (2.57)
Male (n, %)	191 (68.21%)
White (n, %)	154 (55%)
Black (n, %)	118 (42.14%)
Mean Time in Care, days (SD)	484.36 (822.2)
Mean Total Placement Count (SD)	5.22 (5.94)
Youth with Prior Hospitalization (n, %)	75 (26.79%)
Mean Hospitalization Count (SD)	0.55 (0.7)
Youth Ever in Detention (n, %)	67 (23.93%)
Youth with Emotional/Behavioral Needs - QRT 2/3 (n, %)	254 (90.71%)
Youth with Risk Behaviors - QRT 4/5 (n, %)	280 (100%)
Youth with Developmental Disability - Cans34 (n, %)	46 (16.43%)
Danger to Others - Cans64 (n, %)	154 (55%)
Danger to Self - Cans61,62,63 (n, %)	73 (26.07%)
QRTP Algorithm Recommends QRTP Placement (n, %)	158 (56.43%)

Table B-3 shows descriptive statistics for Class 2, also called the "Emerging Behavior Problems" class. This was the largest class in the analysis, with 280 youth, or 33% of the sample. Youth in this class were more likely to be younger males who have been in DCFS care for a shorter period as compared to the rest of the sample. Despite this, they still exhibited significant placement instability, averaging over 5 placement moves in only 484 days in care. These youth had very high rates of emotional/behavioral needs, risk behaviors, and danger to others. Anger control, oppositional behavior, judgment, attention deficit/impulse control, and danger to others were all in this group's top ten actionable CANS items (see Table B-4), further illustrating their high level of behavioral needs. Retroactively applying the QRTP decision support criteria to these youth's CANS assessments reveals that 56%would have been recommended for residential placement.

Table B-4. Top Ten CANS items for Class 2: Emerging Behavior Problems

CANS Number	CANS Item	Percentage of Actionable Responses (CANS score of 2 or 3)
cans60	Anger Control	71%
cans14	Adjustment to Trauma	63%
cans52	Oppositional Behavior	61%
cans24	Coping and Savoring Skills	60%
cans31	Family - Life Functioning Domain	60%
cans68	Judgment	60%
cans4	Neglect	56%
cans49	Attention Deficit/Impulse Control	56%
cans64	Danger to Others	55%
cans29	Relationship Permanence	54%

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Class 3: Justice-Involved Youth (n = 66; 8% of DCFS sample)

Table B-5. Descriptive Statistics for Class 3: Justice-Involved Youth

N	66
Mean Age (SD)	16.83 (1.23)
Male (n, %)	60 (90.91%)
White (n, %)	26 (39.39%)
Black (n, %)	40 (60.61%)
Mean Time in Care, days (SD)	1318.38 (1310.11)
Mean Total Placement Count (SD)	15.73 (18.03)
Youth with Prior Hospitalization (n, %)	29 (43.94%)
Mean Hospitalization Count (SD)	2.08 (6.55)
Youth Ever in Detention (n, %)	62 (93.94%)
Youth with Emotional/Behavioral Needs - QRT 2/3 (n, %)	16 (24.24%)
Youth with Risk Behaviors - QRT 4/5 (n, %)	33 (50%)
Youth with Developmental Disability - Cans34 (n, %)	4 (6.06%)
Danger to Others - Cans64 (n, %)	0 (0%)
Danger to Self - Cans61,62,63 (n, %)	0 (0%)
QRTP Algorithm Recommends QRTP Placement (n, %)	5 (7.58%)

Table 5 shows descriptive statistics for class 3, also called the "Justice Involved Youth" class, which made up 8 percent of the DCFS sample. Youth in this class were disproportionately more likely to be black (61%) and male (91%). Most notably, 94% of youth in this class had been in a detention setting. However, CANS data for these youth revealed low levels of emotional/behavioral needs and risk behaviors, and no likelihood of danger to self nor others. Rather, elevated CANS items suggest the need for educational, legal, housing, and relationship supports for these youth. Retroactively applying the QRTP decision support criteria to these youth's CANS assessments reveals that only 8% would have been recommended for residential placement.

Table B-6. Top Ten CANS items for Class 3: Justice-Involved Youth

CANS Number	CANS Item	Percentage of Actionable Responses (CANS score of 2 or 3)
cans36	Legal	53%
cans66	Runaway	34%
cans4	Neglect	29%
cans42	School Achievement	26%
cans67	Delinquency	25%
cans22	Educational Setting	24%
cans31	Family - Life Functioning Domain	23%
cans20	Family - Strengths Domain	23%
cans29	Relationship Permanence	22%
cans68	Judgment	21%

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Class 4: Severe Behavioral and Developmental Issues (n = 143; 17% of DCFS sample)

Table B-7. Descriptive Statistics for Class 4: Severe Behavioral and Developmental Issues

N	143
Mean Age (SD)	14.39 (2.84)
Male (n, %)	76 (53.15%)
White (n, %)	63 (44.06%)
Black (n, %)	71 (49.65%)
Mean Time in Care, days (SD)	1690.59 (1405.59)
Mean Total Placement Count (SD)	20.32 (14.31)
Youth with Prior Hospitalization (n, %)	143 (100%)
Mean Hospitalization Count (SD)	6.23 (5.11)
Youth Ever in Detention (n, %)	28 (19.58%)
Youth with Emotional/Behavioral Needs - QRT 2/3 (n, %)	134 (93.71%)
Youth with Risk Behaviors - QRT 4/5 (n, %)	143 (100%)
Youth with Developmental Disability - Cans34 (n, %)	47 (32.87%)
Danger to Others - Cans64 (n, %)	133 (93.01%)
Danger to Self - Cans61,62,63 (n, %)	65 (45.45%)
QRTP Algorithm Recommends QRTP Placement (n, %)	108 (75.52%)

Table B-7 shows descriptive statistics for class 4, also called the "Severe Behavioral and Developmental Issues" class, which made up 17% of the DCFS sample. Youth in this class had the highest rates of danger to others (93%) and risk behaviors (100%). This group also had high levels of placement instability and prior hospitalization. Of all groups, youth in this class also had the highest likelihood of having developmental disabilities (33%). The top ten actionable CANS items for this group reveal these youth often have experienced physical abuse (58%) and exhibit attention/impulse control problems (71%), underscoring the connection between trauma and behavior problems and suggesting that earlier, trauma-informed intervention may have been indicated. Retroactively applying the QRTP decision support criteria to these youth's CANS assessments reveals that 76% would have been recommended for residential placement.

Table B-8. Top Ten CANS items for Class 4: Severe Behavioral and Developmental Issues

CANS Number	CANS Item	Percentage of Actionable Responses (CANS score of 2 or 3)
cans64	Danger to Others	93%
cans60	Anger Control	86%
cans14	Adjustment to Trauma	76%
cans24	Coping and Savoring Skills	74%
cans49	Attention Deficit/Impulse Control	71%
cans4	Neglect	66%
cans52	Oppositional Behavior	63%
cans29	Relationship Permanence	58%
cans2	Physical Abuse	58%
cans68	Judgment	56%

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Class 5: Long Stayers with Placement Instability (n = 216; 26% of DCFS sample)

Table B-9. Descriptive Statistics for Class 5: Long Stayers with Placement Instability

N	216
Mean Age (SD)	14.42 (2.76)
Male (n, %)	128 (59.26%)
White (n, %)	101 (46.76%)
Black (n, %)	110 (50.93%)
Mean Time in Care, days (SD)	1469.58 (1335.62)
Mean Total Placement Count (SD)	11.38 (8.39)
Youth with Prior Hospitalization (n, %)	141 (65.28%)
Mean Hospitalization Count (SD)	2.71 (3.33)
Youth Ever in Detention (n, %)	5 (2.31%)
Youth with Emotional/Behavioral Needs - QRT 2/3 (n, %)	104 (48.15%)
Youth with Risk Behaviors - QRT 4/5 (n, %)	10 (4.63%)
Youth with Developmental Disability - Cans34 (n, %)	31 (14.35%)
Danger to Others - Cans64 (n, %)	0 (0%)
Danger to Self - Cans61,62,63 (n, %)	0 (0%)
QRTP Algorithm Recommends QRTP Placement (n, %)	0 (0%)

Table B-9 shows descriptive statistics for class 5, also called the "Long Stayers with Placement Instability" class. This was the second-largest class in the analysis, with 216 youth comprising 26% of the total sample. These youth have been in DCFS care for an average of 1,470 days, with an average of 11 placement moves, or 2.8 placement moves per year. This group has very low rate of risk behaviors (5%) and pose no danger to self nor others (0%). This suggests that youth in this class may be in the residential queue because they have exhausted other treatment options, but not because residential treatment is indicated. Retroactively applying the QRTP decision support criteria to these youth's CANs assessments reveals that 0% would have been recommended for residential placement.

Table B-10. Descriptive Statistics for Class 5: Long Stayers with Placement Instability

CANS Number	CANS Item	Percentage of Actionable Responses (CANS score of 2 or 3)
cans4	Neglect	44%
cans14	Adjustment to Trauma	35%
cans49	Attention Deficit/Impulse Control	34%
cans2	Physical Abuse	28%
cans24	Coping and Savoring Skills	27%
cans29	Relationship Permanence	24%
cans20	Family - Strengths Domain	24%
cans1	Sexual Abuse	24%
cans13	Parental Criminal Behavior	24%
cans60	Anger Control	23%

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Illinois K-12 ISBE Latent Class Analysis

Sample and Data Sources

The Illinois State Board of Education (ISBE) provided Chapin Hall with data on all public and private school students who had an Individualized Education Plan (IEP) and were eligible for residential care[10] within the 2018 through 2021 school years. This resulted in a sample of 1,957 unique youth. Attendance, detention center history, restraint/timeout history, enrollment, and demographic data for these youth were pulled from the ISBE Student Information System (SIS). Data regarding youth's disability and other IEP-related information were pulled from the ISBE IEP-Student Tracking and Reporting System (I-STAR).

LCA Model

Chapin Hall used the data provided by ISBE to create the following dimensions for the LCA model:

- Gender
- Age (over/under 16)
- Emotional disability[11]
- Intellectual disability[12]
- Autism[13]
- Detention history
- Restraint/timeout history

Detention history was coded as a "yes" if the youth had at least one record of staying in a detention center at any point since 2018.[14] Restraint/timeout history was coded as a "yes" if the youth had at least one restraint/timeout record at any point since 2018.[15] Disability dimensions refer to the category of the students' Individualized Education Plan (IEP); these were coded as a "yes" if the youth had a record of the disability in either their "primary disability" or "secondary disability" values from I-STAR.

Model Building and Selection

Table B-11 presents the Log-Likelihood (LL), Akaike Information Criteria (AIC), and Bayesian Information Criteria (BIC) for one- through seven-class LCA models for the ISBE sample. Similar to the DCFS youth Latent Class Analysis, Chapin Hall utilized the above fit indices, as well as model interpretability and contextual factors to select a model. Chapin Hall selected the 4-class model, the results of which are presented below.

10. Residential eligibility was determined by having an Eligibility Type equal to "Group home operated by a public or private agency" or Eligibility Type equal to "Private facility" in I-STAR.
11. "Emotional Disability" value in I-STAR
12. "Intellectual Disability" value in I-STAR
13. "Autism" value in I-STAR
14. Detention Center history was not available prior to 2018 school year.
15. Restraint/timeout history was not available prior to 2018 school year.

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Table B-11. Fit Indices of LCA Models with 1 to 7 classes for ISBE Sample (***N*** = 1,957)

Model	Log-Likelihood (LL)	Akaike Information Criteria (AIC)	Bayesian Information Criteria (BIC)
1 Class	-6373.75	12761.50	12800.55
2 Class	-6215.71	12461.42	12545.11
3 Class	-6179.98	12405.97	12534.29
4 Class	-6154.52	12371.03	12543.98
5 Class	-6141.07	12360.14	12577.73
6 Class	-6126.12	12346.24	12608.46
7 Class*	-6114.48	12338.97	12645.82

* 7-class model did not converge on a global solution

Results

Figure B-2. 4-Class LCA Model of ISBE Youth (***n*** = 1,957)

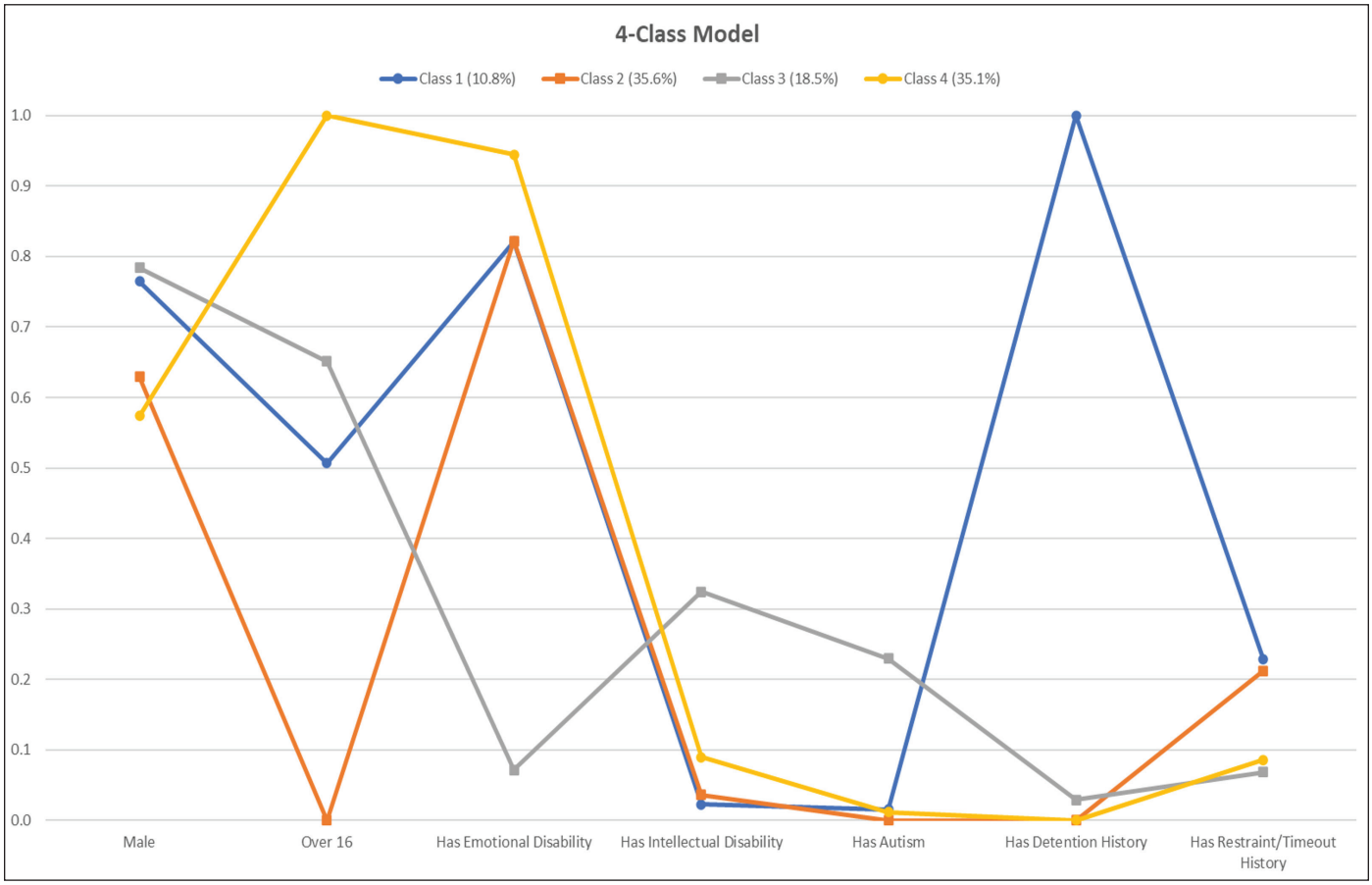

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Figure B-2 shows the results of the 4-class LCA model for the 1,957 ISBE youth. Each line represents one of the four classes. The y-axis represents the predicted probability of a youth in each class exhibiting each respective dimension. The four classes are differentiated from one another by their predicted probabilities on each dimension. These predicted probabilities are then used to assign each youth in the sample to a specific class. Note that the y-axis predicted probabilities from the LCA model may differ from the actual percentage of youth in each class exhibiting a certain dimension once they are assigned. We present descriptive statistics and discuss each class in further detail below.

Class 1: Justice-Involved Youth (n = 211; 11% of ISBE sample)

Table B-12. Descriptive statistics for Class 1: Justice-Involved Youth

N	211
Mean Age (SD)	16 (1.48)
Male (n,%)	162 (76.78%)
White (n,%)	75 (35.55%)
Black (n,%)	112 (53.08%)
Hispanic/ Latino	14 (6.64%)
Free and Reduced Lunch Eligible (n,%)	195 (92.42%)
EL (n,%)	6 (2.84%)
Ever Detention (n,%)	211 (100%)
Ever Restraint (n,%)	47 (22.27%)
Disability*	
Specific Learning Disability (n, %)	47 (22.27%)
Physical Disability[a] (n, %)	1 (0.47%)
Other Health Impairment (n, %)	66 (31.28%)
Developmental Delay (n, %)	0 (0%)
Emotional Disability (n, %)	167 (79.15%)
Intellectual Disability (n, %)	4 (1.9%)
Autism (n, %)	1 (0.47%)

*youth can have more than one disability.

[a] Any of "Deaf-Blindness", "Deafness", "Hearing Impairment", "Orthopedic Impairment", "Speech and/or Language Impairment", "Traumatic Brain-Injury", or "Visual Impairment" values in I-STAR.

Table B-12 presents descriptive statistics for Class 1, also called the "Justice-Involved Youth" class, which represents 11% of the ISBE sample. Youth in this class were slightly older (average age 16 years), primarily male (77%), and Black (53%). Of note, all the youth (100%) in this class have spent time in a detention center. This class also had the highest rate of restraint/timeout history (22%) among the ISBE sample. This class bears a striking resemblance to Class 3: Justice-Involved Youth from the DCFS LCA model. Both these classes were disproportionately older, black males who have spent time in detention settings, but in this analysis Class 1 also appears to have a high rate of Individualized Education Plans (IEP) for "emotional disability".

Class 2: Younger Youth with Emotional Disability and Experience of Restraints (*n* = 697; 36% of ISBE sample)

Table B-13 presents descriptive statistics for Class 2, also called the "Younger Youth with Emotional Disability and Experience of Restraints" class. With a total of 697 youth, this was the largest among all classes in the analysis, comprising 36% of the ISBE sample. Youth in this class were younger (average age 13 years old), and more likely to be Black (49%) as compared to the rest of the sample. This class had the second-highest rate of restraint/timeout history (20%), which suggests moderate behavioral problems among these youth. Seventy-three percent of the youth in Class 2 had an emotional disability. This class most closely parallels Class 2: Emerging Behavior Problems in the DCFS LCA model, in that it consists of younger youth who have a higher level of behavioral needs.

Table B-13. Descriptive Statistics for Class 2: Younger Youth with Emotional Disability and Experience of Restraints

N	697
Mean Age (SD)	12.94 (2.6)
Male (n, %)	449 (64.42%)
White (n, %)	260 (37.3%)
Black (n, %)	338 (48.5%)
Hispanic/ Latino	58 (8.32%)
Free and Reduced Lunch Eligible (n, %)	662 (94.98%)
EL (n, %)	15 (2.15%)
Ever Detention (n, %)	0 (0%)
Ever Restraint (n, %)	137 (19.66%)
Disability (n, %)*	
Specific Learning Disability (n, %)	93 (13.34%)
Physical Disability (n, %)	23 (3.3%)
Other Health Impairment (n, %)	225 (32.28%)
Developmental Delay (n, %)	27 (3.87%)
Emotional Disability (n, %)	507 (72.74%)
Intellectual Disability (n, %)	21 (3.01%)
Autism (n, %)	0 (0%)

*youth can have more than one disability.

Class 3: Youth with Intellectual Disability and Autism (n = 362; 18.5% of ISBE sample)

Table B-14 presents descriptive statistics for Class 3, also called the "Youth with Intellectual Disability and Autism" class, which represents 18.5 percent of the ISBE sample. Youth in this class were older (average age 17 years), and primarily White (50%) and Male (76%). The primary disabilities among youth in this class were Intellectual Disability (38%), Autism (25%), and Other Heath Impairment (35%). Based on lower levels of detention history (2%) and restraint/timeout history (7%), youth in this class may experience fewer disciplinary responses, but it will be important to understand the clinical needs that may inform appropriate residential environments.

Table B-14. Descriptive Statistics for Class 3: Youth with Intellectual Disability and Autism

N	362
Mean Age (SD)	17.28 (2.76)
Male (n, %)	276 (76.24%)
White (n, %)	182 (50.28%)
Black (n, %)	140 (38.67%)
Hispanic/ Latino (n, %)	28 (7.73%)
Free and Reduced Lunch Eligible (n, %)	310 (85.64%)
EL (n, %)	9 (2.49%)
Ever Detention (n, %)	6 (1.66%)
Ever Restraint (n, %)	24 (6.63%)
Disability (n, %)*	
Specific Learning Disability (n, %)	53 (14.64%)
Physical Disability (n, %)	31 (8.56%)
Other Health Impairment (n, %)	125 (34.53%)
Developmental Delay (n, %)	1 (0.28%)
Emotional Disability (n, %)	3 (0.83%)
Intellectual Disability (n, %)	137 (37.85%)
Autism (n, %)	90 (24.86%)

*youth can have more than one disability.

Class 4: Older Youth with Emotional Disability (n = 687; 35% of ISBE sample)

Table B-15 presents descriptive statistics for Class 4, called the "Older Youth with Emotional Disability" class. This was the second-largest class in the ISBE analysis, representing 35% of the entire ISBE sample. Youth in this class had the highest average age (18 years old) and proportion of females (42%) among all classes. Nearly all the youth in this class had an Emotional Disability (99%). This class had lower levels of detention history (0%) and restraint/timeout history (9%). This class most closely parallels Class 1: Mental Health Issues from the DCFS LCA Model, in which youth tended to have mental health needs but did not exhibit high levels of risky and dangerous behaviors.

Table B-15. Descriptive Statistics for Class 4: Older Youth with Emotional Disability

N	687
Mean Age (SD)	17.83 (1.12)
Male (n, %)	398 (57.93%)
White (n, %)	307 (44.69%)
Black (n, %)	283 (41.19%)
Hispanic/ Latino (n, %)	61 (8.88%)
Free and Reduced Lunch Eligible (n, %)	589 (85.74%)
EL (n, %)	10 (1.46%)
Ever Detention (n, %)	0 (0%)
Ever Restraint (n, %)	60 (8.73%)
Disability (n, %)*	
Specific Learning Disability (n, %)	71 (10.33%)
Physical Disability (n, %)	14 (2.04%)
Other Health Impairment (n, %)	117 (17.03%)
Developmental Delay (n, %)	0 (0%)
Emotional Disability (n, %)	678 (98.69%)
Intellectual Disability (n, %)	64 (9.32%)
Autism (n, %)	11 (1.6%)

*youth can have more than one disability.

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Descriptive Characteristics of Youth Placed in HFS- and DHS-Administered Residential Programs

Chapin Hall also received data from the Illinois Department of Healthcare and Family Services (HFS) on individuals in HFS and DHS residential care programs. HFS provided Chapin Hall with a list of all individuals who had spent time at any of five residential program types during fiscal year 2021 or fiscal year 2022, detailed in Table B-16 below. Hospitalization records from 2018 through 2022 were also provided for these individuals. Due to data limitations, Chapin Hall was unable to conduct a Latent Class Analysis (LCA) on these individuals. Instead, Chapin Hall presents descriptive statistics for these individuals, as well as individuals from the ISBE sample and DCFS sample, in Table B-17.

Table B-16. Individuals Aged 21 Years or Younger Served in HFS/DHS-administered Residential Programs in Fiscal Year 21 or Fiscal Year 22.

Program	Unique Youth 21 Years or Younger Served in FY21/FY22	Minimum Age	Maximum Age
Intermediate Care Facilities for Individuals with Mental Retardation (ICF/MR)	327	0	21
State-operated facility (DHS)	24	18	21
Waiver service provider--Adults (DHS/DDD)	840	18	21
Waiver service provider--Children's residential (DHS/DDD)	207	8	21
Family Support Program	259	6	21
Total Unique Recipients	1,630		

Table B-17 shows gender, age, and race data across the ISBE, HFS, and DCFS samples as described in the prior sections. Individuals in the HFS sample were the oldest (average age 18 years), while individuals in the DCFS sample where the youngest (average age 15 years). The percentage of white individuals (44%) was slightly higher than the percentage of black individuals (37%) across the combined sources; however, it is important to note that race was unknown for a significant portion (39%) of individuals in the HFS sample. Nearly two-thirds (64%) of individuals were male across all samples, and 28% of individuals across samples had spent time in a hospitalization setting. Only 22% of individuals across all samples had usable CANS data.

Table B-17. Descriptive Statistics Across DCFS, HFS, and ISBE Data Sources

Source	N	Male (n, %)	Age, years (mean, SD)	Over 16 (n, %)	White (n, %)	Black (n, %)	Race unknown (n, %)	Has hospitalization[a] (n, %)	Has CANS Data (n,%)
DCFS	1379	793 (57.51%)	14.86 (2.66)	522 (37.85%)	668 (48.44%)	668 (48.44%)	5 (0.36%)	814 (59.03%)	846 (61.35%) **
HFS/DHS	1630	1105 (67.79%)	18.04 (3.97)	1272 (78.04%)	673 (41.29%)	280 (17.18%)	628 (38.53%)	391 (23.99%)	274 (16.81%)
ISBE	1957	1285 (65.66%)	15.79 (3.04)	1086 (55.49%)	824 (42.11%)	873 (44.61%)	0 (0%)	206 (10.53%)	0 (0%)
All Combined Sources*	4955	3175 (64.08%)	16.28 (3.53)	2879 (58.1%)	2159 (43.57%)	1818 (36.69%)	631 (12.73%)	1401 (28.27%)	1109 (22.38%)

[a] Hospitalization data for both ISBE and HFS/DHS Samples only goes back through 2018.
*11 youth were duplicated across HFS/DHS and DCFS samples. Due to data limitations, ISBE youth were unable to be linked and therefore de-duplicated between the DCFS and HFS/DHS sources.
**DCFS youth were considered to not have CANS if they did not have any CANS, did not have CANS within 90 days of CIPP or Residential Discharge Date from Hospital, or only had CERAP CANs available

APPENDIX B – RESIDENTIAL SERVICE NEEDS

Lack of consistent data across the DCFS, ISBE, and HFS/DHS samples presented the largest limitation in this analysis. In particular, while CANS assessments were used to identify clinical needs among DCFS youth, these data were not available at all for the ISBE sample, and only minimally available among the HFS/DHS sample. Among ISBE youth, using detention center and restraint/timeout history may reflect systemic responses to youth with different types of problems, rather than a true indication of the presence of behavioral/emotional issues. Without comprehensive assessment, we cannot fully capture and describe the heterogenous needs of the youth in these samples. Assessment data will be needed to identify distinct needs and policy implications. Also, we were also unable to estimate the extent of youth's cross-agency involvement because data across the three agencies could not be reliably linked.

Findings/Implications

Opportunity Groups

The results of the DCFS LCA and ISBE LCA revealed that some youth in the samples did not exhibit a level of clinical need high enough to warrant residential treatment. Specifically, Class 3 (Justice-Involved Youth) and Class 5 (Long Stayers with Placement Instability) from the DCFS sample, and Class 1 (Justice-Involved Youth) from the ISBE sample appeared to have levels of need that could be met in less restrictive treatment environments; we refer to these as "opportunity groups".

The high proportion of Black males in Class 3 (Justice-Involved Youth) from the DCFS sample and Class 1 (Justice-Involved Youth) from the ISBE LCA, is concerning, as it suggests a disparate pattern of seeking residential (the most restrictive) treatment settings for youth without the level of risk or need that would warrant these institutional placements. Case reviews will be needed to determine whether these youth are caught in a pipeline from detention centers to residential treatment, despite their low level of clinical need showing that non-residential placement would be more appropriate (CANS-based QRTP algorithm recommended residential placement for only 7.58% of youth in DCFS Class 3).

Youth from Class 5: Long Stayers with Placement Instability from the DCFS sample tended to be older youth who had been in DCFS care for a significant period while experiencing placement instability. These youth show low levels of risk behavior, and the QRTP algorithm does not recommend QRTP placement for these youth. Difficulties in finding stable placements may have led these youth, who might be more appropriate for home-based placement with comprehensive wraparound services, into residential care.

Together, youth in the above classes comprised 33% of the DCFS sample and 11% of the ISBE sample, thereby representing a significant proportion of the population that has been identified as needing residential care. The opportunity to deflect these youth from residential treatment could not only improve their own outcomes, but also decrease the number of high-need youth who are unable to access residential treatment due to being beyond capacity. Further work, such as conducting case reviews and discussions with child welfare workers, is needed to understand why these youth are being identified for residential care, and to uncover alternative ways to meet the needs of this population.

High-Need Behavioral Health Placement Groups

The LCA also identified high-need youth with behavioral problems in our sample. From the DCFS LCA, two distinct classes emerged that fit this description. Class 2 (Emerging Behavior Problems) consisted of youth who had been in DCFS care for shorter periods, and who exhibited high levels of risk behavior with moderate levels of danger to self and others. Class 4 (Severe Behavioral and Developmental Issues) represented the group with the highest level of need among the DCFS sample. These youth had been in DCFS care for a long time and exhibit very high levels of risk behavior as well as danger to both self and others. Class 2 (Younger Youth with Emotional Disability and Experience

of Restraints) from the ISBE LCA most closely resembled that of the Emerging Behavior Problems class in DCFS. This class was mainly younger youth with emotional disabilities. High rates of restraint/time out suggest a level of behavior disruption that calls for the comprehensive supervision and services offered by residential care.

Unlike the "opportunity groups," youth in the above populations do exhibit behaviors that suggest residential treatment is indicated; namely, a level of behavioral disruption that creates risk of harm to others or themselves requires a level of supervision that can only be provide in a residential setting. Of particular importance is ensuring that these youth receive residential treatment in a timely manner once their high level of clinical need is discovered. Significant levels of placement instability among the DCFS youth in these groups reveal that these youth may not be appropriately placed at earlier points in their child welfare spells, which can exacerbate their behavioral/emotional issues. Identification and the provision of additional resources at an early age should be a focal point for youth in these populations.

Short-Term Mental Health Stabilization Group

Both the ISBE and DCFS LCA also revealed a class of youth who have mental health issues, with moderate-to-high levels of clinical need. Class 1 (Mental Health Issues) represented 16.6% of the total DCFS sample, while Class 4 (Older Youth with Emotional Disability) from the ISBE analysis represented 35% of the ISBE sample. Youth in these classes were more likely to be female. Among the DCFS class, CANS data revealed a high level of emotional and behavioral need for these youth, as well as a high likelihood of trauma due to physical abuse (40%) and sexual abuse (50%). Youth in the ISBE class were most likely to have an emotional disability (99%).

Youth in these classes are also likely to need acute psychiatric care to address depression, anxiety, and risk behaviors. Mental health support and stabilization should be a main priority for these youth. While these youth may need residential care (QRTP algorithm recommended QRTP Placement for 31%of the DCFS sample), the focus should be on the provision of short-term treatment (QRTP) for psychiatric stabilization, rather than long-term placement in residential settings.

Specialized Treatment for Non-Traditional Youth

The ISBE LCA also revealed the presence of a group of youth with unique needs that may be served best in nontraditional residential care settings. Class 3 (Youth with Intellectual Disability and Autism) represented 18.5% of the ISBE sample and was the only class from the ISBE analysis where Emotional Disability (1%) was not the most prevalent disability. The youth in this class instead have developmental disabilities (Intellectual Disability, 38%; Autism, 25%) that may be harder to treat using traditional modalities that depend on verbal communication. It has been challenging to identify appropriate treatment settings for these youth among typical residential care providers; youth who are placed may not always receive the appropriate level of care. A focus on developing residential settings that can meet the specialized needs of these youth is crucial towards ensuring they receive effective treatment.

Improved Data to Inform Decision Making

A primary implication of this analysis is the call for improved tracking and availability of data among youth who are receiving or identified as requiring residential services in Illinois. This analysis was limited by lack of consistent and available data among youth from the ISBE and HFS/DHS samples. Of particular importance is a strategy, like the CANS, for identifying different levels and types of need to ensure that researchers, policymakers, and on-the-ground practitioners have sufficient information to plan for appropriate services. These data are crucial to moving away from a one-size-fits-all approach and toward an array of placements that can accommodate the heterogenous nature and needs of Illinois' residential population. As more data—and the ability to link across agencies—become available, consistent practices, systems, and policies can be built to ensure that all individuals receive the appropriate and optimal care.

APPENDIX B – RESIDENTIAL SERVICE NEEDS

Residential Placements

In analysis conducted for this report, two sources of information were used to shed light on the question of how many residential placements there are at a given time. The first source is DCFS administrative data. Among youth in DCFS custody, there were 728 individual young people placed in residential settings as of the end of November 2022. However, DCFS administrative data only tell us about placements for beds contracted by DCFS, meaning that young people placed only by other agencies will not show up in the DCFS administrative data. Residential settings include living arrangement codes of GRH (Group Home), IPA (Institution - Private Child Care Facility), IPS (Institution – Private) and QRT (Qualified Residential Treatment Program). The latest current living arrangement was selected among residential placements using data covering the end of November 2022.

Table B-18. A Snapshot of the Count of Young People Currently in a Residential Placement Based on DCFS Administrative Data from the End of November 2022

Residential Placement Type	*n*	%
QRT	550	75.5
GRH	114	15.7
IPA	37	5.1
IPS	27	3.7
Total	**728**	**100.0**

The second source is the provider survey that our team designed and disseminated to Illinois residential providers. A total of 678 residential placements were returned in survey results.

The survey contains responses from 72 providers, 53 of which are providers with current DCFS placements based on DCFS administrative data, and 19 of which have no DCFS placements according to administrative data. The 19 providers that have responses from the survey do not have placements in the DCFS administrative data, likely because they are only placed by other agencies.

Furthermore, among providers that have some DCFS placements, there may be additional young people placed only by other agencies. The survey is the only source of information that bears on both non-DCFS and DCFS placements. However, not all providers returned the survey. The response rate was 43% (72 responses out of 167 surveyed providers). Among providers that did not return the survey, 8 do not have an active license, according to the records of the licensing agency, DCFS. After excluding these 8 from the denominator the response rate becomes 45%. One provider that did return the survey does not have an active license according to administrative licensing records.

APPENDIX B – RESIDENTIAL SERVICE NEEDS

Table B-19. Aggregated Provider Survey Responses Pertaining to Residential Placements

Survey Question / Variable	Mean	SD	Sum
In the facilities you supervise, you probably have beds *occupied* by clients placed by state agencies. **Right now, how many beds are occupied by clients placed by the following agencies?**			
DCFS	6.94	11.901	465
DJJ	0.03	0.171	2
ISBE	0.642	2.301	43
DDD/DHS	1.91	5.712	128
HFS/FSP	0.448	1.52	30
HFS Interim Relief	0	0	0
Paid for by private payor	0.149	0.803	10
Total Occupancy	10.119	13.754	678

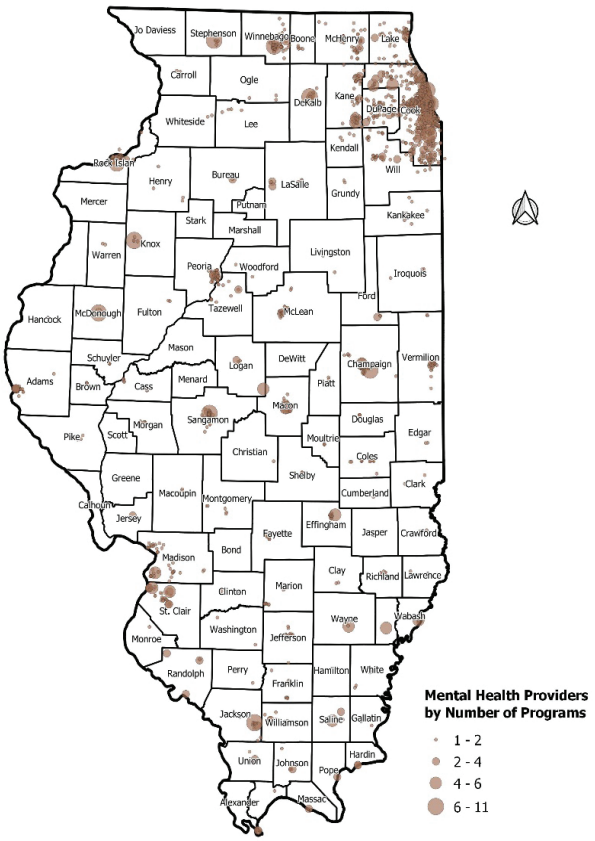
Both sources of the current number of residential placements underestimate the true number of residential placements. The DCFS administrative data does not account for placements by other state agencies (DHS, DJJ, HFS, ISBE), and the provider survey was only returned by 43% of providers.

Appendix C - Gap Analysis Methodology

The completion of a service gap analysis requires the quantification of both the supply of a specified service and the demand for that service. In this instance, both the supply and demand for behavioral health services were estimated at the county level, as service allocation decisions typically occur at the county level within Illinois.

Supply of Behavioral Health Services

To determine the supply of community based behavioral health services, Chapin Hall used data from Illinois Department of Children and Family Services (DCFS). Since 2004, DCFS has maintained a database of community-based service providers (Service Provider Identification & Exploration Resource [SPIDER]). The system contains the locations of all DCFS-contracted and non-contracted family support programs in Illinois. SPIDER stores each program at the point of service, not at the headquarters of the organization, allowing users to find programs that are hosted at offsite locations like libraries, community centers, or religious institutions. This geographic specificity makes it ideal for understanding the existing supply of behavioral health services in Illinois.



For this analysis, we focused on two broad SPIDER service categories: mental health and nonclinical services (which includes nontherapeutic services such as housing, mentoring, vocational training). We selected these service types because they are the most frequent types of supports needed by families of youth with mental health concerns.

According to SPIDER, Illinois has 1,649 mental health and nonclinical services offering 2,390 programs. The distribution of these programs largely mirrors the distribution of population in Illinois, with large concentrations around cities and towns.

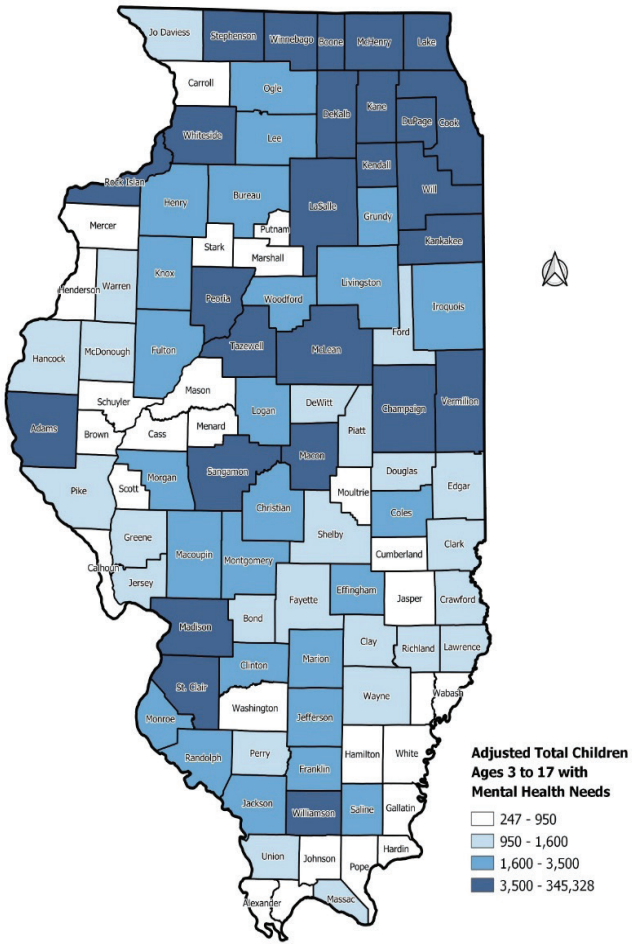
Demand for Behavioral Health Services

Because there is no reliable source of data that captures mental health need in Illinois, we calculated an estimate by combining two national datasets and then modifying them to reflect the impact of violent crime and socio-economic factors on the prevalence of behavioral health needs.

The sources of data we used in this estimate are the 2019–2020 National Survey of Children's Health conducted by the Child and Adolescent Health Measurement Initiative[xxiii] (CAHMI) and the 2020 bridged-race postcensal population estimates from the Centers for Disease Control and Prevention's (CDC) National Vital Statistics System.[xxiv]

The CAHMI survey provided detailed information on the prevalence of behavioral health needs of children and adolescents ages 3 to 17 by race and gender. The CDC data provided counts of the total population by individual age broken out by race and gender. By combining these data sets we were able to calculate a base prevalence of behavioral

APPENDIX C - GAP ANALYSIS METHODOLOGY



health needs at the county level by calculating the total number of individuals by race, gender, and age and applying the appropriate prevalence multiplier from the CAHMI survey.

We then adjusted these county-level calculations by applying measures of violent crime and socio-economic factors, based on research indicating that these two factors have a significant impact on the prevalence of behavioral health needs at the community level. Specifically, for this analysis we relied on a meta-analysis of 114 studies on the influence of violent crime by Fowler[xxv] and a metal analysis of 120 studies by Peverill[xxvi] on the impact of socio-economic factors on the prevalence of behavioral health needs at the community level.

To account for the impact of violent crime on behavioral health needs, we used the Crime in Illinois 2020 Uniform Crime Report from the Illinois State Police.[xxvii] This report provides information on both criminal offenses and crime rates for every county in Illinois. Using the federally defined definition of violent crime (assault, battery, homicide, rape, and robbery), we calculated the total number of violent crimes per county. Then we applied Fowler's estimate that exposure to violence increases an individual's likelihood of developing a behavioral health need by 30%.[xxviii]

To quantify the impact of socioeconomic conditions, we applied Peverill's estimate that receiving public assistance (i.e. Supplemental Security Income [SSI], cash public assistance or Food Stamps/SNAP) increased an individual's likelihood of developing a behavioral health need by 92%.[xxix] Using U.S. Census data, we were able to determine the total number of persons receiving public assistance in every county in Illinois and increased prevalence estimates accordingly.

By combining the demographic estimates from CAHMI, the effect of violent crime from Fowler, and the impact of socio-economic conditions from Peverill, we calculate estimates of behavioral health needs for every county in Illinois *adjusted for economic hardship and exposure to violence*.

Proximity to Services

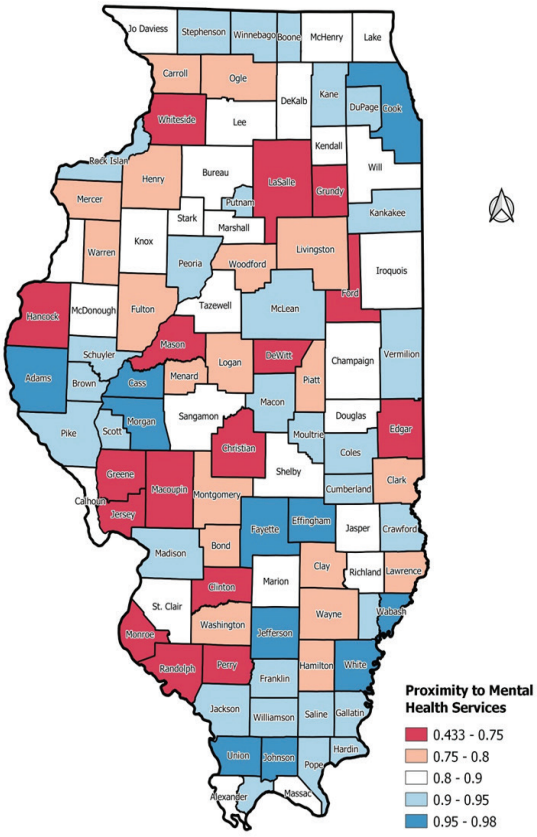
To estimate the supply of services in every county we used proximity scores. Proximity scores are different from distance measurements in that they account for context. Specifically, a proximity score is a summary statistic that captures three dimensions of service access: distance, availability, and travel impedance.[xxx] By including these dimensions, proximity scores are better at approximating service access than distance measurements alone.

For this analysis, we calculated a proximity score for each county in Illinois. To do this we first determined the point within the county from which the distance to behavioral health providers would be calculated. Rather than choose the geographic center of a county, we chose a location that was weighted by the spatial distribution of youth ages 3 to 17. This was achieved by conducting a mean coordinates analysis in QGIS, an open-source geographic information system. A mean coordinates analysis determines the center point of a set of locations based on a weighted value. In this case,

APPENDIX C - GAP ANALYSIS METHODOLOGY

we calculated the central location of all the census tracts in a county based on the total number of youth ages 3 to 17 who lived in those census tracts. This means that the center point of the county would be closer to those tracts with more youth 3 to 17 years old and further away from those census tracts with fewer youth 3 to 17 years old. This method accounts for the uneven distribution of the child/youth population in large counties and ensures a more accurate distance measurement between our target population and service providers.

Next, the proximity score calculates the distance from the weighted county center points to the five nearest behavioral health providers. It does this by measuring distance over a road network not in a straight line. This accounts for things like bridges, railroad tracks, or natural features that impede moving in a straight line from the weighted center point to the nearest provider.



A proximity score measures the distance to the five nearest service providers, instead of the nearest provider, to capture the depth and breadth of services available to a county. The distance to those five providers is averaged to create a final distance score. This method provides a county with more behavioral health providers close to the weighted center of youth ages 3 to 17 a higher score than those where the five are further away. It also rewards areas with a more robust set of service options (in other words, they have more providers close to the center) than those that are reliant on a single close provider. Additionally, statistical analysis shows that little precision is added to the final proximity score by including more than five providers in the calculation.

Finally, proximity scores account for travel difficulty by considering the context in which that travel occurs. It does this by calculating an impedance factor, which is a way to estimate traffic congestion. It is calculated by transforming population density and the percentage of the population living in an urbanized area into z-scores. These z-scores are then averaged to create the rate at which distance reduces the value of a provider to a weighted county center.

The higher the travel impedance score, the faster a provider loses its value to a given location. Specifically, in high population density counties, where a large proportion of the total population lives in urbanized areas, the value of a provider to a given location decreases rapidly the further away it is from that location. In other words, if a family is traveling to a service provider from downtown Chicago it will be much harder, because of traffic congestion and the built environment, to go five miles to that provider than it would in La Salle County, where most travel happens in rural areas via county highways. The travel impedance factor accounts for this contextual difference.

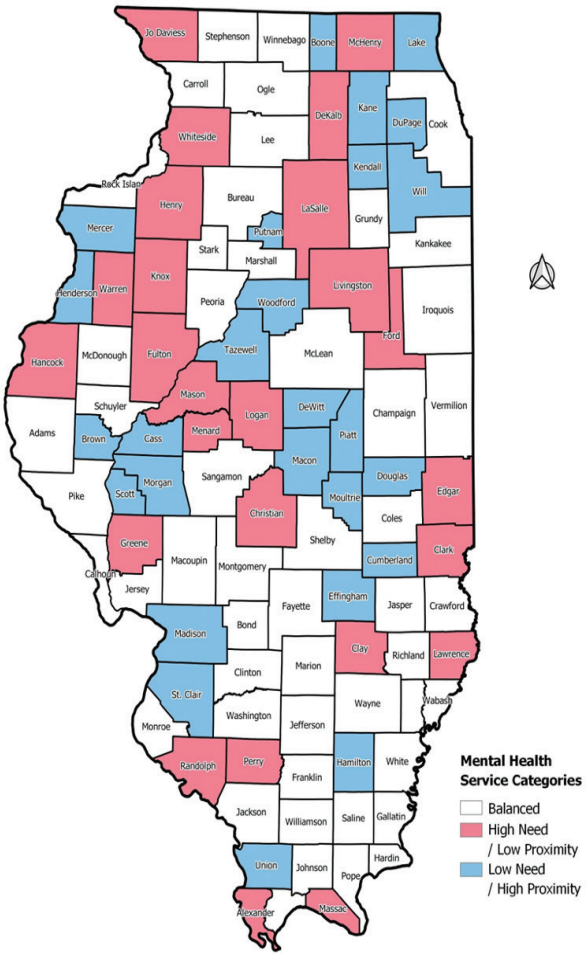
APPENDIX C - GAP ANALYSIS METHODOLOGY

Determining Service Gaps

To determine the gap between the estimated need for behavioral health services in each county and access to those services, each county was classified into quartiles based on the demand for services. The demand was operationalized as the estimated need for behavioral health services per 10,000 residents, and access to those services, represented by proximity scores.

Once counties were sorted into quartiles, their score on need for services was averaged with their score for access. Counties that had an average score between 0.75 and 1.33 were considered balanced, meaning that even if they were in the top quartile for behavioral health needs, they were also in the top quartile for access to behavioral health services. Counties with scores below 0.75 were considered low request/high proximity counties and counties with scores above 1.33 were considered high request/low proximity counties.

This methodology estimates that more than 200,000 youth ages 3 to 17 live in counties with a high demand for behavioral health services and low access to those services. Of these youth we estimate that nearly 80,000 will need behavioral health services, a behavioral health prevalence rate of nearly 40%. These youth live in counties that have less than one-third the population density, 23 percentage points more of their population living outside of urbanized areas, and must travel nearly twice as far to reach behavioral health services as the average resident of Illinois.



Appendix D – Oversight and Monitoring Best Practices

I. Commonly Occurring Oversight and Monitoring Practices

- Licensing and certification
- Announced visits
- Assessment of physical structures (buildings and grounds adhere to safety codes)
- Critical incident reporting system
- Overall assessment of client safety

II. Less Commonly Occurring Oversight and Monitoring Practices

- Interviews with staff and residents
- Unannounced visits
- Review of quality improvement processes
- Review of implementation and use of evidence-based practices
- Oversight of family involvement
- Review of postdischarge processes
- Sharing results of monitoring and oversight activities across placing agencies

Appendix E – Eligibility Crosswalk

During our review of existing services, we identified several factors that are often utilized to establish initial program eligibility, including age, dependency status, and method of service payment. Part one of the Eligibility Crosswalk includes information about program description, age, agency, and funding criteria. Part two of the Eligibility Crosswalk includes information about the clinical and treatment criteria for the same set of services.

Part One: Background and Service Description

	Purpose	Service Description	Agency	Age	Dependency Status (DS)	DS: DCFS	DS: Parent or Guardian	Medicaid / Income
Family Assistance	Monthly stipend to assist in meeting expenses associated with child's presence in home	Examples of stipend use include respite care, purchase of special equipment and supplies * Program not currently funded	DHS	17 or younger	Child lives in home with parent to whom assistance will be provided; may live in out-of-home placement at time of application, must live with parent within 60 days after date of acceptance notification	No	Yes	Maximum taxable annual family income of less than $65,000, verified by federal income tax return; family income limit does not apply to children in FC;
Special Education	To ensure a free appropriate public education to eligible children with disabilities	Specially designed instruction, at no cost to the parents, to meet the unique needs of a child with a disability	ISBE	3–21	N/A	Yes	Yes	N/A
Educational Surrogate Program	Protect educational rights of children without parent or guardian.	Provide representation to children who qualify for and receive special education services and do not have parent or guardian available	ISBE	3–22	Youth in DCFS care; unaccompanied homeless youth; children for whom parent cannot be identified or located after reasonable attempts	Yes	No	N/A
Screening Assessment and Support Services (SASS)	Coordinate delivery of MH services to youth.	Multi-agency crisis response, screening and assessment, short-term follow-up services, linkage to ongoing community MH services, transitional support back to community	HFS	Under 18 if seeking public funding for psychiatric services via DHS; under 21 if enrolled in HFS-administered medical program	Individual for whom DCFS is legally responsible	Yes	Yes	N/A

APPENDIX E – ELIGIBILITY CROSSWALK

	Purpose	Service Description	Agency	Age	Dependency Status (DS)	DS: DCFS	DS: Parent or Guardian	Medicaid / Income
Pathways to Success	Make care coordination and Home and Community-Based Services (HCBS) available to children with complex behavioral health needs identified as N.B. Class Members	Provides access to evidence-informed model of intensive care coordination and additional home and community-based services	HFS	Under 21	N/A	Yes	Yes	Medicaid eligible or enrolled
Comprehensive Community-Based Youth Services (CCBYS)	Family reunification, preservation, stabilization in order to divert or minimize CW and/or JJ involvement	Statewide 24/7 crisis intervention system mandated to serve youth in crisis (runaways, lock-outs, beyond control & in immediate physical danger) to include emergency placement for up to 48 hours.	DHS	11–17	Children in custody of State are **not eligible**	No	Yes	N/A
Children's Support Waiver	Prevent or delay need for out-of-home residential services for children who would otherwise need ICF/IDD level of care	Services to eligible children, young adults with DD who live at home with families. Choice between participant direction, traditional service delivery, or combination. Choice at service initiation, annually thereafter.	DHS	3 – 21	Children in custody of State are **not eligible**	No	Yes	Enrolled in Medicaid
Family Support Program	To strengthen family stability and promote care in the community for qualifying youth with severe emotional disturbance	State-funded program that provides access to intensive mental health services and supports to youth with severe emotional disturbance	HFS	Under age 26	Children in custody of State are **not eligible**	No	Yes	N/A
Children's Residential Waiver	To prevent or delay the need for residential services in an ICF/IDD	Provides 24-hour residential supports to eligible children and young adults with developmental disabilities	DHS	3–21	Children in custody of State are **not eligible.**	No	Yes	Enrolled in Medicaid

APPENDIX E – ELIGIBILITY CROSSWALK

	Purpose	Service Description	Agency	Age	Dependency Status (DS)	DS: DCFS	DS: Parent or Guardian	Medicaid / Income
Specialized Family Support Program	Identify behavioral health needs of youth at risk of custody relinquishment and link youth to clinical services post hospitalization; prevent custody relinquishment solely to access behavioral health services	90-day crisis stabilization, community mental health and assessment services, treatment recommendations, and service linkage	HFS	Under 18 at time of application	Children in custody of the State are **not eligible.**	No	Yes	N/A
Support Service Teams	Promote community stabilization	Interdisciplinary technical assistance, training response to persons with a DD in medical or behavioral situation that challenges ability to live and thrive in community	DHS	Children and adolescents with diagnosed developmental disabilities who receive services from DHS-DDD or are on PUNS (Prioritization of Urgency of Needs) list, as capacity allows	Children in custody of the State are **not eligible**	No	Yes	Adults with DD living in community setting who receive Medicaid services, Waiver services, or on PUNS list, as capacity allows
Intensive Placement Stabilization	Stabilize foster care placements: • Increase # who successfully transition from more to less restrictive placement. • Decrease # in traditional, relative FC placements that subsequently need more restrictive, intensive services.	Short-term services, including in-home evidence-based interventions and support to children and youth with emotional or behavioral problems who are at risk of placement disruption.	DCFS	Under 18	Children, youth in custody or guardianship of Department who meet additional criteria.	Yes	No	N/A
First Illinois	Reduce symptoms of psychotic illness; improve individual and family functioning	Specialized treatment approach that helps individuals who are between the ages of 14 to 40 and who have had a treated or untreated psychotic illness for no more than 18 months	DHS-DMH	14–40	N/A	Yes	Yes	N/A

APPENDIX E – ELIGIBILITY CROSSWALK

	Purpose	Service Description	Agency	Age	Dependency Status (DS)	DS: DCFS	DS: Parent or Guardian	Medicaid / Income
Youth Care HealthChoice Illinois program (Managed Care Program)	Coordinate physical health, behavioral health, dental, and vision care for current, former youth in care; improve access, continuity of care, healthcare outcomes	Specialized healthcare program built cooperatively with parents, other stakeholders for current, former DCFS youth in care	DCFS	Under 21	1) DCFS youth in care - DCFS legally responsible; live foster parents, group homes, res. settings 2) former youth in care (previously in DCFS; adopted, living with kinship providers, returned to bio parents, and/or left DCFS system.	Yes	No	N/A—DCFS youth in care are automatically enrolled
Intact Family Services	Provide in-home services and case management to families at risk of child welfare system involvement who have been referred for continuing assistance and monitoring following a child abuse or neglect investigation	Ensures safety and well-being of children without need for protective custody by providing families with needed in-home services, (counseling, domestic violence prevention, substance use and mental health treatment, parenting coaching/ classes or housing)	DCFS	Under 18	Children in custody of the State are **not eligible**	No	Yes	N/A
Extended Family Support Services	Assist relative caregivers to promote placement stability and prevent involvement of the relative or child in the child welfare system	Short-term services to relative caregiver families that are not involved in the formal child welfare system.	DCFS	Under 18	Works with relative caregivers who have been caring for relative's children for more than 14 days until guardianship is obtained. Does not support families if biological parent lives in the home or if caregiver or child have open DCFS case.	No	No	N/A
Post Adoption	Promote postadoption placement stability	Support and service referrals to families with Adoption/Guardianship subsidies	DCFS	Under 18	In care and custody of adoptive family	No	Yes	N/A
Child Welfare Service Referrals	Link families to needed community resources when reports of suspected abuse or neglect do not warrant investigation under Illinois law	Family referrals to local DCFS office or private agency partners in the community for needed services	DCFS	Under 18	Children in custody of the State are **not eligible**	No	Yes	N/A

APPENDIX E – ELIGIBILITY CROSSWALK

	Purpose	Service Description	Agency	Age	Dependency Status (DS)	DS: DCFS	DS: Parent or Guardian	Medicaid / Income
The Comprehensive Assessment and Treatment Unit (UIC-CATU)	Provide psychiatric treatment to youth in custody of the State between ages 11 and 17 and identified by DCFS as being the most at risk	Nine-bed acute psychiatric unit housed at the University of Illinois Medical Center in Chicago.	DCFS	11—17	Children in care and custody of DCFS who have experienced multiple placement disruptions and are at risk for another placement disruption and need psychiatric stabilization.	Yes	No	N/A

Part Two: Clinical and Behavioral Requirements

	Diagnosis	Behavior	Treatment History and Needs		
Family Assistance	Severe or profound intellectual disability; severe emotional disturbance, which meets DSM-III-R criteria of mental disorder with onset in childhood, adolescence	N/A	Must meet DSM-III-R-Axis V criteria for severe functional impairment	Significant limitations of major life activities in capacity for living in family in 2+ areas: self-care at appropriate developmental level; perceptive, expressive language; learning; or social interaction, self-direction	N/A
Special Education	Intellectual disability; hearing impairment; speech, language impairment; visual impairment; serious emotional disturbance; orthopedic impairment; autism; developmental delays, ages 3–9; traumatic brain injury; other health impairment; specific learning disability; deaf-blindness; multiple disabilities; cognitive disability	N/A	Children with qualifying disability who need specialized educational services to benefit from their education	N/A	N/A
Educational Surrogate Program	Qualifying diagnosis required for special ed. eligibility	N/A	Children eligible, under evaluation for eligibility for special education services	N/A	N/A
SASS	N/A	N/A	Children and adolescents experiencing a mental health/ psychiatric crisis	Any child enrolled in managed care organization is ineligible	Ability to function at home, in school, in community significantly impaired
Pathways to Success	Serious emotional disturbance (SED) or Severe and Persistent Mental Illness (SPMI)	Stratified into Tier 1 or Tier 2 of the State's Behavioral Health Decision Support Model	N. B. Class Members with complex behavioral needs	Demonstrate need for intensive services pursuant to State's IM + CANS decision support criteria	Meet eligibility criteria, enrolled in Pathways program. Medicaid eligible children not enrolled have access to existing Medicaid-covered behavioral health services, including services covered under 89 Ill. Ad. Code 140.453.

APPENDIX E – ELIGIBILITY CROSSWALK

	Diagnosis	Behavior	Treatment History and Needs		
Comprehensive Community-Based Youth Services (CCBYS)	N/A	Youth in high-risk situations	Also serves youth in high-risk situations, their families when appropriate		
Children's Support Waiver	1) Developmental disability (Intellectual disability or related condition) 2) Assessed as eligible for ICF/IID level of care	N/A	at-risk of placement in an Intermediate Care Facility for persons with Developmental Disabilities (ICF/DD).	Not in need of 24-hour nursing care.	N/A
Family Support Program	1) Demonstrates severe emotional disturbance 2) Youth's history of mental health challenges and treatment efforts demonstrate chronic condition rather than acute episode	Youth demonstrates behaviors or symptoms that are likely to respond to treatment services available in the FSP	1) Demonstrates severity of need indicating clinical needs not being met via active participation in traditional outpatient MH services	2) Demonstrates sufficient cognitive capacity to respond to psychiatric treatment, intervention	N/A
Children's Residential Waiver	1) Developmental disability (Intellectual disability or related condition) 2) Assessed as eligible for ICF/IID level of care	Only available to children in crisis	Must need active treatment and need of Children's Residential Waiver services	Must not need nursing assessment, 24-hour monitoring, intervention, supervision	N/A
Specialized Family Support Program	Clinically appropriate for discharge from hospital	Parent or guardian refuses to take youth home from hospital or other acute treatment facility because of reasonable belief that youth will harm himself/herself or other family members upon returning home.	1) Youth admitted to hospital or similar treatment facility for primary purpose of psychiatric treatment; determined clinically appropriate for discharge from facility	2) Youth's parent or guardian refuses to take youth home from hospital or similar treatment facility because parent or guardian has reasonable belief that youth will harm himself or herself or other family members upon returning home	3) Youth has been referred, accepted for SFSP enrollment to the CARES Line
Support Service Teams	Children, adults with DD	Most challenging medical or behavioral concerns; may have severe emotional disturbance	Children must be receiving services; adults with DD do not need to be	In medical or behavioral situation that challenges their ability to live, thrive in the community	N/A
Intensive Placement Stabilization	Emotional or behavioral problems		History of placement disruptions or at risk of disruption		

APPENDIX E – ELIGIBILITY CROSSWALK

	Diagnosis	Behavior	Treatment History and Needs		
First Illinois	Schizophrenia; schizoaffective disorder; schizophreniform disorder or other specified/unspecified schizophrenia spectrum and other psychotic disorder; bipolar disorder with psychotic features; major depressive disorder with psychotic features; PTSD with dissociative symptoms	N/A	No more than 18 months of psychotic symptoms, whether treated or untreated	Must be willing to consent to participate in at least two of the five treatment modalities	N/A
Youth Care HealthChoice Illinois program (Managed Care Program)	N/A	N/A	Former youth receiving Home- and Community-Based Waiver Services **included** in managed care enrollment. Persons with: 1) Disabilities waiver, 2) HIV or AIDS waiver, 3) Brain Injuries waiver	Former Youth with Home and Community Waiver Services **not considered** for managed care enrollment: 1) Aging waiver, 2) Supported Living Program waiver, 3) DD waiver services (0-18), 4) Medically Fragile Technology Dependent waiver, 5) Nursing and Personal Care Services (NPCS) program approval	N/A
Intact Family Services	N/A	N/A	N/A	N/A	N/A
Extended Family Support Services	N/A	N/A	N/A	N/A	N/A
Post Adoption	N/A	N/A	N/A	N/A	N/A
Child Welfare Service Referrals	N/A	N/A	N/A	N/A	N/A
The Comprehensive Assessment and Treatment Unit (UIC-CATU)	Emotional disturbance and behavioral problems	Demonstrate severe, repetitive aggression directed toward others, self, or property	Meet criteria for an acute psychiatric hospital admission	Have had three or more psychiatric hospitalizations in the preceding 18 months	Have emotional disturbance and behavioral problems that have not been successfully managed in less restrictive settings

Appendix F – Engagement Summary

Many stakeholders' perspectives and analyses inform these recommendations. The Director of the Transformation Initiative met with over 720 stakeholders across the state from 129 unique organizations to learn about existing behavioral health challenges and system strengths. In addition to regular engagement with the Governor's Office and child-serving state agencies, Dr. Weiner also met with advocates (*n*=76), elected representatives (*n*=21), experts (*n*=35), service providers (*n*=129), state agency representatives (*n*=569), and system partners (*n*=83). Engagements with state agency representatives included frequent contact with DCFS (*n*=141), DHS (*n*=163), DJJ (*n*=17), DPH (n=4), the Governor's Office (*n*=46), the Governor's Office of Early Childhood Development (*n*=3), HFS (*n*=81); and ISBE (*n*=102).

The Transformation Initiative conducted interviews with 12 subject matter experts (SMEs) who shared in-depth knowledge of the current system, existing challenges, and potential solutions to improve service access and delivery. Experts included a mix of senior leadership from state agencies (*n* = 8), mental health service providers (*n* = 2), and parent advocates (*n* = 2). In addition, we conducted three business process map consultations with experts (*n* = 3) from two state agencies. SME's demonstrated expertise in a variety of areas and provided insights from the contexts of program and placement (*n* = 7); data (*n* = 2); service provision (*n* = 2); lived experience (*n* = 2); and legal (*n* = 1). We conducted all interviews via Zoom, and each lasted approximately 1 hour.

Figure E-1. Subject Matter Expert Interviews and Business Process Map Consultations

APPENDIX F – ENGAGEMENT SUMMARY

In addition to subject matter expert interviews, Chapin Hall staff facilitated group discussions with parents and youth to learn from their experiences navigating the behavioral health system to obtain services and supports. The Chapin Hall team hosted two group discussions with parents (n = 5) who have experience accessing school-based services for their children to understand how well and to what extent their experiences were in line with, or differed from, the processes described in educational policy. The Chapin Hall team also met with two family-led advocacy groups who shared their experiences navigating the behavioral health system, more broadly. In addition, The Chapin Hall team facilitated one group discussion with former youth from the Chicagoland area (n = 6) who have experienced mental health challenges to understand what supports these youth received, the resources they would like to see available, and their perspectives on how to make the children's mental health system better for the youth it serves. Finally, The Chapin Hall team hosted a group discussion with hospital social workers (n = 10) who shared their experiences and challenges working with state agencies to support youth while they are hospitalized and as they transition back into the community.

Taken together, state agency representatives, service providers, and parents and youth with lived experience provided unique perspectives on system challenges, needs, and solutions. They demonstrated widespread agreement on the need for a coordinated approach for supporting the behavioral and mental health needs of children and youth throughout the state.

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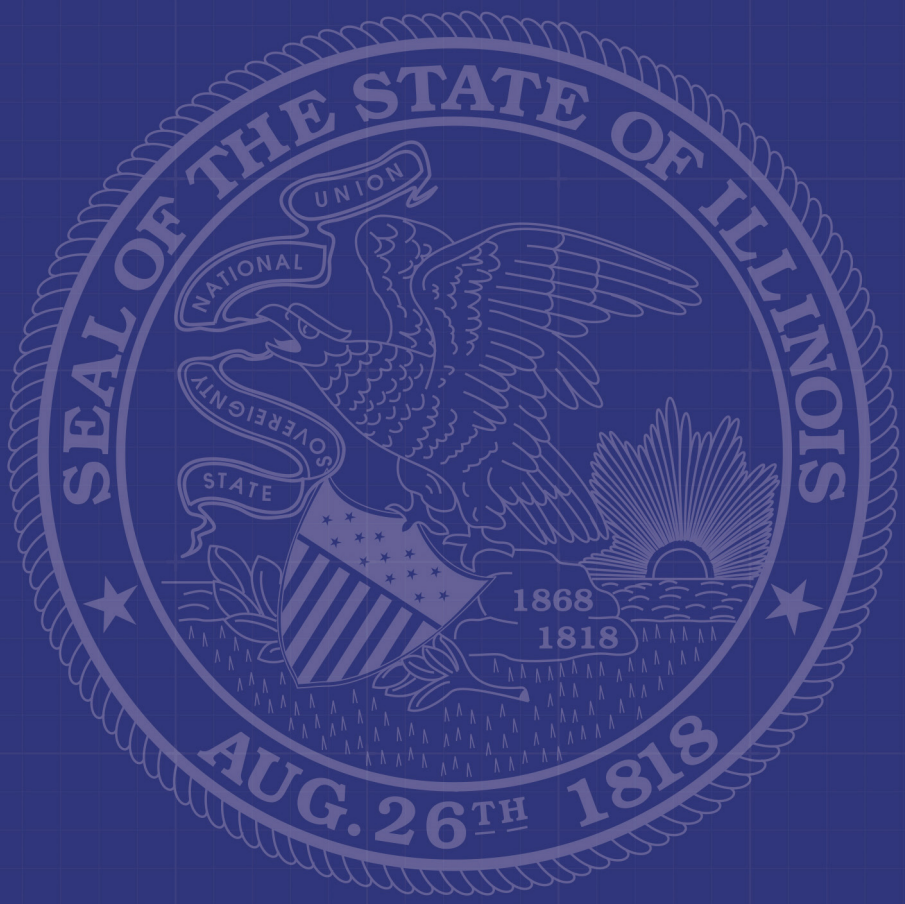

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