

# Illinois Action Plan to Integrate Early Childhood Mental Health into Child- and Family-Serving Systems, Prenatal through Age Five



*January 2016*

# Table of Contents



<b>Acknowledgements .....</b>	<b>1</b>
<b>Executive Summary.....</b>	<b>2</b>
Shared Values .....	3
Goals at a Glance.....	4
<b>Introduction.....</b>	<b>5</b>
<b>Background and Context.....</b>	<b>6</b>
What is Early Childhood Mental Health? .....	6
Why is Early Childhood Mental Health Important? .....	6
What Happens When Young Children Experience Challenges? .....	7
What is Childhood Trauma? .....	7
National Data.....	7
State of the Illinois Young Child.....	9
Services and Systems for Young Children in Illinois .....	10
Developing the Illinois Early Childhood Mental Health Action Plan.....	10
Stakeholder Input - Key Themes .....	12
<b>Illinois Early Childhood Mental Health Action Plan .....</b>	<b>13</b>
Goal One .....	17
Goal Two.....	23
Goal Three.....	27
Goal Four .....	31
Goal Five .....	32
<b>Conclusion and Next Steps .....</b>	<b>35</b>
<b>Appendix:</b>	
Glossary of Acronyms.....	36
Planning Committee and Stakeholder Participants .....	37
Illinois Early Childhood Mental Health Timeline.....	40-41
Illinois Guiding Principles for Cultural and Linguistic Responsiveness.....	42
Findings from the System Scan .....	43
What We Heard: Priorities for the Action Plan .....	58



## Acknowledgements

This Action Plan resulted from the collaboration of many stakeholders from the public and private sectors in Illinois. We want to express our appreciation to all who generously shared their expertise and gave their time to provide insight and to reflect on the status of early childhood mental health in Illinois and how the systems of supports and services can be improved to best serve our state's young children and families. These stakeholders included state agency leaders across systems, early care and education providers, health and mental health care providers, philanthropic partners, home visitors, child and family advocates, parents, and professionals from the Early Intervention, health, early learning, education, Head Start, Early Head Start, child care, public health, child welfare, home visiting, and mental health systems. These stakeholders also included parents with concerns about the social-emotional development of their children who provided valuable insight into their experiences and their desire for a more responsive and effective family-centered system that meets the needs of their young children. We would also like to thank the experts outside Illinois who provided us with insight into other state systems. Finally, we would like to acknowledge and express our gratitude to our fellow planning group members — the Governor's Office of Early Childhood Development, Voices for Illinois Children, the Illinois Children's Mental Health Partnership, the Ounce of Prevention Fund, and our partners at the BUILD Initiative—for their leadership, commitment and support in helping us think through and develop this Action Plan.

Phyllis Glink  
Executive Director



IRVING HARRIS  
FOUNDATION

# Executive Summary

Research has shown that early childhood mental health is just as important to school readiness, health and overall well-being as cognitive, physical and literacy development. The Illinois General Assembly recognized this importance when it passed the Children's Mental Health (CMH) Act of 2003, definitively making a fundamental commitment to support children's mental health beginning at birth and to reform the state's highly fragmented and under-resourced mental health system. While Illinois has made great strides over the years in addressing the mental health needs of young children, very significant gaps in services and strategies unfortunately persist across the continuum of social-emotional health promotion, prevention/intervention and treatment services. When early childhood mental health is not sufficiently supported, we not only risk continuous or worsening challenges for children as they enter school, but we also reduce the effectiveness and impact of investments made in other child and family serving systems, including early care and education, health, mental health, family support, child welfare, and K-12 education. **Our state must now go further and do more to assure the success of all our children.**

The resulting *Illinois Action Plan to Integrate Early Childhood Mental Health into Child- and Family-Serving Systems, Prenatal through Age Five* (Action Plan) seeks to create aligned and integrated child- and family-serving systems that promote school readiness and family success by integrating child and family mental health and health systems and services with early learning systems and by working toward creating equitable systems of care that reduce racial and socioeconomic disparities that will ultimately ensure children succeed in school and in life.

In early 2014, the Irving Harris Foundation initiated a process to examine early childhood mental health in Illinois and partnered with public and private sector leaders in the field who shared the Foundation's view that Illinois was in the midst of a critical moment to address key gaps for integrating early childhood mental health into systems serving young children, pregnant women and families. They sought to build on work already done or underway, integrate the experiences and perspectives of parents and families, and leverage their own and other leading expertise to identify ways Illinois can help children of diverse race, language and culture succeed in school and life by more effectively integrating early learning systems with child and family mental health and health services and systems.

The core of the process was a system scan that included comprehensive data drawn from: (1) a review of relevant reports and documents; (2) an analysis of key informant interviews, parent and provider focus groups, and expert interviews from other states; and (3) an analysis of survey results of program managers and service providers, much of which is summarized from "Findings" section of the Appendix. The data was then organized in a planning guide to provide an understanding of the current system of early childhood mental health supports and services and to outline the priorities and goals to consider when developing a plan of action. Priority areas that emerged from the assessment process included: Shared Vision; Equity; Parent Leadership and Voice; Public Education; Parent Education and Outreach; Workforce Development; Mental Health Consultation; Mental Health Treatment, 0-5; Integration of Social-Emotional Health; State Government Leadership; Early Childhood Mental Health System Capacity Building, and Governance and Implementation. (See Appendix at page 58.) Stakeholders noted the need to:

- Build partnerships with diverse stakeholders to systematically address issues of culture, race, disparities, and gaps in continuity of care;
- Create more public awareness and understanding of social and emotional health and reduce the stigma families face when seeking assistance for their children with social-emotional concerns;
- Integrate the perspective of parents;
- Support the current workforce and build capacity including through ongoing professional development, trainings, and reflective supervision;
- Make mental health consultation a core component of early childhood programs;
- Resolve the systemic issues that prevent access to mental health treatment; and
- Establish an accountable governance structure and a dedicated state leadership position responsible for early childhood mental health.

This data and analysis then informed two large facilitated gatherings of more than 80 state and local stakeholders from the public and private sectors who discussed the data and developed recommendations that have been distilled and organized around five goal areas: **Program Access and Availability, Workforce Development, Funding and Finance, Public Awareness and Education, and System Governance and Implementation** (*see table page 4*). The resulting Illinois Action Plan to Integrate Early Childhood Mental Health into Child- and Family-Serving Systems, Prenatal through Age Five (Action Plan) seeks to create aligned and integrated child- and family serving systems that promote school readiness and family success by integrating child and family mental health and health systems and services with early learning systems and by working toward creating equitable systems of care that reduce racial and socioeconomic disparities that will ultimately ensure children succeed in school and in life. It aligns with the overall commitment of the Governor's Office of Early Childhood Development (GOECD) and the Early Learning Council (ELC) to serve the most at-risk children and families through coordinated, community-based comprehensive systems. The Action Plan contains objectives and action steps that span the full continuum of *promotion* of healthy development, *prevention/intervention* to reduce mental health difficulties, and *treatment* of these difficulties. The Action Plan also emphasizes the need to assure that the proposed strategies and programs (*see graphic page 16*) provide equitable access to supports and services and reflect the cultural and linguistic diversity of the children and families being served in Illinois<sup>1</sup>.

**Finally, the Action Plan clearly calls for a higher level of integration, which will require a significant change in Illinois' approach to delivering early childhood mental health services from the primary responsibility of a single system to the responsibility of all child- and family-serving systems. The recommendations are based on the belief that Illinois can more effectively improve how it is investing its resources and can realize not only greater efficiencies but, more importantly, improved outcomes for young children and their families.**

## Vision for Young Children and their Families in Illinois

Every child enters kindergarten safe, healthy, ready to succeed, and eager to learn because, beginning prenatally, families have access to resources, services, and supports in their communities that include promotion, prevention/intervention, and treatment services.

## Shared Values

- Early childhood services and systems will actively work to reduce racial disparities and class inequities in all actions and responses. This includes fostering inclusion and countering the effects of discrimination and marginalization that jeopardize healthy development.
- Programs and services must be culturally and linguistically responsive, taking into account how different cultures and ethnic groups, in particular, may have different views and interpretations both of the concept of children's social and emotional development and of the type of system needed to address the needs of young children and their families.
- Services and supports must be coordinated, aligned, and integrated at the state and local/community-based levels.
- Strong local systems within a comprehensive state system are key to improving child and family outcomes.
- Programs, services and practices will be developmentally-appropriate, evidence-informed, and trauma-informed.
- Programs, services, and practices will emphasize a whole-family and whole-child approach that aims to strengthen and develop parent-child relationships.
- The voice of parents will be heard at all decision-making tables.
- All planning will emphasize shared responsibility and accountability.
- Data will be collected and used to implement, improve and report.

<sup>1</sup> The Illinois Early Learning Council recently adopted Guiding Principles for Cultural and Linguistic Responsiveness in early childhood programming and made a commitment to embed these principles in all new and existing policies. (See Appendix at page 42)

# Executive Summary

## Purpose of the Action Plan

The purpose of the Action Plan is to support the intentional integration of early childhood mental health promotion, prevention/intervention, and treatment services and supports into child- and family-serving systems, prenatal through age five, so that:

- All young children and their families experience optimal healthy social-emotional development that is critical to school readiness and success in life.
- People working with and on behalf of young children have the knowledge, skills, and professional supports necessary to work effectively with programs, providers, and families of diverse race, culture and language and are able to draw on the community/neighborhood supports that are needed to help children realize healthy social-emotional development and prepare them for success in school and in life, and to help families thrive.
- All child- and family-serving systems in Illinois that work with children prenatal through age five – the health (primary care and public health) system, the early learning and care system (center-based, home based, prekindergarten, and home visiting), the mental health system, the Early Intervention system, the special education system, the child welfare system, and the family support system – are collaborating to fund, coordinate, and provide early childhood mental health promotion, prevention/intervention, and treatment services and supports to young children and their families.

## Goals At a Glance

The Action Plan has five interrelated goals and some example priorities for each goal are outlined below:

1. **Program Access and Availability:** Families are able to easily obtain mental health information, resources, supports, and services that they and their children need and that will be supported along the continuum of equitable promotion, prevention/intervention, and treatment, and families will be able to do so in the context of their daily lives and communities.
2. **Workforce Development:** The Illinois early childhood workforce is well-equipped to provide comprehensive, effective and culturally and linguistically responsive early childhood mental health promotion, prevention/intervention, and treatment services to help address the mental health and developmental needs of all young children and their families beginning prenatally.
3. **Funding and Finance:** Investments and policies for early childhood mental health efforts are carried out within the framework of equitable promotion, prevention/intervention, and treatment; are embedded in the Illinois comprehensive early childhood system; are designed to meet the needs of all children and their families with a focus on the most vulnerable; and are organized to demonstrate accountability.
4. **Public Awareness and Education:** The people of Illinois have a shared understanding of what early childhood mental health consists of and support the healthy social-emotional development of young children and families.
5. **System Governance and Implementation:** An accountable structure for governance and an approach that generates dedicated leadership are established to oversee the effective implementation of the Action Plan.

Program Access and Availability	Workforce Development	Funding and Finance	Public Awareness and Education	System Governance and Implementation
Increase access and availability to high quality mental health services along the promotion to treatment continuum by developing and implementing a sustainable, scalable and consistent model for mental health consultation and access to other services through building capacity and increasing and integrating funding across systems.	Establish a cross-system approach to organizing all early childhood mental health workforce development efforts, including infusing early childhood mental health knowledge and best practices into coursework and training and establishing an entity to build a robust consultation network, supported by training and reflective supervision.	Increase coordination and effectiveness of public and private funding, including through innovative public-private partnerships, and by leveraging current and planned investments in promotion, prevention/ intervention, and treatment services.	Increase awareness and understanding of early childhood mental health including through the creation of a public awareness workgroup of stakeholders, including parents, to inform the development of a social marketing and information campaign for promotion, prevention/ intervention, and treatment services	Establish a formal governance structure as a focal point for early childhood mental health (ECMH) systems and services, including an ECMH Director in the Governor's Office of Early Childhood Development or a similar priority position in another state agency, and a cross-system state leadership committee on ECMH.



## Introduction

This *Illinois Action Plan to Integrate Early Childhood Mental Health into Child- and Family-Serving Systems, Prenatal through Age Five* (Action Plan) is the result of a thorough process that draws on extensive and diverse sources of knowledge and information, encompassing results from field research, interviews, focus groups, a survey, and two large facilitated stakeholder meetings. In early 2014, the Irving Harris Foundation initiated this process and partnered with public and private sector leaders in the early childhood field who shared the Foundation's view that Illinois was in the midst of a critical moment to address key gaps for integrating early childhood mental health into systems serving young children, pregnant women and families. They sought to build on work already done or underway, to integrate the experiences and perspectives of parents and families, and to leverage their own and other leading expertise to identify ways Illinois can help children of diverse race, language and culture succeed in school and life by more effectively integrating early learning systems with child and family mental health and health services and systems.

The core of the process was a system scan that included comprehensive data drawn from a review of relevant reports and documents, an analysis of key informant interviews, parent and provider focus groups, expert interviews from other states, and an analysis of survey results of program managers and service providers, much of which is summarized in the "Findings" section in the Appendix. The data was then organized into a planning guide to provide an understanding of the current system of early childhood mental health supports and services and to outline the priorities and goals to consider when developing a plan of action. Priority areas that emerged from the assessment process included: Shared Vision; Equity; Parent Leadership and Voice; Public Education; Parent Education and Outreach; Workforce Development; Mental Health Consultation; Mental Health Treatment, 0-5; Integration of Social-Emotional Health; State Government Leadership; Early Childhood Mental Health System Capacity Building; and Governance and Implementation. (See Appendix at page 58)

This data and analysis then informed two facilitated gatherings of more than 80 state and local stakeholders from the public and private sectors who discussed the data and developed recommendations that have been distilled and organized into the Action Plan. In total over 600 stakeholders contributed to the development of the 5 main goals and the supporting action steps and priorities detailed below. Ultimately the Action Plan aims to achieve the Vision that was refined throughout this process, namely: **Every child enters kindergarten safe, healthy, ready to succeed, and eager to learn because, beginning prenatally, families have access to resources, services, and supports in their communities that include promotion, prevention/intervention, and treatment services.**

# Background and Context

## *What Is Early Childhood Mental Health?*

**Early childhood mental health** is defined as the developing capacity of a child from birth to age 5 to: experience, regulate, and express emotions; form close and secure interpersonal relationships; and explore the environment and learn in the context of family, community, and cultural expectations for young children. The term **early childhood mental health** is synonymous with “social and emotional development,” and “infant-early childhood mental health,” and for purposes of this Action Plan, we may use the terms interchangeably but will most often use early childhood mental health. It is useful to think of responses to early childhood mental health needs as being arrayed on a continuum that ranges from responses focused on promotion to prevention/intervention to treatment.<sup>2</sup> (See graphic on page 16).

Young children are acutely sensitive to the emotional well-being and life circumstances of their caregivers. Young children do not exist or develop alone, but within relationships. The socio-cultural and socio-political context in which the relationship exists shapes the caregiver-child relationship. Discriminatory policies and practices that harm adults harm the infants in their care.<sup>2</sup> Historical and contemporary forms of racism have led to stark racial disparities resulting in young children of Black and Latino descent disproportionately experiencing challenges in their social and emotional development.<sup>3</sup> Moreover, community or familial cultural values may determine how children’s social and emotional development is understood and/or interpreted. In order to understand the mental health of a young child, one needs to first consider the baby’s experience within the context of caregiving relationships as well as the larger cultural context in which he or she lives.

Public policy plays an integral role in the conceptualization of early childhood mental health because society plays a pivotal role in promoting consistent, reliable, and nurturing caregiver-child relationships which are essential for raising developmentally competent children. This can include direct supports for families as well as supports to enhance the quality and sensitivity of systems that serve them including child care, early education, pediatrics, child welfare, mental health, the judicial system, and others<sup>4</sup> (See graphic on page 16).

## *Why Is Early Childhood Mental Health Important?*

**The science of child development shows that the foundation of sound mental health is built in the first five years of life, when early experiences—which include children’s relationships with parents, caregivers, relatives, teachers, and peers—shape the architecture of the developing brain.** Disruptions to this developmental process can impair a child’s capacities for learning and relating to others, creating lifelong negative implications. And many costly societal problems, ranging from the failure to complete high school to incarceration to homelessness, could be dramatically reduced if more attention were paid to improving the environment that helps shape children’s relationships and experiences early in life.

Sound mental health provides an essential foundation of stability that supports all other aspects of human development — from the formation of friendships and the ability to cope with adversity to success in school, work, and community life. Whether a child’s mental health difficulties stem from factors in his/ her environment, from factors associated with the child’s own temperament and disposition, or (most often) from both, the effective management of these difficulties in young children requires early identification of and appropriate attention to the sources of the difficulties.<sup>5</sup> Understanding how emotional well-being can be strengthened or disrupted in early childhood can help policymakers promote the kinds of environments and experiences that prevent problems and remediate the early difficulties that can destabilize the developmental process.<sup>6</sup>

<sup>2</sup> St. John, M.S., Thomas, K. & Noroña, C.R. (2012). Infant Mental Health Professional Development: Together in the Struggle for Social Justice. In Thomas, K., Osofsky, J.D. & Powers, S. (Eds.) (2012). Emerging issues in infant mental health from the Irving Harris Foundation Professional Development Network. *Zero to Three Journal*, 33(2), 13-21.

<sup>3</sup> House, J., & Williams, D. R. (2000). Understanding and Reducing Socioeconomic and Racial/Ethnic Disparities in Health. In B. D. Smedley & S. L. Syme (Ed.), *Promoting Health: Intervention Strategies from Social and Behavioral Research*, Promoting Health: Intervention Strategies from Social and Behavioral Research (pp. 81-124). presented at the Washington, D.C., Washington, D.C.: National Academy Press.

<sup>4</sup> What is Infant Mental Health by J. Osofsky and K. Thomas, *ZERO TO THREE Journal*, November 2012, Vol. 33 No. 2

<sup>5</sup> U.S. Department of Health and Human Services. (2001). *Mental Health: Culture, Race and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration., Center for Mental Health Services. Retrieved from <http://www.ncbi.nlm.nih.gov/books/ NBK44243/>

<sup>6</sup> Center on the Developing Child, Harvard University - *InBrief on Early Childhood Mental Health*

## *What Happens When Young Children Experience Challenges with Early Childhood Mental Health?*

Research has identified a number of factors that promote readiness to learn, including two that are critical: caring relationships with parents and caregivers, and supportive and positive early life experiences. When young children are fortunate enough to have these experiences, they will have the supports they need for learning and success in school and in life.

But far too many young children are at risk of early school failure due to exposure to poverty, toxic stress, trauma, poor quality early learning and care, and life situations that may limit parents' capacity to nurture their young children.<sup>7</sup> Black and Latino children are more likely to live in poor families than white and Asian children and research indicates that poor children are disproportionately exposed to factors that may impair brain development and affect social and emotional development.

As noted, deeply rooted issues of discriminatory practices and structural and institutional racism and classism have led to inequities across race and class lines that lead to family economic instability, under-resourced communities, community violence, incarceration, police surveillance, substance abuse, and other stressors that impact children's healthy development.<sup>8</sup> The greater the number of risk factors, the greater the potential for poor mental health outcomes for both young children and their caregivers.



## *What is Childhood Trauma?*

*Childhood trauma* is an exceptional experience in a child's life when powerful stimuli can overwhelm the child's developmental and regulatory capacity (including the capacity to regulate emotions) and when the child has insufficient emotional resources to cope with the event. When a child experiences prolonged adversity, the result is very likely to be *toxic stress*. (Toxic stress refers to the stress response system's effects on the body, not to the stressful event itself.) Trauma and toxic stress can result from an intentional threat to a child, such as physical, mental, or sexual abuse or witnessing interpersonal violence at home or in the community. These conditions can also result from a natural disaster, accidents, or loss of a parent or parents due to war or incarceration.

Young children who experience trauma and toxic stress are particularly at risk because early childhood trauma and toxic stress have been associated with impaired brain architecture, particularly a smaller brain cortex, which is responsible for complex human functions such as memory, attention, perceptual awareness, language, thinking, consciousness, and executive function. Moreover, the Adverse Childhood Experience Survey demonstrates that childhood trauma and toxic stress can increase the risk of stress-related diseases. It is during these critical early childhood years that parents, practitioners, policymakers, interventionists and clinicians can help mitigate trauma and improve a child's long-term well-being (<http://www.cdc.gov/violenceprevention/acestudy/findings.html>).

## *National Data*

National data indicate that mental health challenges are surprisingly common among young children under the age of 6.

- Between 9 and 14 percent of children between birth and 5 years old experience social-emotional problems that negatively impact their functioning, development, and school readiness.<sup>8</sup>
- Approximately 9 percent of children who receive specialty mental health services in the U.S. are younger than 6 years old.<sup>9</sup>

<sup>7</sup> *Child Trends Databank*. (2014). *Children in poverty*. Available at: <http://www.childtrends.org/?indicators=children-in-poverty> - See more at: [http://www.childtrends.org/?indicators=children-in-poverty#\\_edn22](http://www.childtrends.org/?indicators=children-in-poverty#_edn22)

<sup>8</sup> U.S. Department of Health and Human Services. (2001). *Mental Health: Culture, Race and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration., Center for Mental Health Services. Retrieved from <http://www.ncbi.nlm.nih.gov/books/NBK44243/>

<sup>9</sup> Brauner, C.B.; Stephens, B. C. 2006. Estimating the Prevalence of Early Childhood Serious Emotional/Behavioral Disorder: Challenges and Recommendations. *Public Health Reports* 121: 303-310

# Background and Context

- One-third of children ages 2 to 5 in the child welfare system need mental health services and related interventions.<sup>10</sup>
- Emotional behavior problems are identified for less than 1 percent of young children who have them.<sup>11</sup>
- The number of preschool-aged children who are diagnosed with trauma-related impairment is much lower than the number who exhibit symptoms of these conditions (nearly two to three times more of children in this age group with symptoms than the number diagnosed).<sup>12</sup>
- Between 80 and 97 percent of children ages 3 to 5 with identified behavioral health needs who were followed in one study did not receive services.<sup>13</sup>
- Another study showed that compared to children birth to 2 years old, children ages 6 to 10 were four times more likely to get access to developmental services.<sup>14</sup>
- The prekindergarten expulsion rate is 3.2 times higher than the national rate of expulsion for K-12 students. African-Americans attending state-funded prekindergarten were about twice as likely to be expelled as Latino and Caucasian children, and over five times as likely to be expelled as Asian-American children.<sup>15</sup>

Without intervention, challenges like the ones just described have life-long impacts on healthy development and learning. For example, children who struggle with severe behavioral and emotional problems between birth and age 6 have a 50 percent chance of continuing to struggle into adolescence and adulthood. But despite the demonstrated need for early childhood mental health services and supports, most mental health services are targeted to older children. This is, in part, because many mental health providers have little formal training in early child development, in assessment and treatment of young children, and specifically, in evidence-based approaches to treatment of young traumatized children and their families (Osofsky & Lieberman, 2012). In addition, the policies and procedures within child- and family-serving systems and funding sources (for example, Medicaid and private insurance) often are developed for older children and adults, and services for the promotion of early childhood mental health, prevention of difficulties, and intervention to address difficulties are often not targeted or included in these systems and funding sources. Aligning and integrating early childhood systems in Illinois can help mitigate young children's experience of trauma, toxic stress, and associated adversities. Integrated systems can ensure that families have access to promotion, prevention/intervention, and treatment services that can mitigate trauma in young children and that support the family.

<sup>10</sup> Burns, B.; Phillips, S.; Wagner, H.; Barth, R.; Kolko, D.; Campbell, Y.; et al. 2004. Mental Health Need and Access to Mental Health Services by Youths Involved With Child Welfare: A National Survey. *Journal of the American Academy of Child and Adolescent Psychiatry* 43(8): 960-970. Leslie, Laurel K.; Hurlburt, Michael S.; James, Sigrid; Landsverk, John; Slymen, Donald J.; Zhang, Jinjin. 2005. Relationship Between Entry into Child Welfare and Mental Health Service Use. *Psychiatric Services* 56(8): 981-987.

<sup>11</sup> Conroy, M. 2004. Early Identification, Prevention and Early Intervention for Young Children at Risk for Emotional, Behavioral Disorders: Issues, Trends, and a Call to Action. *Behavioral Disorders* 29(3): 224-236

<sup>12</sup> Scheeringa, M. S.; Zeanah, C. H.; Myers, L.; Putnam, F. W. 2005. Predictive Validity in a Prospective Follow-up of PTSD in Preschool Children. *Journal of the American Academy of Child and Adolescent Psychiatry* 44(9): 899-906

<sup>13</sup> New, M.; Razzino, B.; Lewin, A.; Schlumpf, K.; Joseph, J. 2002. Mental Health Service use in a Community Head Start Population. *Archives of Pediatrics & Adolescent Medicine* 156: 721-727. Kataoka, S.; Zhang, L.; & Wells, K. 2002. Unmet Need for Mental Health Care among U.S. Children: Variation by Ethnicity and Insurance Status. *American Journal of Psychiatry* 159: 1548-1555

<sup>14</sup> Zimmer, M. H.; Panko, L. M. 2006. Developmental Status and Service use among Children in the Child Welfare System: A National Survey. *Archives of Pediatrics & Adolescent Medicine* 160: 183-188

<sup>15</sup> Gilliam WS. Prekindergarteners left behind: Expulsion rates in state prekindergarten programs (Abbreviated as Foundation for Child Development Policy Brief Series No. 3, May 2005). Available at: [http://www.fcd-us.org/usr\\_doc/ExpulsionComplete Report.pdf](http://www.fcd-us.org/usr_doc/ExpulsionComplete%20Report.pdf).

## State of the Illinois Young Child

This chart, which is based on data from a variety of sources drawn from the BUILD Initiative's 50 State Chartbook, provides data on young children in Illinois. In reviewing this data, it is particularly important to note the significant racial disparities in the data among Caucasian, African American and Hispanic children and families. In this Action Plan, and in all other planning for Illinois's early childhood system, these disparities must be taken into consideration and factored into strategies to work toward equity for all children and families.

Supplementing the information revealed by the national data in the chart, the planning group conducted its own survey to better understand issues related to early childhood mental health in Illinois. The survey was sent to more than 1,200 people who were identified as either directing, managing, or providing services in an early childhood program or programs. When asked if any children in their programs had exhibited social-emotional developmental concerns in the last year, nearly 83 percent of respondents reported that their programs had served children with these concerns. The survey results also showed that nearly 30 percent of children with a social-emotional concern needed additional intervention outside of the typical program services. Moreover, slightly more than 15 percent of respondents had to discontinue services to a child or ask a family to withdraw a child from the program owing to social-emotional concerns.

	White, Non-Hispanic	African- American, Non-Hispanic	Hispanic
Population (2010)	508,805	154,865	255,630
Population by percentage (2010)	50.6	15.4	25.4
Percentage of children 0-8 below 100% of poverty, Illinois, 2008-2010	11	44.7	27.3
Percentage of children 0-8 below 200% of poverty by race/ethnicity, U.S. and Illinois, 2008-2010	25.8	68.4	60.9
Percent of births at low birthweight, U.S. and Illinois, 2012	6.9	13.4	7
Infant mortality rates (per 1,000 live births) by race/ethnicity, U.S. and Illinois, 2008-2010	5.45	13.59	5.92
Uninsured children 0-17, 2011-2012	1.7	2.8	0.5
Percentage of children 0-17 reported as <i>not</i> having coordinated, ongoing comprehensive care within a medical home, 2011-2012	27.1	54.7	72.9
Percentage of children who have <i>not</i> seen a doctor, nurse, or other health care provider for preventive medical care, such as a physical exam or well-child checkup, in the past 12 months, 2011-2012	9.6	9.4	14.8
Percentage of children 10 months-5 years who during the past 12 months were <i>not</i> screened for developmental, behavioral, and social delays using a parent-reported standardized screening tool during a health care visit, 2011-2012.	68.1	59.7	58.6
Children 0-2 receiving intervention services under IDEA, Part C, U.S. and Illinois, 2011-2013	3.8	3.5	4.9
Foster care placement rates (per 1,000 children) among children 0-4, U.S. and Illinois, 2012	6.0	18.6	1.3
Percentage of children whose mother's mental/emotional health status is fair or poor, U.S. and Illinois, 2011-2012	4.3	14.9	10.0
Percentage of children whose parents report their neighborhood or community is never safe/sometimes safe for children, U.S. and Illinois, 2011-2012	7.0	24.5	27.1



### *Services and Systems for Young Children in Illinois*

In many states, there still is a large gap between what is known about how to support young children's healthy social-emotional development and what happens in practice – notably, how resources and services are actually organized and how well the different child- and family-serving systems, prenatal through age 5, are connected to and coordinated with one another. In comparison to most states, Illinois has been ahead of the curve in recognizing how social-emotional development and overall mental health relate to children's health, well-being, and academic success. (See the Timeline in the Appendix on page 40.) When the Illinois General Assembly passed the Children's Mental Health (CMH) Act of 2003, the state communicated a fundamental commitment to children's mental health beginning at birth and to the reform of the state's highly fragmented and under-resourced mental health system. The CMH Act created the Illinois Children's Mental Health Partnership (ICMHP) and charged it with developing a Children's Mental Health Plan for children birth to age 18. The *Strategic Plan for Building a Comprehensive Children's Mental Health System in Illinois* was completed in 2005 and its implementation since that time has created:

... significant statewide impact, creating a comprehensive system of programs, services and supports that promote the importance of children's mental health; reaches more children at younger ages and earlier stages of need; reduces fragmentation of services; enhances interagency collaboration by serving children...in homes, schools and communities.<sup>17</sup>

Despite progress over the years, the system of services that was created has never been funded at the level needed and the reality is that the extent of need has only increased while resources have been cut.

### *Developing the Action Plan*

Given the level of need in Illinois - and the erosion of funding and services over the past decade, Illinois leaders have come together to develop a plan that works toward integrating early childhood mental health into child- and family-serving systems, prenatal through age 5, and developing policies to fund services and supports along the continuum of promotion, prevention/ intervention, and treatment. The findings from the system scan and the stakeholder meetings demonstrated the urgency to address the social-emotional health of young children and their families.

<sup>17</sup> Illinois Children's Mental Health Partnership, Annual Report 2013

Hundreds of individuals and groups, representing parents in need, service providers across the sectors of the early childhood system, and state agencies and organizations essentially all said the same thing: **The social and emotional health of young children and their families is too fundamental, too essential to the future of our families, our communities, and our state not to take action now.**

Some of what needs to change will cost little in terms of dollars, but will require fundamental changes in how people think, work together, interact with families and partners, and make decisions. Other changes will require new investment. Even if efficiencies can be found in how current resources are being used, there simply will not be enough funding, for example, to expand access to social-emotional interventions or mental health treatment to all young children who need this help, unless new resources are devoted to meeting this need. Moreover, we will need to invest in new thinking and systems change efforts to assure that the decisions we are making, the policies we are developing and the services we are funding are reducing racial disparities and are not overtly or covertly creating further inequities. We must support a system that is responsive to the diverse needs of children and families of different races, languages and cultures and that intentionally addresses racial and economic disparities.

During the system scan and stakeholder convenings process, state leaders recognized that more resources are needed -- and this recognition is reflected in the Action Plan. But they also recognize that more can be done with existing resources to develop a more effective approach to meeting young children's needs - an approach that better integrates early childhood mental health services and supports into child- and family-serving systems.

**Some of what needs to change will cost little in terms of dollars, but will require fundamental changes in how people think, work together, interact with families and partners, and make decisions.**



# Stakeholder Input - Key Themes

Nearly 600 stakeholders contributed to the final version of the Action Plan and the overall planning process. All stakeholders were strongly in agreement and aligned in terms of:

- A sense of urgency to take action now to shift the status quo;
- Strengthening fundamental mental health and social and emotional supports so that all children and families in Illinois have equal opportunity to thrive;
- Developing a shared vision, with a strong focus on key values, such as equitable, trauma-informed, and evidence-informed practices; and
- Measuring progress, impact, and success with a set of shared outcomes.

Parents spoke passionately about their hopes for a future where finding information, resources and supports for their children related to social and emotional health and development would be simpler than it is today. Their own, mostly negative, experiences in learning about, accessing, and using existing services and resources made them eager for an easier path for other parents. In particular, parents want the Action Plan to address:

- The stigma that is frequently associated with a family that has a child with social, emotional, and behavioral concerns;
- The need for professionals to truly respect and act on parents' instincts about their children's developmental needs, rather than taking a "wait and see" approach; and
- Access to community-based resources and services designed to support parents as leaders in their own children's health, development and learning.

Many service providers expressed appreciation for the increased professional development and mental health consultation that resulted from the CMH Act of 2003. These same individuals, however, noted that the scope and scale of available promotion, prevention/intervention and treatment services is currently insufficient to meet the needs they experience in their day-to-day work with families. In particular, providers noted the need for the following:

- Reform in how families with a medical card are able to access mental health treatment in the communities where they live;
- More professionals to provide evaluation of and treatment for children and families, as well as regular and consistent mental health consultation;
- Consistent, ongoing, in-depth professional development, across all sectors of the early childhood system and, in particular, in mental health intervention and treatment services; and
- Reforms that result in a more aligned, integrated, systemic approach that allows providers to be more effective partners with families.

State leaders interviewed during the planning process were acutely aware of the current challenges involved in making the right set of services and supports available to young children, families and the early childhood workforce. From a financial perspective, they acknowledged the need to use existing resources more effectively and to take on the long-term challenge of securing additional, sustainable public resources. In addition to addressing these financial challenges, state leaders identified the need for the following:

- Formalized shared commitment and leadership for the successful integration of early childhood mental health services into the different sectors of the early childhood system – notably, health, mental health, child care, early learning, family support and child welfare services;
- Fundamental changes in how leaders and providers in the different sectors of the early childhood system understand their role, work with partners, interact with families, and make decisions; and
- More widespread public education to build momentum and create a call to action in order to shift the mindset of voters and policy makers to value and choose to invest in social emotional health as a fundamental element of children's health, well-being and school success.



# Illinois Action Plan to Integrate Early Childhood Mental Health into Child- and Family-Serving Systems, Prenatal through Age Five

January 2016





## Illinois Action Plan

### Illinois Action Plan to Integrate Early Childhood Mental Health into Child and Family Serving Systems, Prenatal through Age Five

As noted, Illinois leaders engaged in a systems scan during spring and summer 2014 and then undertook an extensive planning process over two full days in fall 2014 that brought together a range of stakeholders to develop the Action Plan. The planning process identified five main goals along with associated outcomes, objectives, and detailed action steps as high priorities to develop and/or accomplish in the upcoming months and years. The goals reflect the shared values outlined and a lens toward equity and inclusion. The goals are framed within a number of cross-cutting strategies relating to mental health consultation, data-based decision making, continuous quality improvement, public and parent education, and workforce preparedness, among others, that appear in descriptions of more than one Goal Area. This presentation demonstrates the Action Plan's purpose of supporting increased integration of services and supports into all child- and family-serving systems, through short-, medium-, and long-term strategies. Finally, as noted earlier and illustrated by the following "ovals" graphic, the Action Plan centers on an agreed-upon approach to an early childhood mental health system that spans promotion, intervention/prevention, and treatment and is responsive to the needs of children of diverse races, languages and cultures and rooted in principles that work toward reaching equity.

The Action Plan that is presented on the following pages is grounded in a vision for young children and their families in Illinois and in a set of values shared by the stakeholders who developed it.

## Framework for a Coordinated Mental Health System in Illinois for Children and Families

### Promotion

A coordinated system of supports and services designed to encourage and support the healthy social and emotional development of all young children and their families. Healthy social and emotional development is a critical key to school readiness and life success. Promotion approaches are universal, designed to support young children and provide the adults who interact with them the skills to contribute to their healthy social and emotional development. All adults, including but not limited to parents and family members, caregivers, early care and education providers and teachers, and health care providers, all play a role in the social and emotional development of young children. Examples of promotion approaches include universal screening, warm phone line for parents, high quality early learning programs, and educational opportunities for parents and providers on the importance of healthy social and emotional development.

### Prevention/ Intervention

A coordinated system of targeted supports and services designed to minimize or prevent the development of social or emotional delays and early childhood mental health difficulties. These supports and services work to intervene early in order to identify concerns and prevent or minimize more severe challenges later. Prevention and intervention supports and services are targeted to families that are experiencing risk factors such as exposure to trauma, toxic stress, poverty or other adverse circumstances that could increase the likelihood of their young child developing social or emotional delays or mental health concerns. Prevention and intervention approaches focus on the development of nurturing and responsive caregiving relationships and supportive home and early learning environments. Prevention and intervention approaches help build the capacity of the adults in a child's life to understand and respond effectively to the child's social and emotional needs including various behaviors. Examples of prevention and intervention approaches include home visiting; mental health consultation services for providers, children and families; Part C Early Intervention evaluation, assessment, and services; and family support programs.

### Treatment

A coordinated system of treatment services designed to address emerging challenges for young children exhibiting serious, persistent mental health difficulties and their families. Mental health treatment services are intended to alleviate distress and provide primarily to parents but also other significant adults in a child's life with the tools and strategies to help the child respond to challenges in a functional manner with the ultimate goal of returning to healthy development and behavior. Mental health assessment, diagnosis, and treatment are provided by a range of highly trained professionals in various settings, including the home. Some examples of treatment include dyadic therapies such as Infant-Parent Psychotherapy and Child-Parent Psychotherapy (CPP).

*The supports and services are along the continuum of promotion to prevention/intervention to treatment.*

## Vision for Young Children and their Families in Illinois

Every child enters kindergarten safe, healthy, ready to succeed, and eager to learn because, beginning prenatally, families have access to resources, services, and supports in their communities that include promotion, prevention/intervention, and treatment services.

### Shared Values

- Early childhood services and systems will actively work to reduce racial disparities and class inequities in all actions and responses. This includes fostering inclusion and countering the effects of discrimination and marginalization that jeopardize healthy development.
- Programs and services must be culturally and linguistically responsive, taking into account how different cultures and ethnic groups, in particular, may have different views and interpretations both of the concept of children's social and emotional development and of the type of system needed to address the needs of young children and their families.
- Services and supports must be coordinated, aligned, and integrated at the state and local/community-based levels.
- Strong local systems within a comprehensive state system are key to improving child and family outcomes.
- Programs, services and practices will be developmentally appropriate, evidence-informed, and trauma-informed.
- Programs, services, and practices will emphasize a whole-family and whole-child approach that aims to strengthen and develop parent-child relationships.
- The voice of parents will be heard at all decision-making tables.
- All planning will emphasize shared responsibility and accountability.
- Data will be collected and used to implement, improve and report.

### Goal One: Program Access and Availability

**Families are able to easily obtain mental health information, resources, supports, and services that they and their children need and that will be supported along the continuum of equitable promotion, prevention/intervention, and treatment, and families will be able to do so in the context of their daily lives and communities.**

**Outcome 1.1 - Promotion** – *A coordinated system of supports and services designed to encourage and support the healthy social-emotional development of all young children and their families.* A coordinated system includes: periodic social-emotional screening using agreed-upon tools; linkages to and interfacing with primary health care providers; linkages to and integration into child- and family- serving systems; parent education and support services, beginning prenatally and continuing through a child's entry into kindergarten; and programs and curricula focused on social-emotional development.

### Short-Term Objectives and Action Steps: By December 31, 2016

- 1) Assess current child- and family-oriented services and systems to understand what is needed to create a more coordinated system of early childhood mental health promotion.
  - a. Discern strengths, weaknesses, gaps, and opportunities for coordination and expansion within the current system, and do so by drawing on current needs analyses and recommendations.
  - b. Determine what data needs to be collected and submit questions to the Data, Research, and Evaluation Subcommittee of the Early Learning Council (ELC). Consider collecting data to look for inequities in outcomes and access. Identify and implement an agenda for development of data and for data-sharing agreements.



- c. Identify what resources (financial, human, and social) and creative models (both publicly and privately funded) are supporting the current approaches, how they are being used, and how they might be expanded, taking into account such potential vehicles for expansion as the Affordable Care Act, Medicaid, and Mental Health Block Grant.
- 2) Create a shared vision and understanding of the desired structure for the coordinated system for promotion, making sure that supports and services are culturally and linguistically responsive and that there are guidelines for shared communication and feedback loops between agencies and programs that can facilitate smooth referral processes and the transition of families from one service or system to another.
- 3) Define outcomes for success, funding, and an advocacy agenda for the promotion system.

## **Medium-Term Objectives and Action Steps: By December 31, 2017**

- 1) Use results from the assessment to develop a plan for the coordinated system as defined in Outcome 1.1 of the Action Plan:
  - a. Work with diverse group of stakeholders, including parents, to develop a shared definition and understanding of core constructs of healthy social-emotional development and define successful outcomes – with an emphasis on strategies to promote well-being in parents and caregivers.
  - b. Review the list of Medicaid-approved social-emotional screening tools and identify new or missing screening tools with a particular emphasis on identifying culturally and linguistically responsive screening tools.
  - c. Determine how best to require child- and family-serving systems to screen for social and emotional milestones at appropriate intervals, and determine how communication, referral, and follow-up will take place between all system partners. Build on current needs analyses and recommendations and incorporate useful elements of those recommendations and analyses into screening systems developed under this Action Plan.
  - d. Create unified referral forms and processes for systemwide use.
  - e. Work with the Illinois Children's Mental Health Partnership (ICMHP) to create a shared understanding of what the message for the coordinated system for promotion will be.
  - f. Build on and expand current initiatives already in place – for example, build capacity within the local early childhood community collaborations (including the MIECHV and Innovation Zones collaborations), build on and expand the impact of the Illinois Childhood Trauma Coalition's public awareness campaign, and increase efforts to screen for perinatal and maternal depression in early childhood programs and in physicians' offices.

## Long-Term Objectives and Action Steps: 2 years+

- 1) Implement the coordinated system plan for promotion of early childhood mental health.
- 2) Begin implementation of the identified funding and advocacy strategies.
- 3) Design and implement a cross-sector evaluation of Illinois' consultation efforts.
- 4) Develop training and/or guidelines for a coordinated system that supports promotion.

**Outcome 1.2 –Prevention/Intervention** - *A coordinated system of targeted supports and services designed to minimize or prevent the development of social or emotional delays and early childhood mental health difficulties.* These supports and services are structured as early interventions in order to identify concerns as soon as possible and prevent or minimize more severe challenges later. A coordinated system of prevention/intervention services and supports includes: linkages to and interfaces of these systems and supports with primary health care providers; linkages to and integration into child- and family-serving systems; mental health consultation services with providers, children, and families; early identification, assessment, referral, and follow-up activities in order to advocate for families; access to short-term counseling and crisis support for children and families; and educational opportunities targeted to families at risk for mental health difficulties.

## Short-Term Objectives and Action Steps: By December 31, 2016

- 1) Assess the current state of coordinated systems (as defined in Outcome 1.2 above) for early childhood mental health prevention/intervention.
  - a. Discern strengths, weaknesses, gaps, and opportunities for coordination and expansion in the current system, and do so by drawing on current needs analyses and recommendations.
  - b. Determine what data needs to be collected and submit questions to the Data, Research, and Evaluation Subcommittee of the ELC. Consider collecting data to look for inequities in outcomes and access. Identify and implement an agenda for the development of data and data-sharing agreements.
  - c. Identify what resources (financial, human, and social) and creative models (both publicly and privately funded) are supporting the current approaches, how they are being used, and how they may be expanded, taking into account such potential vehicles as the Affordable Care Act, Medicaid, and the Mental Health Block Grant.
- 2) Create a shared vision and understanding of the desired structure for the coordinated system for prevention/intervention, making sure that supports and services are culturally and linguistically responsive, and that there are guidelines for shared communication and feedback loops between agencies and programs that can facilitate smooth referral processes and the transition of families from one service or system to another.
- 3) Define outcomes for success, funding, and a policy agenda for the prevention/intervention system.
- 4) Systematize how Illinois implements mental health consultation in the different systems through the identification of a consistent model that allow for variations and that accommodate the needs and practices of different sectors and the needs of individual families.
  - a. Identify core knowledge and competencies for the identified models and develop a funding mechanism to support scaling them up.
  - b. Develop a plan to train, supervise, and support a statewide network of consultants working across systems.
  - c. Identify both current efforts underway to provide mental health consultation in the various sectors and possible future opportunities to sustain and take these efforts to scale, taking into account both public and private models and models with both public and private funding. Place a particular emphasis on the recruitment of and providing





access to training, supervision and support to mental health consultants of color or from under-represented racial and ethnic groups. Identify opportunities for Illinois Children's Mental Health Partnership to work with the Governor's Office of Early Childhood Development (GOECD) to explore using the Preschool Expansion Grant to support the overall implementation of consultation efforts in the sub-grantee communities.

- 5) Build capacity and increase cross-system funding for mental health consultation that will lead to sustainability and scaling. (See Objective 3 above and the Action Plan's Workforce Development goal.)

#### **Medium-Term Objectives and Action Steps: By December 31, 2017**

- 1) Build on and expand current initiatives already in place.
  - a. Coordinate with the Home Visiting Task Force to take advantage of the plan for the newly created home visiting/child welfare collaboration.
  - b. Share the progress and learning of Project PROTECT's work to organize different efforts being made in the early childhood sectors to create and strengthen trauma-informed practices.
  - c. Develop an agreement with the Illinois Department of Healthcare and Family Services so that the Home Visitors Credential, now in development, will be recognized by the Medicaid system.
- 2) Expand early childhood mental health intervention, with particular attention to two elements – first, funding, and second, workforce development (for example, shaping trainings and credentials to ensure they are tailored to each role in the interventions – the roles of consultants, teachers, therapists, home visitors, directors, and others).
  - a. Ensure that the Illinois Association for Infant Mental Health (ILAIMH) will continue to certify professionals with the Master's level credential (current practice) such as mental health consultants, licensed mental health practitioners, LCSWs, psychologists, etc., and work toward developing the Bachelor's level credential for front line workers such as home visitors, teachers, child care staff, family support specialists, etc.
  - b. Re-evaluate the wording of the eligibility requirements for Early Intervention (ages 0-3) and expand eligibility to children and families with fewer than three risk factors. Provide appropriate funding to support more children and families coming into the Early Intervention system as a result of this change. Ensure that services as defined in the rule match the needs of the Early Intervention population and include service descriptors specific to the Early Intervention population.
  - c. Re-evaluate and expand eligibility and services provided by the Special Education system (ages 3-5) to secure greater inclusion of families and community agencies/service providers in efforts to shape the service plans.
  - d. Standardize and strengthen the American Academy of Pediatrics/Bright Futures screening policies and timelines.
  - e. Increase the use of social-emotional screenings in all early care and education programs.
  - f. Increase the use of screening for perinatal and maternal depression, where appropriate, in early care and education programs, and require that programs that screen for depression have protocols in place for referral should there be severe indications of depression or suicide.

- g. Track screenings across sectors to minimize duplication and ensure that there are communication, referral, and follow-up processes for all system partners.
  - h. Create and use shared assessment and service planning processes and documents.
- 3) Allow for short-term mental health services to be available to children and families in early care and education programs.

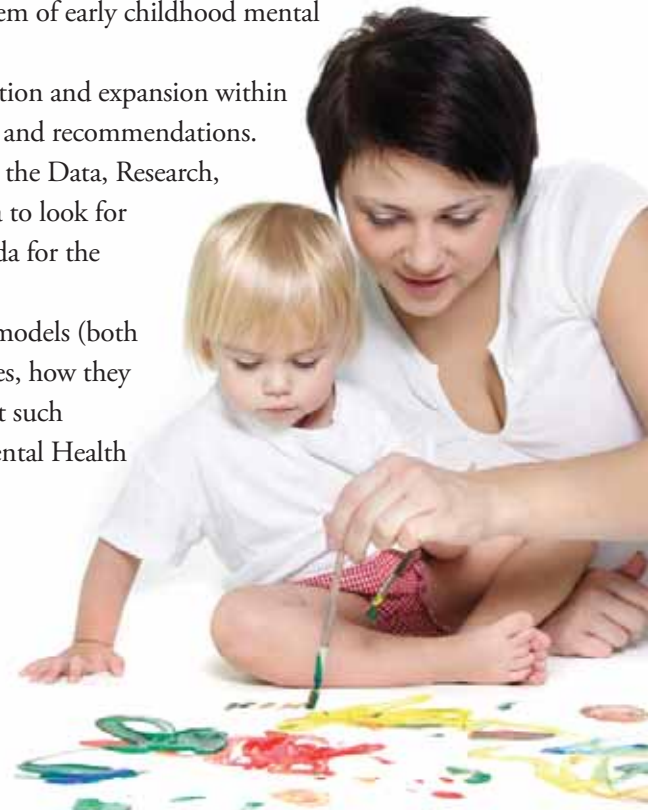
## **Long-Term Objectives and Action Steps: 2 years+**

- 1) Implement the early childhood mental health intervention coordinated system plan.
- 2) Continue to implement and evaluate the policy and funding strategies and any advocacy strategies designed to support the recommended changes.
- 3) Conduct a study to determine the feasibility of providing early intervention-like services to children up to age 5.
- 4) Finalize and implement an agreement on home visiting services and mental health consultation and treatment services to be covered by Medicaid.
- 5) Track the outcomes of the coordinated system plan and use data to inform expansion and refinement of the system.

**Outcome 1.3 - Treatment** – *A coordinated system of treatment services designed to address emerging challenges facing both young children experiencing serious, persistent mental health difficulties and their families.* A coordinated system includes: linkages to and interfaces with the health care system, including but not limited to, linkages to and interfaces with hospitals, primary care physicians, pediatricians, and OB-GYNs; linkages with and integration into child- and family-serving systems; a comprehensive array of services, including child-parent psychotherapy and/or family therapy; support groups; services targeted to treatment-specific issues of women/mothers, such as perinatal and maternal depression, and similarly services targeted to the needs of fathers; trauma-informed treatment; comprehensive screening, assessment, diagnostic, and referral services for children and their family members; appropriate settings, including therapeutic settings, (for example, therapeutic nurseries) for services; and support services for families.

## **Short-Term Objectives and Action Steps: By December 31, 2016**

- 1) Assess current child- and family-oriented services and systems from the perspective of understanding how many elements are already in place and how many are needed to create a more coordinated system of early childhood mental health treatment (as defined in Outcome 1.3 above).
  - a. Discern strengths, weaknesses, gaps, and opportunities for coordination and expansion within the current system, and do so by drawing on current needs analyses and recommendations.
  - b. Determine what data needs to be collected and submit questions to the Data, Research, and Evaluation Subcommittee of the ELC. Consider collecting data to look for inequities in outcomes and access. Identify and implement an agenda for the development of data and data-sharing agreements.
  - c. Identify what resources (financial, human, and social) and creative models (both publicly and privately funded) are supporting the current approaches, how they are being used, and how they may be expanded, taking into account such potential vehicles as the Affordable Care Act, Medicaid, and the Mental Health Block Grant.



- 2) Create a shared vision and understanding of the desired structure for the coordinated system for treatment, making sure that supports and services are culturally and linguistically responsive and that there are guidelines for shared communication and feedback loops between agencies and programs that can facilitate smooth referral processes and the transition of families from one service or system to another.
- 3) Define outcomes for success, funding, and a policy agenda for the treatment system. In doing so, consider and focus analysis on:
  - a. How to create a continuum of treatment to give families access to treatment in the environment of their choice.
  - b. Needs and/or strategies for creating an infant mental health credential, tailored specifically to treatment.
  - c. How to create an environment of *no wrong door* to ensure that families do not have to navigate multiple agencies and systems to obtain treatment services. (“No wrong door” refers to the idea that all people should receive the full spectrum of services to address their needs regardless of which system or agency they enter.)

## **Medium-Term Objectives and Action Steps: By December 31, 2017**

- 1) Identify and document key action steps to address needs and gaps identified through the assessment process outlined above. At minimum, focus on:
  - a. Capacity building and workforce development that will allow early childhood system partners to expand the supply of early childhood mental health treatment services and supports, ensuring that they are culturally and linguistically responsive.
  - b. Linking child- and family-serving systems (for example, the health, education, and Early Intervention systems) with early childhood mental health treatment providers.
  - c. Development and identification of shared service planning processes and documents.
  - d. Development of a funding and policy agenda.
  - e. Identification of outcomes and data that will be used to evaluate and inform practice, noting and addressing where there may be inequities in outcomes and access.

## **Long-Term Objectives and Action Steps: 2 years+**

- 1) Implement the early childhood mental health treatment coordinated systems plan.
- 2) Continue implementation and evaluation of the policy, funding, and advocacy strategy.
- 3) Track the outcomes and use data to inform efforts to expand and refine the system.



**Outcome 1.4** - *Information about early childhood mental health promotion, prevention/intervention and treatment is culturally and linguistically responsive, widely available and easily accessible to families, programs, and service providers.*

**Short-Term Objectives and Action Steps: By December 31, 2016**

- 1) Conduct a review of written resources currently available on early childhood mental health promotion, prevention/intervention and treatment.

**Medium-Term Objectives and Action Steps: By December 31, 2017**

- 1) Develop written resources in English, Spanish and other languages on early childhood mental health promotion, prevention/intervention and treatment and ensure that they are available in an easily accessible centralized location.

Program Access and Availability Action Steps To Be Completed by December 31, 2016	Responsible Entities/Organizations
Assess current child- and family-oriented services and systems to understand what is needed to create a more coordinated system of early childhood mental health promotion.	<i>Illinois Children's Mental Health Partnership; System leads from state agencies and offices including DCFS, DHS, DHS-DMH, GOECD, ISBE, and IDPH; Ounce of Prevention Fund.</i>
Systematize how Illinois implements mental health consultation in different systems through the identification of a consistent model that allows for variations and that accommodates the needs and practices of different sectors and the needs of individual families.	<i>Illinois Children's Mental Health Partnership and other public and nonprofit partners</i>
Build capacity and increase cross-system funding for mental health consultation that will lead to sustainability and scaling.	<i>Illinois Children's Mental Health Partnership; Irving Harris Foundation and other philanthropic partners; advocacy organizations; and System leads from agencies and offices including DCFS, DHS, DHS-DMH, GOECD, ISBE and IDPH.</i>

## Goal Two: Workforce Development

**The Illinois early childhood workforce is well equipped to provide comprehensive, effective and culturally and linguistically responsive early childhood mental health promotion, prevention/intervention, and treatment services to help address the mental health and developmental needs of all young children and their families beginning prenatally.**

**Outcome 2.1** - *Illinois has a coordinated, systemic, capacity-building and ongoing knowledge- development approach to training its early childhood workforce.*

**Short-Term Objectives and Action Steps: By December 31, 2016**

- 1) Establish a cross-system approach to organizing all early childhood mental health workforce development programs, including trauma-informed practice, to allow for alignment among systems. Consider and focus on:
  - a. Identification of models and delivery systems that currently provide workforce training opportunities.
  - b. Scanning workforce development trainings and programs that currently exist and identifying existing approaches to adult learning that are evidence-informed and that use best practices.
  - c. Understanding similarities and differences between different workforce development training efforts across sectors.
- 2) Begin to identify current resources (financial, human, and social) for workforce development efforts and identify funding to staff the work.



- 3) Collect data on service professionals currently working in the early childhood mental health field (for example, consultants, therapists, and Early Intervention professionals) including the number of professionals, information on education background and experience, certifications, cultural and racial and ethnic background, second language proficiency, service area, and other relevant information.
- 4) Connect to other tables and entities focused on workforce development and social-emotional health and coordinate efforts when appropriate. This includes but is not limited to ELC Committees, CCDBG state plan efforts, ICTC and ICMHP Committees.
- 5) Provide incentives for members of the workforce to obtain credentialing and certification.
  - a. Work with funding agencies to encourage them to acknowledge the value of credentialing or certification.
  - b. Work with funding agencies to define and provide incentives for credentialing or certification with a particular emphasis on persons of color.

**Medium-Term Objectives and Action Steps: By December 31, 2017**

- 1) Review and build on core knowledge and competencies already developed for the early childhood mental health workforce including, but not limited to, core knowledge and competencies already identified for program directors, supervisors, and consultants involved in promotion, prevention/intervention, and treatment. The review should include:
  - a. Information on how other states and other groups such as the National Association for the Education of Young Children (NAEYC) have defined core knowledge and core competencies.
  - b. Identification of any gaps in current definitions of core knowledge and competencies.
  - c. Confirm that core knowledge and competencies include information about: pregnancy and the prenatal period; child development and atypical development; social-emotional development; trauma; toxic stress; the promotion, prevention/intervention, and treatment framework; reflective practice; culturally attuned and relationship-based approaches to efforts to promote mental health in young children; and efforts to form effective working relationships with the families of young children who are served.
- 2) Propose a set of workforce development recommendations that include core knowledge and core competencies that are culturally and linguistically responsive and intentionally work toward alleviating race and class inequities.
  - a. Work with the Public Awareness and Program Access Workgroups to identify the core language, concepts, and elements that need to be included in all workforce development training.
  - b. Develop cross-system agreements on core elements of training.
  - c. Provide professional development opportunities for mid-career and advanced-career professionals.

- 3) Make recommendations for access for professionals and staff in all relevant systems to needed early childhood mental health training opportunities, making certain that the process of developing the recommendations includes an investigation of the value and feasibility of establishing an Early Childhood Mental Health Training Institute.
- 4) Review the systems of support for staff working with trauma-exposed and other children and families with significant stressors in their lives and make recommendations to bolster the system of support if needed.

## **Long-Term Objectives and Action Steps: 2 years+**

- 1) Implement the core knowledge and core competencies curriculum within two years. Specifically, reach agreement that all training entities incorporate early childhood mental health approaches and perspectives into all trainings within two years.
- 2) Complete core training of all target audiences within five years.
- 3) Increase access to reflective supervision for members of the early childhood workforce.
  - a. Identify training opportunities for reflective supervision.
  - b. Define and provide incentives for supervisors to receive training on reflective supervision and to implement this practice in agencies.
  - c. Partner with funding agencies, especially fee-for-service programs and models, to support the use of reflective supervision in community-based and other agencies that serve children and families.
  - d. Ensure that training for reflective supervision accounts for different roles – home visitors, clinicians, early childhood teachers, caregivers, and other providers.
- 4) Connect to other tables and entities focused on workforce development and social-emotional health.
- 5) Ensure that the workforce has access to updated research and information and peer to peer networks.

**Outcome 2.2** – *Illinois has a robust early childhood mental health workforce of consultants, which expands and builds on current initiatives.*

## **Short-Term Objectives and Action Steps: By December 31, 2016**

- 1) Fund an entity/organization to build a robust, cross-system early childhood mental health consultation network that will deliver high-quality, evidence informed services and be supported by training and reflective supervision.
- 2) Identify a cross-sector group that will advise the work of the entity and its efforts.
  - a. Define a research-informed model relevant to cultural and community needs in Illinois.
  - b. Define core competencies and training focused on the research-informed model for mental health consultants.
  - c. Promote mental health consultation as a cost-effective model and include it in the social marketing plan for early childhood mental health that will be developed under this Action Plan.

## **Medium-Term Objectives and Action Steps: By December 31, 2017**

- 1) Collaborate with partners to identify cross-system funding, using the fiscal mapping to be carried out under this Action Plan as a resource for the partners.
- 2) Coordinate professional development planning and opportunities linked to core competencies.
- 3) Coordinate the provision of statewide, accessible reflective supervision.
  - a. Use technology to establish reflective practice groups across systems and the state.
- 4) Determine best practice recommendations to best mentor, recruit and retain culturally and linguistically diverse candidates and professionals of color (i.e., use cohort models or provide other incentives).





### **Long-Term Objectives and Action Steps: 2 years+**

- 1) Determine the role of certification and/or credentialing in the expansion of a cadre of mental health consultants.
- 2) Establish mental health consultation as a component of every early childhood program within two years.
- 3) Advocate at the state and federal levels for dedicated funds for mental health consultation.
- 4) Examine how CCDBG language/guidance on social-emotional development can inform how Illinois improves pre-service education.

**Outcome 2.3** - *Social and emotional development, trauma, toxic stress, and relationship-based approaches are embedded in pre-service education, beginning with community college programs and continuing through graduate programs.*

### **Short-Term Objectives and Action Steps: By December 31, 2016**

- 1) Review comparative analysis done by ZERO TO THREE/Erikson Institute on early childhood mental health competencies to compare across levels of service delivery and other systems of competencies.
- 2) Review early scan done by Erikson Institute on mental health training programs to learn how institutions of higher education provide training on early childhood mental health.
- 3) Use the core knowledge and core competencies that will be defined as part of the planning process to complete an assessment of pre-service education practices.

### **Medium-Term Objectives and Action Items: By December 31, 2017**

- 1) Determine what recommendations need to be made to ensure that social and emotional development, trauma, toxic stress, and relationship-based approaches are part of higher education and pre-service programs.
- 2) Examine principal training programs as a model for pre-service training.

### **Long-Term Objectives and Action Steps: 2 years+**

- 1) Establish relationships with institutions of higher education to encourage and work with them to embed early childhood mental health components into classroom curricula. Create circles of discussion with institutions of higher education – for example, Adler University, Loyola University, and the University of Illinois Urbana-Champaign School of Social Work.
- 2) Target social work programs in efforts to embed early childhood mental health topics into curricula, stressing that many social workers gravitate to working with young children and would benefit from studying these topics.
- 3) Encourage leaders and staff in institutions of higher education to arrange and sponsor occasional guest lectures on early childhood mental health. Suggest *Ghosts in the Nursery* as a pivotal reading assignment to transform students' thinking about early childhood mental health.
- 4) Partner with institutions of higher education to encourage the inclusion of

presentations focused on early childhood at conferences held at these institutions, or submit presentations on early childhood to such conferences.

- 5) Discuss how institutions can sponsor an adequate supply of both internships focused on early childhood mental health and supervision for these internships with a particular emphasis on providing internships to persons of color and providing bilingual supervision (to reflect on culturally and linguistically responsive practices).

**Outcome 2.4** - *Advocacy organizations and advocacy tables work to ensure that the Illinois early childhood workforce is well equipped to provide comprehensive and effective mental health promotion, prevention/intervention, and treatment services to help address the mental health needs of young children.*

### Short-Term Objectives and Action Steps: By December 31, 2016

- 1) Work to develop an advocacy plan that integrates mental health services and supports into maternal child health and early learning policies and strategies to ensure that these services are part of a broader advocacy agenda.
- 2) Partner with committees established through the Action Plan to align policy and advocacy efforts.
- 3) Collaborate with early childhood mental health advocates at the Ounce of Prevention Fund, Illinois Action for Children, Voices for Illinois Children, Latino Policy Forum, other Quality Alliance advocates, and ICMHP's Advocacy workgroup to ensure that the advocacy efforts recommended by the Workforce Development Committee are aligned with other efforts.

### Medium-Term Objectives and Action Steps: By December 31, 2017

- 1) Develop talking points for the early childhood mental health advocacy agenda including projected cost savings from intervening early.

### Long-Term Objectives and Action Steps: 2+ years

- 1) Ensure that all early childhood mental health advocacy and public policy efforts continue to be aligned.

Workforce Development Action Steps To Be Completed by December 31, 2016	Responsible Entities/Organizations
Establish a cross-system approach to organizing all early childhood mental health workforce development programs, including trauma-informed practice, to allow for alignment among systems.	<i>Illinois Children's Mental Health Partnership, Illinois Association of Infant Mental Health, Erikson Institute and ICTC</i>
Collect data on service professionals currently working in the early childhood mental health field (for example, consultants, therapists, and Early Intervention professionals) including the number of professionals, information on education background and experience, certifications, cultural and ethnic and racial background, second language proficiency, service area, and other relevant information.	<i>Illinois Children's Mental Health Partnership, Ounce of Prevention Fund</i>
Fund an entity/organization to build a robust, cross-system early childhood mental health consultation network that will deliver high-quality, evidence informed services and be supported by training and reflective supervision.	<i>Illinois Children's Mental Health Partnership, Irving Harris Foundation and other philanthropic, public and nonprofit partners</i>

## Goal Three: Funding and Finance

**Investments and policies for early childhood mental health efforts are carried out within the framework of equitable promotion, prevention/intervention, and treatment; are embedded in the Illinois comprehensive early childhood system; are designed to meet the needs of children and their families with a focus on the most vulnerable; and are organized to demonstrate accountability.**

# Illinois Action Plan • Goal #3

**Outcome 3.1-** *Sufficient funding and programming sustains effective, high-quality early childhood mental health, promotion, prevention/intervention, and treatment services and supports for young children and their families in their communities.*

## **Short-Term Objectives and Action Steps: By December 31, 2016**

- 1) Identify public and private funding to create a fiscal map of current public investments in early childhood mental health promotion, prevention/intervention, and treatment services and supports to determine how to more effectively allocate resources. The map would identify current state, federal, and county investments, show gaps and duplications in services, and help the state determine how to align and coordinate resources more effectively.
  - a. Explore fiscal mapping work with state funders and private funders to define the process, explore potential funding sources for the project, and begin the fiscal mapping process.
  - b. Collect data on gaps in services and inequities in resource allocation as well as funding limitations that may reflect the gaps in service.
- 2) Secure public and private resources for a public/private partnership to support a new position for an Illinois Early Childhood Mental Health Director within the GOECD or a similar position in another state agency as identified by state leaders and establish a plan for long-term cross-sector public funding for this position from multiple programs/agencies.
  - a. Examine how other states have put a similar position and funding structure in place.
  - b. Examine how to expand the supply of Medicaid providers who offer early childhood mental health promotion, prevention/intervention, and treatment services and supports. Work with the new administration to ensure Medicaid coverage expands to include reimbursement for prevention and intervention services such as mental health consultation, services that include parents and other adult caregivers as well as children, and home visiting.
  - c. Work with the Department of Healthcare and Family Services to implement changes that were previously made in the Public Aid Code that allow Licensed Clinical Social Workers (LCSWs) to bill Medicaid for the provision of services.
- 3) Identify funding to support strengthening the mental health consultation network across the state.
  - a. Examine how certification could be tied to Medicaid reimbursement.
  - b. Explore the use of a public/private partnership to fund an entity/organization to build the state's capacity to sustain and expand its cadre of mental health consultants.
  - c. Examine pooled resources across state and city agencies and offices (DHS, DHS-DMH, DCFS, GOECD, IDPH, ISBE, HFS, DFSS, CDPH, Head Start, Early Head Start, and others) and federal agencies (HHS, SAMHSA,



and others) for workforce development and expanded services (for example, funding being provided for ILAIMH Bachelor's level credential, which is now in development), and explore procurement and contracting processes to identify barriers to pooling resources in order to achieve goals shared by different agencies. Pilot the creation of a joint agreement and procurement process to align resources.

- d. Review how child-serving organizations have blended public and private funds to provide mental health services and supports (for example, Christopher House, Erie House, Skip-A-Long and Educare).
  - e. Review the Louisiana and Nebraska models under which Magellan Healthcare Systems is funding infant mental health training. Engage the Department of Healthcare and Family Services to pursue the possibility of expanding the investment made in building capacity for services, supports, and systems focused on early childhood mental health in Illinois.
- 4) Examine the potential for funding under private insurance and managed care.
    - a. Determine coverage possibilities for mental health services under the Affordable Care Act.
    - b. Investigate whether there is any cost/benefit analysis on early childhood mental health services and support that can help make the case that these services lead to cost savings realized through better outcomes.

## **Medium-Term Objectives and Action Steps: By December 31, 2017**

- 1) Complete the fiscal mapping process and a strategy for communicating what is learned.
  - a. Examine the possibility of using existing cross-sector groups, possibly with some expansion of a group (for example, the Inter-Agency team with some additional members added), to oversee the fiscal mapping process and to identify current state, federal, and county investments in promotion, prevention/intervention, and treatment services and supports at the state and local levels (for example, 708 Mental Health Board and local tax).
  - b. Create strategies for communicating the results of the mapping process.
- 2) Identify and consult with other states that have increased and expanded public sector funding for early childhood mental health promotion, prevention/intervention, and treatment services and supports, particularly: funding from Medicaid, other insurance plans, public-private partnerships, the Mental Health Block Grant, and Title V.
- 3) Review federal funding opportunities to support mental health supports and services.

## **Long-Term Objectives and Action Steps: 2 years+**

- 1) Communicate to the public at large, political leaders, policymakers, and other relevant audiences what has been learned about early childhood mental health funding using the fiscal map.
  - a. Link this communication effort to public education efforts focused on early childhood mental health that are already underway.
  - b. Identify key champions to promote the use of fiscal mapping data, make the case for recognizing unmet needs and inequities in resource allocation revealed by the data, and emphasize the cost-effectiveness of promotion, and prevention/intervention and treatment services and supports for young children and their families.
  - c. Gather state advocates to identify the advocacy strategy needed to communicate what actions should be taken that would be informed by the results of the mapping process – for example, improved use of existing resources, improved alignment and/or pooling of resources, and identification of additional resources.
- 2) Make the case that all insurance benefit plans should cover mental health promotion, prevention/intervention, and treatment services.
- 3) Reform the procurement and contracting process to allow for the use of pooled resources across agencies to realize shared goals set forth in this Action Plan.

## Illinois Action Plan • Goal #3

- 4) Embed funds for promotion, prevention/intervention, and treatment services and supports into programming funds.
- 5) Identify a compensation strategy to support the development and sustainability of a high-quality workforce.
- 6) Measure progress toward identified outcomes to understand the impact of investments.
- 7) Establish a process for data development and tracking. Create data-sharing agreements across state and city agencies and offices (DHS, DHS-DMH, DCFS, GOECD, IDPH, ISBE, HFS, DFSS, CDPH and others).

**Outcome 3.2** - *Sufficient funding and programming sustains effective, high-quality early childhood policies of state agencies (for example, IDEA Part C and 619, and EPSDT) that facilitate both the provision of early childhood mental health promotion, prevention/intervention, and treatment services and supports to young children and their families and their integration into other child- and family-serving systems.*

### **Short-Term Objectives and Action Steps: By December 31, 2016**

- 1) Identify existing state agency policies related to the provision and integration of early childhood mental health promotion, prevention/intervention, and treatment services and supports.

### **Medium-Term Objectives and Action Steps: By December 31, 2017**

- 1) Strengthen current state agency policies related to the provision and integration of early childhood mental health promotion, prevention/intervention, and treatment services and supports.
- 2) In conjunction with the workforce development efforts outlined in this Action Plan, ensure that sufficient funding and policies are in place to meet the mental health training and professional development needs of the early childhood workforce.

### **Long-Term Objectives and Action Steps: 2 years+**

- 1) Develop state agency policies related to the provision and integration of early childhood mental health promotion, intervention/prevention, and treatment services and supports.

Funding and Finance Action Steps To Be Completed by December 31, 2016	Responsible Entities/ Organizations
Secure public and private resources to support a new position for an Illinois Early Childhood Mental Health Director within the GOECD, or a similar position in another state agency as identified by state leaders, and establish a plan for long-term cross-sector public funding for this position from multiple programs/agencies.	<i>Irving Harris Foundation and other philanthropic partners, GOECD, DHS, ISBE, DHS-DMH, IDPH, DCFS and other state agencies</i>
Identify public and private funding to create a fiscal map of current public investments in early childhood mental health promotion, prevention/intervention, and treatment services and supports to determine how to more effectively allocate resources; and begin the fiscal mapping process.	<i>Irving Harris Foundation and other philanthropic partners, GOECD, DHS, ISBE, DHS-DMH, IDPH, DCFS and other state agencies</i>

## Goal Four: Public Awareness and Education

**The people of Illinois have a shared understanding of what early childhood mental health consists of and support the healthy social-emotional development of young children and families.**

**Outcome 4.1** - *The general public has increased awareness and understanding of what constitutes healthy social-emotional development, why it matters, and how a promotion, prevention/intervention, and treatment framework is necessary for children to achieve healthy social-emotional development, school readiness, and success in life.*

### Short-Term Objectives and Action Steps: By December 31, 2016

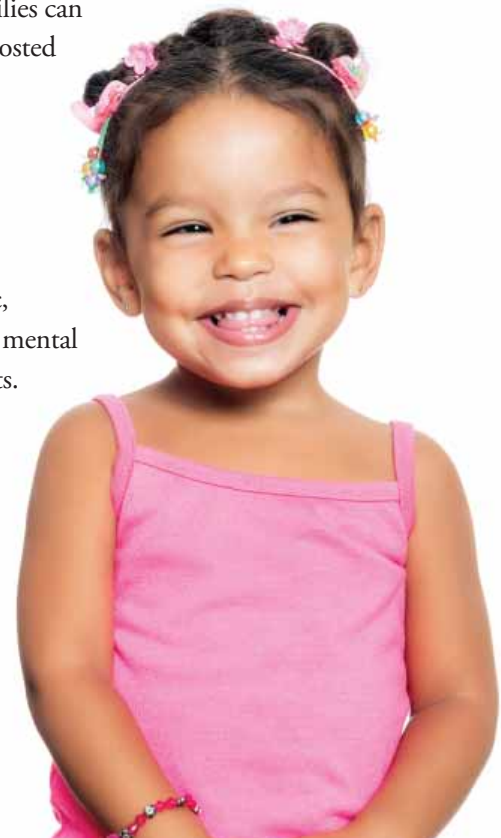
- 1) Identify and secure funding for a social marketing firm to develop the core and related messages to help the public reach this common understanding, ensuring that efforts to increase awareness include strategies to reach diverse communities and engage them in message development. Secure resources needed for dissemination of the message via strategies like bulk printing of materials.
- 2) Develop a social marketing plan that is culturally and linguistically responsive and includes a unifying message.
- 3) Once the ELC Committee on Early Childhood Mental Health is created (as proposed in Outcome 5.1, Short Term Objective 3), establish a public awareness workgroup to inform the development of the social marketing plan.
  - a. Identify current public awareness work already underway in Illinois to determine how to best align existing messages and/or to incorporate the new messages into other messages and to connect these efforts to local efforts to strengthen community systems.
  - b. Identify target audiences as well as key messengers and talking points.
  - c. Consider levels of awareness of different audiences in developing messages and materials and use the research from the Frameworks Institute as a foundation for messages that resonate with the public. (For more information on the research from the Frameworks Institute, go to: <http://www.frameworksinstitute.org/toolkits/cmh/>).
  - d. Use a variety of resource materials, including brochures, fact sheets, and posters, that can be tailored to different audiences and that both speakers/key messengers and families can place in a variety of locations where families regularly gather and that can be posted on social media.

### Medium-Term Objectives and Action Steps: By December 31, 2017

- 1) Implement the social marketing plan, by:
  - a. Establishing agreements among public and private partners to incorporate messaging and materials into all their programs.
  - b. Establishing a Speaker's Bureau with responsibility for regular speeches to civic, parent, and professional groups on the importance of access to early childhood mental health promotion, prevention/intervention, and treatment services and supports.

### Long-Term Objectives and Action Steps: 2 years +

- 1) Secure agreement of public and private partners to merge or link existing early childhood/family support help lines (and the resources that fund them) into an easily accessible phone number, website, and/or database that parents can seek out to obtain advice on a range of issues related to young children.
  - a. Coordinate with other state efforts to develop and implement a single website and help line for parents to learn about child development broadly, and social and emotional development, in particular, with the information building on and taking into account current initiatives and work already being done.



# Illinois Action Plan • Goal #4

- b. Ensure that the website offers information and resources on how to promote social-emotional health, with the information covering milestones of healthy social-emotional development.
- c. Share simple information about how to find help or further assistance when a child's social-emotional development is suspected to be off track. Provide a list of entities/organizations/programs to contact for assistance.
- d. Make certain that key messages and resources in the website link with Outcome 4.1 of the Action Plan.
- 2) Identify resources for developing the website and an organization to host it.
- 3) Create a marketing campaign to expand the audience for the messages conveyed on the website and through other related outlets to encompass not only parents but the general public, the business sector, and non-traditional groups.
  - a. Create a self-assessment of strengths and deficits of organizations regarding how and where they may be promoting healthy social-emotional development.
- 4) Analyze the success of the marketing campaign and establish a continuous quality improvement approach to improving it, using relevant data and follow-up for communications with targeted outreach.

Public Awareness and Education Action Steps To Be Completed by December 31, 2016	Responsible Entities/Organizations
Identify and secure funding for a social marketing firm to develop the core and related messages to help the public reach a common understanding of healthy social-emotional development.	<i>Illinois Children's Mental Health Partnership, Illinois Childhood Trauma Coalition, Irving Harris Foundation</i>
Create a public awareness workgroup that includes parents to inform the development of the social marketing plan.	<i>Illinois Childhood Trauma Coalition, ICMHP and parent and advocacy groups</i>

## Goal Five: System Governance and Implementation

**An accountable structure for governance and an approach that generates dedicated leadership are established to oversee the effective implementation of the Action Plan.**

**Outcome 5.1** - *A state government leadership position (such as Early Childhood Mental Health Director) is established in the GOECD, or another state agency as identified by state leaders, and the leader collaborates and coordinates with state agency leaders in the different child- and family- serving systems in Illinois -- the health system (primary care and public health), the early learning and care system, the mental health system, the Early Intervention system, the special education system, the child welfare system, the family support system, and others -- to lead the implementation of the Action Plan with guidance and input from a new cross-sector committee of the ELC.*

### Short-Term Objectives and Action Steps: By December 31, 2016

- 1) Obtain approval/endorsement/implementation authority for the Action Plan.
  - a. Submit the Action Plan to the Governor for approval/endorsement/implementation.
  - b. Submit the Action Plan to the ELC executive committee for approval/endorsement/implementation and determine the ELC point person responsible for leading the new cross-sector ELC committee.
  - c. Submit the Action Plan to ICMHP for approval, endorsement, implementation, and determination of the ICMHP point person.
- 2) Secure buy-in for establishing the position of Illinois Early Childhood Mental Health Director within the GOECD or a similar position in another state agency as identified by state leaders.
  - a. Examine how other states have put a similar position in place and potential funding structures for the position.
  - b. Secure private and public resources to support the new position.

- 3) Create the ELC Committee on Early Childhood Mental Health that includes ELC members, other state and city agencies and offices (DHS, DHS-DMH, DCFS, GOECD, IDPH, ISBE, HFS, DFSS, CDPH, and others), and other early childhood mental health and trauma experts, including the Illinois Children's Mental Health Partnership, the Illinois Childhood Trauma Coalition, service providers, advocates, parents, and philanthropic partners to manage and make decisions about the work outlined in the Action Plan and to direct the work of the state government early childhood mental health position.

## **Medium-Term Objectives and Action Steps: By December 31, 2017**

- 1) Establish the position of Illinois Early Childhood Mental Health Director within the GOECD, or a similar position in another state agency as identified by state leaders, to work closely with the Partnership and the ELC to coordinate implementation of the Action Plan and to serve as a member of the Partnership, the ELC executive committee, and the inter-agency team.
  - a. Determine a plan for long-term cross-sector public funding of the new position from multiple programs/agencies (including DHS and HFS) beyond the initial funding stage.
  - b. Conduct a search process to fill the position.

## **Long-Term Objectives and Action Steps: 2 years+**

- 1) Measure and report on progress made in implementing the Action Plan priorities.
  - a. Establish how progress will be tracked, and identify any data, that will be collected, tracked, and analyzed to help measure progress, noting and addressing where there may be inequities in outcomes and access.
  - b. Determine appropriate methods for reporting on progress.

**Outcome 5.2** - *The implementation of the Action Plan remains a priority in Illinois and the importance of integrating early childhood mental health services and supports is recognized by the state's different child- and family-serving systems.*

## **Short-Term Objectives and Action Steps: By December 31, 2016**

- 1) Create buy-in from state and city agencies and offices (DHS, DHS-DMH, DCFS, GOECD, IDPH, ISBE, HFS, DFSS, CDPH, and others) to work toward more effective integration of priorities identified through the Action Plan into existing programs.
  - a. Develop an Infant Mental Health 101 presentation/training for state and city agency leaders that demonstrates the importance of early childhood mental health. (Partner with the Workforce Development Committee.
  - b. Establish point persons within each agency who will focus on early childhood mental health and who will have management authority.



# Illinois Action Plan • Goal #5

- c. Create any needed inter-agency agreements between key agencies and offices serving young children and families to support integration. Work toward joint funding for infrastructure, training, and services.

## Medium-Term Objectives and Action Steps: By December 31, 2017

- 1) Create and advocate for an early childhood mental health policy agenda for the 2016-2018 legislative sessions.
  - a. Pull together state advocacy organizations, ILAIMH, ICMHP, infant mental health leaders and practitioners and others for discussion and for making commitments to a shared agenda.
  - b. Determine priorities for the early childhood mental health policy agenda.
- 2) Work through local and regional community systems-building entities to prioritize the integration of early childhood mental health services into all aspects of local early childhood systems.

**Outcome 5.3** - *Parents of young children with social-emotional concerns have a defined and supported role in the governance and implementation of the Action Plan.*

## Short-Term Objectives and Action Steps: By December 31, 2016

- 1) Secure participation of at least two parents on the ELC Committee on Early Childhood Mental Health to be engaged in the governance and implementation of the Action Plan.
  - a. Conduct outreach to parent groups to discuss how to structure parent representation on the Committee. Also use this opportunity to offer parents information on the Action Plan process.
  - b. Identify appropriate financial and professional-development support to ensure effective and equitable parent participation.

## Medium-Term Objectives and Action Steps: By December 31, 2017

- 1) Determine how parents want to be involved in the governance and implementation of the Action Plan.
  - a. Continue to reach out to parent groups in various communities.
  - b. Conduct a series of focus groups in English, Spanish and other languages to get parent input on the Action Plan and its progress.
  - c. Use this input in determining how to support parent engagement.
  - d. Identify appropriate financial- and professional-development support to ensure effective and equitable parent participation.

System Governance and Implementation Action Steps To Be Completed by December 31, 2016	Responsible Entities/Organizations
Submit the Action Plan to the Governor for approval/endorsement/implementation authority.	<i>Irving Harris Foundation, Illinois Children's Mental Health Partnership, and GOECD</i>
Secure buy-in for and establish the position of Illinois Early Childhood Mental Health Director within the GOECD or a similar position in another state agency as identified by state leaders.	<i>Irving Harris Foundation, state agency or office leads from GOECD, DHS, ISBE, DHS-DMH, IDPH, DCFS and other state agencies</i>
Create the ELC Committee on Early Childhood Mental Health that includes ELC members, other state and city agencies and offices (DHS, DHS-DMH, DCFS, GOECD, IDPH, ISBE, HFS, DFSS, CDPH, and others), and other early childhood mental health and trauma experts, including the Illinois Children's Mental Health Partnership, the Illinois Childhood Trauma Coalition, service providers, advocates, parents, and philanthropic partners to manage and make decisions about the work outlined in the Action Plan and to guide the work of the state government early childhood mental health position.	<i>Early Learning Council</i>



## Conclusion and Next Steps

The development of the Action Plan brought together stakeholders from the local and state levels of government and from many different child- and family-serving systems. Successfully implementing the details of the Action Plan will take continued work on the part of these different systems and stakeholders. It will also take the creation of new and unprecedented partnerships. But these new investments have the potential to realize enormously important returns for Illinois. Implementing the Action Plan will forge connections between different systems in Illinois, all of which are dedicated to a common state vision of how to best promote the well-being of children and families. Ultimately, it will strengthen not only the early childhood mental health system but the entire early childhood system.

Throughout the process of developing the Action Plan, many different stakeholders expressed their views about why it is in the best interest of institutions concerned with children and families in Illinois, parents, and others to come together to implement the Action Plan. Reflecting the strength of conviction of many of the planners about the need for new action, the words of a key stakeholder in the early care and education system offer one insightful observation about why the Action Plan matters:

*In today's society, young children are exposed to so much more than they were years ago. Their families are fragmented and are exposed to early trauma and violence. The environment they are raised in is so different and it is displayed in their social-emotional development. It is crucial to find ways to detect mental health difficulties early and refer children to the appropriate supports and interventions as early as possible -- for the well-being of the child and because the delay in interventions makes the child less successful later. I cannot be successful in furthering my own agency goals to build a high-quality early care and education system with good outcomes for children unless I can assure access to needed mental health supports for the children we are serving in our programs. - Excerpted from a Stakeholder Interview*

# Appendix

## Glossary of Acronyms

<b>CDPH</b> .....	Chicago Department of Public Health
<b>CMH</b> .....	Children’s Mental Health
<b>DHS</b> .....	Illinois Department of Human Services
<b>DHS-DMH</b> .....	Illinois Department of Human Services, Division of Mental Health
<b>DCFS</b> .....	Illinois Department of Children and Family Services
<b>DFSS</b> .....	Chicago Department of Family and Support Services
<b>ELC</b> .....	Illinois Early Learning Council
<b>GOECD</b> .....	Governor’s Office of Early Childhood Development
<b>HFS</b> .....	Illinois Department of Healthcare and Family Services
<b>HHS</b> .....	US Department of Health and Human Services
<b>IDEA</b> .....	Individuals with Disabilities Education Act
<b>ICMHP</b> .....	Illinois Children’s Mental Health Partnership
<b>IDPH</b> .....	Illinois Department of Public Health
<b>ILAIMH</b> .....	Illinois Association for Infant Mental Health
<b>ICTC</b> .....	Illinois Childhood Trauma Coalition
<b>ISBE</b> .....	Illinois State Board of Education
<b>LCSW</b> .....	Licensed Clinical Social Worker
<b>NAEYC</b> .....	National Association for the Education of Young Children
<b>SAMHSA</b> .....	Substance Abuse and Mental Health Services Administration



# Planning Group Members, Stakeholder Meeting Participants and Key Informants\*

## Planning Group Members

**Karen Berman**, *Assistant Director*, Illinois Policy, Ounce of Prevention Fund

**Denise Castillo Dell Isola**, *Program Officer*, Irving Harris Foundation

**Karen Freel**, *Co-Chair*, Early Childhood Committee, Illinois Children's Mental Health Partnership

**Gaylord Gieseke**, *President*, Voices for Illinois Children and Co-Chair, Early Childhood Committee, Illinois Children's Mental Health Partnership

**Phyllis Glink**, *Executive Director*, Irving Harris Foundation

**Theresa Hawley**, *Executive Director*, Governor's Office of Early Childhood Development

**Allison Lowe-Fotos**, *Policy Specialist*, Ounce of Prevention Fund

**Colette Lueck**, *Managing Director*, Illinois Children's Mental Health Partnership

**Kandace Thomas**, *Senior Program Officer*, Irving Harris Foundation

## Persons who participated in the development of the Action Plan through their contributions at the October and November 2014 stakeholder meetings:

**Heather Higgins Alderman**, *President*, Illinois Children's Healthcare Foundation

**Karen Berman**, *Assistant Director*, Illinois Policy, Ounce of Prevention Fund

**Anita Berry**, *Director*, Healthy Steps for Young Children, Advocate Children's Hospital

**Lisa Betz**, *Associate Deputy Clinical Director*, Child & Adolescent Services, Division of Mental Health, Illinois Department of Human Services

**Juanona Brewster**, *Director*, Early Childhood Projects, Illinois Chapter, American Academy of Pediatrics

**Ted Burke**, *Director*, Early Intervention Training Program at the University of Illinois

**Glendean Burton**, *Acting Associate Director* - Family Wellness; Chief, Bureau Maternal & Infant Health, Illinois Department of Human Services

**Jeanna Capito**, *Consultant*

**Deborah Chalmers**, *Director of Consultation Programs*, Illinois Action for Children

**Lindsay Cochrane**, *Program Officer*, Education, McCormick Foundation

**Shawn Cole**, *Manager*, Illinois Department of Healthcare and Family Services

**Sharon Coleman**, *Associate Director for Forensic Sciences*, Division of Mental Health, Illinois Department of Human Services

**Paula Corrigan Halpern**, *Vice President of Public Policy and Strategic Initiatives*, Children's Home + Aid

**Joni Crounse**, *Director*, Virginia Frank Child Development Center

**Linda Delimata**, *Consultation Coordinator*, Illinois Children's Mental Health Partnership

**Denise Castillo Dell Isola**, *Program Officer*, Irving Harris Foundation

**Elizabeth Dierksheide**, *Special Assistant to the Executive Director*, Chapin Hall at the University of Chicago

**Shannon Ellison**, *Developmental Screening Coordinator*, Collaboration for Early Childhood-Oak Park

**Nancy Fishman**, *Executive Director*, Grand Victoria Foundation

**Karen Freel**, *Co-Chair*, Early Childhood Committee, Illinois Children's Mental Health Partnership

**Gaylord Gieseke**, *President*, Voices for Illinois Children

**Phyllis Glink**, *Executive Director*, Irving Harris Foundation

**Andria Goss**, *Program Director*, Early Childhood Project, Illinois Department of Children and Family Services

**Chelsea Guillen**, *Early Intervention Ombudsman*, Early Intervention Training Program at the University of Illinois

**Theresa Hawley**, *Executive Director*, Governor's Office of Early Childhood Development

\*Titles/organizations listed are as of the October and November 2014 stakeholder meetings.

# Planning Group Members, Stakeholder Meeting Participants and Key Informants\*

**Kristine Herman**, *Associate Deputy Director*, Medicaid Behavioral Health and Care Coordination

**Reyna Hernandez**, *Assistant Superintendent*, Illinois State Board of Education

**Jake Jacob**, *Mental Health Consultant*, Illinois Children's Mental Health Partnership

**Madelyn James**, *Director*, Birth to Eight, Voices for Illinois Children

**Teresa Kelly**, *Project Director*, Strong Foundations Partnership, Governor's Office of Early Childhood Development

**Jon Korfmacher**, *Associate Professor*, Erikson Institute

**Allison Lowe-Fotos**, *Policy Specialist*, Ounce of Prevention Fund

**Colette Lueck**, *Managing Director*, Illinois Children's Mental Health Partnership

**Sarah Martinez**, *President*, Illinois Association for Infant Mental Health

**Janet Maruna**, *Executive Director*, Illinois Network of Child Care Resource & Referral Agencies

**Elizabeth Mascitti-Miller**, *Early Childhood Chief Officer*, Chicago Public Schools Office of Early Childhood Education

**Deb McCarrel**, *Illinois Department of Healthcare and Family Services*

**Marcy Mendenhall**, *President and Chief Executive Officer*, Skip-a-Long Child Development Services

**Nacole Milbrook**, *Vice President*, Youth Counseling and Development Services, UCAN

**Geoff Nagle**, *President and Chief Executive Officer*, Erikson Institute

**Carolyn Newberry Schwartz**, *Executive Director*, Collaboration for Early Childhood

**Christine Nicpon**, *Birth to Three Policy Coordinator*, Latino Policy Forum

**Edith Njguna**, *Senior Program Officer*, Grand Victoria Foundation

**Gail Nourse**, *Director*, Illinois Policy, Ounce of Prevention Fund

**Sessy Nyman**, *Vice President*, Policy and Strategic Partnerships, Illinois Action for Children

**Andrea Palmer**, *Division Chief*, Maternal, Child & Family Health Services Division, Illinois Department of Public Health

**Anna Potere**, *Policy Specialist*, Illinois Policy Team, Ounce of Prevention Fund

**Mary Pounder**, *Program Officer*, Comer Family Foundation

**Vanessa Rich**, *Deputy Commissioner and Director of Head Start*, City of Chicago, Department of Family and Support Services

**Christine Robinson**, *Director*, Public Policy & Advocacy, Illinois Action for Children

**John Roope**, *Director*, Early Childhood Mental Health Consultation Program, Caregiver Connections

**Phyllis Russel**, *Executive Director*, Association of Community Mental Health Authorities of Illinois

**Michelle Saddler**, *Secretary*, Illinois Department of Human Services

**Linda Saterfield**, *Associate Director*, Division of Family and Community Services, Illinois Department of Human Services

**Delreen Schmidt**, *Mental Health Consultant*, Illinois Children's Mental Health Partnership

**Jeff Schoenberg**, *Advisor*, The J.B. & M.K. Pritzker Family Foundation

**Diane Scruggs**, *Healthy Families Chicago*

**Christy Serrano**, *Program Officer*, McCormick Foundation

**Nancy Shier**, *Consultant*

**Sara Slaughter**, *Program Director - Education*, McCormick Foundation

**Julie Smith**, *Education Deputy Director*, Governor's Office, Co-Chair, Early Learning Council

**Anne Studzinski**, *Managing Director*, Illinois Childhood Trauma Coalition

**Cynthia Tate**, *Deputy Director*, Office of Child Well-Being, Department of Children and Family Services

**Kandace Thomas**, *Senior Program Officer*, Irving Harris Foundation

\*Titles/organizations listed are as of the October and November 2014 stakeholder meetings.

# Planning Group Members, Stakeholder Meeting Participants and Key Informants\*

**Carolyn Vessel**, *CEO/President*, I AM ABLE

**Nick Wechsler**, *Director*, Program Development, Ounce of Prevention Fund

**Maria Whelan**, *President*, Illinois Action for Children

**Lauren Wiley**, *Mental Health Consultant*, Illinois Children's Mental Health Partnership

**Jay Young**, *Director of Community Impact*, Children's Home + Aid

**Amy Zimmerman**, *Director*, Chicago Medical-Legal Partnership for Children, The Legal Council

**Cindy Zumwalt**, *Division Administrator*, Early Childhood, Illinois State Board of Education

## Key Informants

**Scott Allen**, *Executive Director*, Illinois Chapter of the American Academy of Pediatrics

**Lisa Betz**, *Associate Deputy Clinical Director*, Child and Adolescent Services, Division of Mental Health, Illinois Department of Human Services

**Juanona Brewster**, *Director Early Childhood Development*, Illinois Chapter of the American Academy of Pediatrics

**Jake Jacobs**, *Mental Health Consultant*, Illinois Children's Mental Health Partnership

**Brenda Jones**, *Deputy Director and Title V Director*, Office of Women's Health and Family Services, Illinois Department of Public Health

**Jon Korfmacher**, *Associate Professor*, Erikson Institute

**Andrea Palmer**, *Division Chief*, Maternal, Child and Family Health Services Division, Illinois Department of Public Health

**Sarah Martinez**, *President Elect*, Illinois Association of Infant Mental Health

**Nacole Milbrook**, *Vice-President*, Youth Counseling and Development Services, UCAN

**Carolyn Newberry Schwartz**, *Executive Director*, Collaboration for Early Childhood

**John Roope**, *Director of Early Childhood Mental Health Consultation Program – Caregiver Connections, & Director of Early Childhood Mental Health Services at Chaddock*

**Linda Saterfield**, *Associate Director*, Division of Family and Community Services, Illinois Department of Human Services

**Delreen Schmidt**, *Mental Health Consultant*, Illinois Children's Mental Health Partnership

**Nancy Shier**, *former Director of Illinois Policy*, Ounce of Prevention Fund

**Anne Studzinski**, *Managing Director*, Illinois Childhood Trauma Coalition

**Cynthia Tate**, *Deputy Director*, Office of Child Well-being, Department of Child and Family Services

**Joan White**, *Director*, First United Church Nursery School

**Lauren Wiley**, *Mental Health Consultant*, Illinois Children's Mental Health Partnership

**Penny Williams Welford**, *Professional Development Advisor and Certified Trainer* with Illinois Gateway Professional Development System

**Rachel Wood**, *Division Chief of Children's Services*, Oak-Leyden Developmental Services

**Cindy Zumwalt**, *Early Childhood Division Administrator*, Illinois State Board of Education

## Focus Group Coordination

**Virginia Frank Child Development Center**

**Skip-a-Long Child Development Services**

**Caregiver Connections**

\*Titles/organizations listed are as of the October and November 2014 stakeholder meetings.

# Illinois Early Childhood Mental Health Timeline

## .....1960s

Head Start – mental health component part of program performance standards.

## .....1992

Early Head Start – mental health component part of program performance standards.

## .....1998

Federal lawsuit, *Marie O. v. Edgar*, resulted in implementing the mandate of Part C of IDEA which provides for EI services for all eligible infants and toddlers under age 3.

## .....1999

Birth to Three Project forms statewide Social and Emotional Health Committee.

## .....2000

Safe from the Start; Chicago Safe Start (*0-5 year olds exposed to violence*).

## .....2002

IL Children's Mental Health Task Force created.

Erikson begins offering Infant Mental Health Certificate Program.

## .....2003

IL General Assembly passes Children's Mental Health Act. Governor signs act creating the IL Children's Mental Health Partnership with an Early Childhood Committee.

Early Learning Council created in statute by Illinois Legislature.

Fussy Baby program begins.

## .....2004

IL Department of Public Aid revises its Medicaid policy to reimburse for peri-natal depression screening during a prenatal, postpartum or infant well-child or episodic visit up to one year postpartum, based upon the mother's or the child's eligibility for Medicaid.

IL Department of Children and Family Services begins transformation of Department to become trauma informed.

Medicaid Lawsuit – EPSDT services in IL required to provide enhanced reimbursements. IL Children right to EPSDT services. Only pertained to physical health.

## .....2005

IL Department of Children and Family Services expands its Integrated Assessment Program statewide to assess social emotional issues for all 0-5 wards.

IL early childhood career lattice launched, with social emotional development as a required core competency for all staff working with young children from entry- to Masters-level.

HFS, ICAAP and Advocate Health Care begin training federally-qualified health centers, pediatric and family practice groups, and public health departments on use of developmentally appropriate

## 2005, continued

screens for social-emotional health in the primary care setting.

The Bureau of Early Intervention in the IL Department of Human Services expands the social emotional component and Social-Emotional Consultants to all 25 points of entry for Early Intervention statewide.

Resource Link launched which provides centralized resources for psychiatric care to pediatricians and other healthcare professionals in communities located in the central part of the state.

ASQ–SE screening tool implemented in Part C Early Intervention

## .....2006

Preschool for All legislation passed with funding for mental health consultation to PFA programs as well as for birth to three Prevention Initiative programs.

First Illinois early childhood mental health consultation project focused on community mental health centers.

Medicaid reimbursement established for developmental and social emotional screening.

Medicaid reimbursement established for developmental and social emotional screening.

Domestic Violence and Mental Health Policy Initiative launched its children exposed to violence training and curricula for domestic violence advocates and clinicians working with young children exposed to domestic violence.

## .....2007

Illinois Childhood Trauma Coalition, composed of public and private organizations, begins the work of promoting the prevention and treatment of childhood trauma.

Perinatal Mental Health Disorders Prevention and Treatment Act passed which calls for development of procedures for maternal depression screening in the first year of an infant's life by health care professionals. Procedures went into Rules in 2014.

ACEs (Adverse Childhood Experiences) work in Illinois.

2007-2010 – ISBE contracted with the Erikson Institute on the Infant and Early Childhood Mental Health Consultation Project to provide a statewide system of mental health consultation for programs serving children ages 0-5.

## .....2008

Caregiver Connections (mental health consultation to child care programs) expands state-wide.

DocAssist Primary Care Consultation Line launches providing mental health consultation to primary care providers who treat children.

AAP Policy on screening in the first 3 years.

2008-2011 – DHS funded a treatment demonstration project for young children served by seven community agencies around the state. HFS Enhanced Reimbursements for developmental screening by pediatricians and family care doctors.

## .....2009

Partnership launches Mental Health Consultation in home visiting programs.

Statewide Reflective Learning Groups begin.

The Irving Harris Foundation and Erikson Institute launch the ILChild-Parent Psychotherapy (CPP) Learning Collaborative that trains clinicians in evidence based mental health model for young children.

Illinois Governor's Office of Early Childhood Development created.

Ability of licensed clinical social workers to bill for services added to Public Aid Code but not yet implemented by HFS. (2009-2010)

## .....2009-2014

Illinois receives SAMHSA federal grant for Project LAUNCH to promote mental health wellness for families with young children birth to age eight in East and West Garfield Park and North and South Lawndale.

## .....2010

Crosswalk from DC: 0-3R to DSMIV completed.

K-12 schools need to develop social/emotional plans and interventions under Response to Intervention.

Illinois Department of Mental Health introduces Devereux Early Childhood Assessment (DECA) for 0-5 year olds.

MIECHV Initiative using federal funds began in Illinois.

## .....2011

IL Children's Healthcare Foundation funds four communities to implement plans for the Children's Mental Health Initiative *Building Systems of Care, Community by Community*.

MIECHV competitive grant supports research projects for Fussy Baby and Doula.

I AM ABLE launched first early childhood trauma conference outside of downtown in North Lawndale.

Family Institute Preschool Behavioral Problems Training Clinic.

MIECHV introduced Illinois Benchmarks/Training for home visiting focused on mental health issues.

## .....2012

Revision of Medicaid Rule 132 to allow providers to bill for children birth to age three and billing for intervening early before diagnosis.

Partnership re-vitalized and revised infant and early childhood mental health consultation to communities with the Three Tier model that focuses on raising awareness, enhancing skills and building capacity in child serving programs across three geographic areas of the state.

Early Learning Standards for birth to three completed with roll-out beginning in 2013.

Illinois Early Learning Guidelines for birth to age three completed.

## 2012, continued

Social/Emotional Standards K-12

MIECHV formula grant included funding for mental health consultation in 6 communities

## .....2013

The IL Association for Infant Mental Health awarded the first group of mental health practitioners with an Early Childhood Mental Health Credential.

IL Department of Children and Family Services implements new program under Title IV-E Waiver that provides therapeutic services to children birth to age three and their caregivers (*including foster parents*).

Reflective Practice Guide completed by the Partnership.

Kindergarten Readiness Assessment includes attention to the social/emotional domain. Emphasizes the need to capture and push up the importance of social emotional functioning in school and overall success.

Early Intervention Bureau issues guidance to CFCs and Early Intervention providers that social/emotional evaluation can be done for initial eligibility as one of two evaluations without special permission. Also children may be found eligible for early intervention based solely on delay in the social/emotional domain.

Illinois Children's Healthcare Foundation funds two new system of care projects in Englewood and Logan Square. (*\$2 million each over five years*).

## .....2014

Project PROTECT launches that will create a virtual center to expand access to resources, to coordinate efforts among systems and to engage and work with families and communities exposed to trauma.

The Health sub-committee of the Early Learning Council's Systems Integration and Alignment Committee prioritizes recommendations for early care and education regarding several mental health areas: social-emotional screening, trauma, child abuse and neglect, and parental depression.

IL Childhood Trauma Coalition's multi-media campaign "Look through their Eyes" launched.

Children's Behavioral Health Reform efforts begin under the Governor's Office of Health Innovation and Transformation (GOHIT).

Erikson launches 1st cohort for MSW program – Only social work program focused solely on early childhood development.

Expanded Doc Assist to include peri-natal health and treatment consultation.

MIECHV formula grant included funding for Mothers and Babies curriculum including identification for maternal depression.

## .....2014/2015

Illinois State Board of Education proposes an amendment to the Early Childhood Block Grant Administrative Rules to include the Illinois Early Learning Guidelines.

Illinois Childhood Trauma Coalition adds a birth to five special focus to the "Look Through Their Eyes" public awareness campaign.

# Illinois Guiding Principles for Cultural and Linguistic Responsiveness

In Illinois we share a collective vision that each and every child will have early childhood experiences that promote healthy development and learning that respects, promotes, and builds on their cultural, racial, ethnic, and other family backgrounds and experiences.

## We believe:

- Every individual is rooted in culture.
- The cultural groups within communities and families are the primary sources for culturally relevant programming.
- Culturally relevant and diverse programming requires learning accurate information about the culture of different groups and discarding stereotypes.
- Addressing cultural relevance in making curriculum choices is a necessary, developmentally appropriate practice.
- Every individual has the right to maintain his or her own identity while acquiring the skills required to function in our diverse society.
- Effective programs for children who speak languages other than English require continued development of the first language while the acquisition of English is facilitated.
- Culturally relevant programming requires staff who both reflect and are responsive to the community and families served.
- Multicultural programming for children enables children to develop awareness of, respect for, and appreciation of individual cultural differences.
- Culturally relevant and diverse programming examines and challenges institutional and personal biases.
- Culturally relevant and diverse programming and practices are incorporated in all systems and services and are beneficial to all adults and children

## We are committed to:

- Early childhood professionals who understand that developing a child's first language supports the acquisition of a second language.
- Early childhood classrooms that embrace and include a rich range of diversity, allowing all to learn from it and enhancing all children's healthy development and learning.
- Teacher preparation programs that incorporate the individual and unique needs of each child and family and the experiences they bring to the classroom.
- Culturally responsive and diverse programming that incorporates all types of diversity, including but not limited to: gender, culture, language, ethnicity, ability, race and economic status.
- Policy implementation that reinforces families and communities as children's first teachers.
- Diverse state and local organizations and agencies that are meaningfully responsive to each and every child and family they serve.

## We will act to:

- Enable professionals to incorporate the authentic language and culture of the children and families they serve.
- Increase professional development opportunities and resources addressing all types of diversity, including understanding stereotypes and biases.
- Increase all types of diversity content in teacher preparation programs.
- Increase and enhance teacher preparation practicum experiences in diverse settings.
- Promote practices in classrooms and programs that incorporate and address the diverse needs of children.
- Use an "all types of diversity" lens whenever we develop and implement policy, staff our agencies & organizations and evaluate our programming, systems and services.

These guiding principles were developed by a group of Illinois public and private state leaders in 2014 with a commitment made to embed these principles in all new and existing policies. The work of this planning group was facilitated by the BUILD Initiative and led by:

Governor's Office of Early Childhood Development

Illinois State Board of Education

Illinois Department of Human Services, Bureau of Child Care and Development

Illinois Head Start State Collaboration Office

This section first discusses findings from interviews with key informants in Illinois, followed by findings from focus groups conducted with parents and with providers. The section then presents information from the survey conducted for this project and concludes with a summary of observations made in interviews with leaders in five other states. The interviews, focus groups and the survey were completed from July - September 2014. The final pages are the “Priorities for the Action Plan” as identified through the input from key informants.

## *Key Informants in Illinois*

One-hour interviews were conducted with 29 individuals representing groups and organizations across different systems that are deeply committed to and concerned about the health, safety, development and early learning of young children in Illinois. The goal of these interviews was to gain insight into how these leaders viewed the past accomplishments, best practices, issues, and priorities of the current system. Additionally, these interviews were designed to elicit the advice of cross-system leaders about how to set the vision for the Action Plan and how to identify key issues and make recommendations for what should be addressed.

### **What are some of the most important accomplishments to date?**

- Systems for the screening and identification of young children;
- Establishment of mental health consultation across programs;
- Foundation of accomplishment in social and emotional health and the development of a comprehensive early childhood system;
- Robust Inter-agency Team convened by the Governor’s Office of Early Childhood Development that is working collaboratively to strengthen the programs and projects that are under the direction of individual team members;
- The leadership and accomplishments of the Systems Integration and Alignment Committee, the Early Learning Council and the Illinois Children’s Mental Health Partnership; and
- Strong early childhood advocacy community and the long-term dedication and commitment of the philanthropic community to promoting strong services and supports for young children and their families.

### **Should early childhood mental health be a priority in developing a comprehensive early childhood system?**

All stakeholders who were interviewed ranked early childhood mental health as a medium-high to high priority. In the words of one interviewee from a state agency:

*In today’s society, young children are exposed to so much more than they were years ago. Their families are fragmented and are exposed to early trauma and violence. The environment they are raised in is so different and it is displayed in their social-emotional development. It is crucial to find ways to detect that early and refer them to the appropriate supports and interventions as soon as possible - for the well-being of the children and because the delay in interventions makes them less successful later. In teacher surveys, the biggest feedback is around the challenging behaviors in the classroom.*

### **What will success look like and how will we know the status quo is shifting?**

Direct service providers measured success by a shift in the time and opportunity service providers would have available to reflect on their work, learn from their successes and challenges, build their strengths and identify areas in which they wished to develop. Service providers also mentioned that para-professionals would be a part of these conversations. One interviewee said:

*The criteria to be an effective early childhood mental health professional may not just include formal education. All people that touch children are contributing to their mental health and wellness.*

## Findings from the System Scan

Program directors noted that in a successful system, reflective supervision would be valued and its unique qualities and effects would be better understood by a broader audience. These same individuals identified success as a shared mindset about how mental health consultation should be implemented – a mindset that would lead to more coherence and consistency in the consulting role across programs, or, in other words, the creation of a consistent model of consultation. The potential for the science of brain development to help create shared understandings that could unite the early childhood system's early learning and care sector with its social and emotional health sector was also noted.

State agency leaders talked about a future where children would not be getting “kicked out” of early childhood programs - a future where teachers would have the support, time and resources they need to work with a child who is challenging. In this future, there would be shared goals of using productive practices to keep children in programs and of using an inclusion model. There would be fewer placements into foster care because foster parents would have more knowledge about good parenting practices and better skills in parenting children affected by toxic stress and trauma. Leaders also observed that under the best possible circumstances, no children would actually need to come to the Division of Mental Health for treatment because the prevention and intervention resources, services and supports would be so effective.

In defining what success would look like, state agency leaders noted that when at least a couple of communities had working, integrated systems, it would be clear that the status quo had really shifted. They talked about a future with cross-referrals and partnerships between clinics and programs and said that in that future, the benefits of coordination would be visible because the data would have been collected to document those benefits. They said that a strategy would be in place for how to use the data to tell the story of success to the Legislature.

A diverse group of stakeholders said that success will really be about parents – with more parents understanding the importance of the environment they create for their children, more parents sending constructive messages about social and emotional development to their children, and more parents engaged in the early childhood programs in which their children are participating. According to two staff members of statewide programs:

***We know (parent) involvement is related to better outcomes.***

***Parent voices need to shape the plan for it to have meaning to those it is meant to help.***

Leaders of mental health membership organizations said that success would mean that anyone who is working with infants and young children knows what mental health consultation is and how to access it and, most important, success would mean that these individuals use consultation. They expressed the belief that if this plan is successful, leaders of the Medicaid system and private insurance companies would be at the table, placing a priority on ensuring the accessibility of services that promote the social-emotional health and wellness of young children.

Another measure of success noted by interviewees from various sectors was commitment to and investment in young children and families regardless of what state administration was governing. As one interviewee put it, the early childhood system as a whole would not worry that a change in the Governor would negatively impact all progress made to date. It was noted that success would also mean that financial resources were committed by multiple entities to fund the activities of the Plan and that such a commitment would mean there was buy-in across multiple sectors. One member of an advocacy organization expressed the vision in this way:

***Private funders, advocacy organizations, providers and state government work together, using a cross-systems provider/advocate approach. Illinois has success with this approach.***

## What does the Action Plan need to address?

The Action Plan	Stakeholders
<b>A Shared Vision, including...</b> <ul style="list-style-type: none"> <li>Outcomes that define what success looks like.</li> <li>A set of values dependent on equitable, evidence-based, trauma-informed, strengths-based practices. In addition, these practices build family resiliency, have a whole child-whole family focus and assume both a shared responsibility and accountability for all children, and that the parent's voice will be heard at decision-making tables. Ways in which diverse stakeholders will be engaged in ongoing ways to ensure these commitments are more than just words on paper.</li> <li>Shared definitions and common language for key terms like social and emotional health, early childhood mental health and system integration, so that stakeholders can "see" and understand what is being sought.</li> </ul>	State Agencies, Higher Education, Direct Service Providers, Planning Committee & State-wide Programs
<b>Cross-System Buy-In, as evidenced by...</b> <ul style="list-style-type: none"> <li>The community mental health system being prepared to serve young children.</li> <li>The Division of Mental Health defining its commitment to young children and families.</li> <li>Memorandums of understanding or commitment statements by leadership of the big government divisions.</li> <li>Effective implementation of laws that protect children with the highest risk, i.e., Early Intervention (Part C of IDEA), child welfare, special education.</li> <li>An advocacy strategy.</li> </ul>	Direct Service Providers, Advocacy Organizations State and Local Government Agencies
<b>Public Education, resulting in...</b> <ul style="list-style-type: none"> <li>Reduction of the stigma associated with mental health.</li> <li>Wider understanding of what social and emotional health is, why it matters and how to know it's not on track.</li> <li>Wider knowledge of the services that children and families are entitled to receive through Early Intervention, child welfare, and special education.</li> <li>Increased parental and provider understanding of the benefits of gaining assistance with healthy social and emotional development.</li> </ul>	Direct Service Providers, State Agencies
<b>A clear picture of the current scope/scale/funding of promotion/prevention, intervention and treatment that includes...</b> <ul style="list-style-type: none"> <li>A report on what is happening in the implementation of resources and policies around perinatal depression.</li> <li>A report on the status of mental health consultation in IBSE-funded programs.</li> <li>A report on the adequacy of existing prevention, intervention and treatment in light of defined need, including but not limited to what is necessary in terms of funding, policy, workforce development, etc., to close the gap.</li> </ul>	State Agencies, Planning Committee
<b>System Integration and Alignment that results in...</b> <ul style="list-style-type: none"> <li>Families being able to enter the early childhood system at any intake site and be offered, based on need and eligibility, an integrated array of services (e.g., social and emotional, home visitation, early learning and health).</li> <li>More integration of screening within and across systems – for adults and children.</li> <li>Strengthened two-way connections between screening and early intervention.</li> <li>More effective information and referral targeted to parents.</li> <li>More effective information and referral targeted to providers.</li> <li>Intentional, highly functional connections with primary care, where it matters most in the different sectors of the early childhood system.</li> <li>Intentional strategies to use committees in ways that increase integration and alignment.</li> </ul>	State Agencies, Advocacy Organizations, Planning Committee

# Findings from the System Scan

The Action Plan	Stakeholders
<ul style="list-style-type: none"> <li>The workforce having time and financial resources to prioritize ways of working that increase systems integration and alignment.</li> </ul>	Direct Service Providers, State Agencies, State-wide Coalition, & State-wide Programs
<p><b>Increased capacity and competency of the early childhood workforce as a result of...</b></p> <ul style="list-style-type: none"> <li>Defined shared standards and expectations for “Early Childhood Mental Health Practitioners” across systems.</li> <li>Pre-service education, from community colleges to graduate programs, with required content on social and emotional development, trauma, toxic stress, and relationship-based approaches.</li> <li>Ongoing required (and optional) in-service learning opportunities, from basic through advanced, with content on social and emotional development, trauma, toxic stress, and relationship-based approaches.</li> <li>Investment in best-practice approaches for in-service learning opportunities, e.g. inter-professional approaches (peer learning communities, job-embedded learning, etc.) that increase integration and alignment of the system and workforce.</li> <li>Implementation within early care and education and other non-mental health programs of a model like the <i>Circle of Security</i>.</li> <li>Increased availability of reflective supervision as a workforce support within and across the sectors of the early childhood system.</li> </ul>	Direct Service Providers, State Agencies, State-wide Coalition, & State-wide Programs
<p><b>Increased Access to Mental Health Treatment as a result of...</b></p> <ul style="list-style-type: none"> <li>Increased funding, including for therapeutic settings for stabilization.</li> <li>Community-based treatment response systems.</li> </ul>	State-wide Programs, Planning Committee
<p><b>Parents have more awareness, understanding and knowledge about social and emotional health due to...</b></p> <ul style="list-style-type: none"> <li>More broadly based parent education, with sessions available for those for whom English is a second language, with specialized educational opportunities for pregnant moms and dads, teen moms and dads and foster parents.</li> <li>Parent education topics that include, but are not limited to: enriching the home environment to support social and emotional health and development; how to build family resiliency; behavior management; and how to be self-sufficient.</li> </ul>	State Agencies, State-wide Program
<p><b>Medicaid payment is available for social and emotional prevention and intervention for children, adults and families.</b></p>	Direct Service Providers
<p><b>Early childhood programs include more Trauma-Informed universal interventions.</b></p>	State Agencies
<p><b>Increased cadre of Mental Health Consultants in every sector of the early childhood system, such that...</b></p> <ul style="list-style-type: none"> <li>The approach to mental health consultation is consistent across the entire early childhood system regardless of program type.</li> <li>Mental health consultation is considered a core component of every early childhood program.</li> <li>Core competencies and standards are defined and shared, and serve as the basis for workforce development.</li> <li>The funding to support the cadre is sustainable and every sector of the early childhood system contributes.</li> <li>Larger early childhood programs have embedded on-site mental health consultants.</li> </ul>	Direct Service Providers, State Agencies, State-wide Coalition, Membership and Advocacy Organizations, Planning Committee & State-wide Programs

A leader of an advocacy organization noted:

*It (the Action Plan) must be inclusive and include ALL the programs that serve the most at-risk children, including early intervention, special education and child welfare. It must focus on the whole system from prevention through treatment for young children.*

What opportunities ought to be capitalized on in the development of the Action Plan?

Opportunities on which to Capitalize	Stakeholders
<b>Early Childhood Workforce Development</b> <ul style="list-style-type: none"> <li>The Illinois Children's Mental Health Partnership Program could be expanded rather than creating something new.</li> <li>Existing early learning professional development offerings could integrate information about social and emotional development.</li> <li>For those pursuing degrees in early childhood education, pre-service education could include course work in the mental health of young children.</li> <li>The <i>Illinois Association for Infant Mental Health</i> early childhood mental health credentialing process could be used to designate individuals who have reached a level of accomplishment and achievement.</li> <li>Agencies could be incentivized to hire individuals with an early childhood mental health credential for key positions.</li> <li>The virtual Promoting Resiliency of Trauma Exposed Communities Together PROTECT Center, for which the Illinois Chapter of the American Academy of Pediatrics (ICAAP) was awarded a federal grant, could be utilized. The goal is for the center to expand access to resources systemically and statewide, and will include a website, consistent training and messaging, standards and protocols.</li> </ul>	Direct Service Providers, State Agencies, Institutions of Higher Education
<b>Early Childhood System Integration and Alignment</b> <ul style="list-style-type: none"> <li>The Inter-Agency Team, led by the Governor's Office of Early Childhood Development, could add an early childhood mental health team member.</li> <li>State agencies could use a consistent approach in the development of programs and pilots that, by design, would increase system integration and alignment.</li> <li>The Innovation Zones and QRIS (the state's Quality Rating and Improvement System, which is now called ExceleRate Illinois) could have an intentional focus on social and emotional development and overall early childhood mental health by defining social and emotional health as a core component of quality.</li> <li>Early childhood focused organizations in Illinois could work together to seek a grant from the National Child Traumatic Stress Network.</li> <li>Different models, i.e., <i>Life Course</i> from Title V or the Head Start requirements on mental health could support system alignment.</li> <li>Advisory committees, like the Maternal Health Advisory Committee, and/or programs like Child and Family Connections, or the DCFS pilot projects could be formally linked with other committees or programs in the interest of achieving shared outcomes.</li> </ul>	State-Wide Programs, State Agencies, Member Organizations, Coalitions
<b>Parent Education</b> <ul style="list-style-type: none"> <li>Teen parents could benefit from intentional education so that they understand that their baby's learning matters just as much as completing their own education.</li> <li>Foster parents, in particular, could benefit from education on trauma, toxic stress and how to parent.</li> </ul>	State-Wide Programs, State Agencies

# Findings from the System Scan

Opportunities to Capitalize	Stakeholders
<b>Governance and Implementation of the Action Plan</b> <ul style="list-style-type: none"> <li>The Illinois Children's Mental Health Partnership could lead the implementation of the Action Plan.</li> <li>The foundation of collaboration between the Governor's Office of Early Childhood Development, the Early Learning Council and the Illinois Children's Mental Health Partnership could be the basis for the governance of the Action Plan.</li> <li>The Action Plan ought to define clear roles, expectations and shared accountabilities for its implementation.</li> </ul>	State Agencies, Advocacy and/or Membership Organizations
<b>Access to Mental Health Treatment</b> <ul style="list-style-type: none"> <li>Community mental health-based agencies could increase their capacity to effectively serve young children and their families.</li> <li>The Affordable Care Act and the changes in the parity laws at the state/federal level (health care parity between physical and mental health) ought to be explored for resources to expand treatment services for Medicaid eligible children.</li> </ul>	State Agencies, Membership and/or Advocacy Organizations

**One state agency leader made a plea for collaboration:**

*Voices for Illinois Children, the Illinois Mental Health Partnership, the Trauma Coalition and Behavior Health Integration – all of these are reaching across agencies. Work with them.*

## Parent Focus Groups

Twenty-two parents or grandparents of young children experiencing social and emotional concerns participated in two focus groups, one in Chicago and one in Moline. Parents were asked about the sources and types of information they found most helpful, the types of services and supports their family had received, and how those services and supports might be improved. They were also asked what would be most helpful to do for parents of young children with social-emotional developmental concerns and what would be most critical to include in an action plan.

**When you started to worry about your child's social and emotional development, what information that you found or were given helped you most? And who shared information with you?**

- Many parents noted they found family, friends and community more helpful than early childhood or health-related programs or providers.
- Parents specifically mentioned that pediatricians were often not helpful sources of information because the physician's "wait-and-see approach" led to delays in getting help for their children. Due to these delays some parents were not referred to Early Intervention until their children were 2 to 2.5 years old.
- In the course of responding to multiple questions, parents strongly recommended that pediatricians gain greater knowledge of and ability to correctly diagnose social and emotional concerns as early as possible in the life of a child and that these doctors respectfully treat parents as experts in the behavior and development of their own children. An analogy was made between the annual education requirement of teachers and the annual social and emotional health requirement that should be made of pediatricians.
- Parents also noted that family, friends, and members of their communities had often provided essential emotional support and encouragement to them to be persistent in getting the needs of their children addressed in the face of obstacles they faced when they interacted with physicians, or professionals in the special education and Early Intervention systems.

### **What help has your family received with your child's social and emotional development? What has helped the most? Helped you the least?**

Parents in the focus groups had received a variety of different services, including Early Intervention services, mental health consultation and intervention, and mental health treatment. Parents held strong, mostly negative opinions about their experiences in learning about, accessing and using existing resources and services. Many parents felt they had been disrespected by the professionals with whom they had interacted. The services provided by the Virginia Frank Child Development Center and mental health consultants through Caregiver Connections were cited as the exceptions to that kind of experience. Parents who were clearly frustrated, angry, and saddened by the pattern of negative experiences they had in finding out about, accessing and using needed services shared many anecdotes about those upsetting experiences. The parents' comments about how they felt about their treatment included:

*Don't treat us like we're garbage. Don't beat me up. Don't bounce us from provider to provider. I'm not looking for a handout. I'm only trying to make sure my child gets what they need.*

*Don't talk down to me. I know my grandchild has problems. I came to you for help. Everyone is important and their needs need to be attended to.*

*What was valuable to me about the Virginia Frank Center was their holistic approach and addressing the needs of the entire family. The grieving process and the guilt and thinking about what is my family going to look like was huge for our marriage. If the family is stronger, we can deal better with the issues.*

### **If you could improve one thing about the help that you received, what would that be?**

- Require service providers to return our phone calls and emails within an agreed-upon timeframe.
- Improve developmental guidance provided by pediatricians and teach people working with families to trust parents' instincts more.
- Raise community awareness of social and emotional health and make services that address problems in these areas easy for parents to find.
- Provide easier access to services for young children. The current eligibility criteria for Early Intervention services and mental health treatment have created a barrier to serving young children.
- Increase access to early childhood programs for children ages 0-5 who do not have a mental health diagnosis but who have visible social and emotional health concerns.
- Allow early intervention-like services to last longer and integrate more of these kinds of services into child care.
- Help families who don't meet income criteria and yet can't afford to pay for services.
- Provide more frequent services and provide services at times when parents aren't working.
- Give parents more help with becoming advocates for their children, so they know what their rights are and whom to call to help them get what their children need.

*By the time we got him to early intervention, he was 2.5 years of age and it was not enough.*

# Findings from the System Scan

**If you could tell the people who are creating the Early Childhood Mental Health Action Plan one thing you think is critical to include in the Plan, what would that one thing be?**

- Increase parent participation in the decision-making processes that are shaping early childhood and mental health services, including their participation in making the decisions that will affect the development and implementation of the Action Plan.
- Focus on educational efforts that will help to normalize differences within a community, so parents of children who might be considered different can be comfortable asking for help.
- Address the needs of the family as a whole, not just the needs of the child.
- Teach service providers to be more encouraging, empathetic and respectful to families. Start with the basics – returning phone calls and emails, acknowledging and responding to communications. Decrease the amount of disrespect families currently feel in working with pediatricians, Early Intervention programs and other early childhood services.
- Provide more education to pediatricians about social and emotional health and development, and about how to better partner with parents when they express concerns about their children's development. Make it a goal to build parents' confidence in their own ability to recognize developmental concerns early, rather than making them doubt themselves for months or years, only to finally be given a referral when development has gone very off track.
- Make it easier for parents to learn about overall child development, what social-emotional development is, how to promote it, how to know when it goes off track and whom to call for help. One website and one phone number would help parents so much.
- Provide parents with more information about child development and opportunities for learning about it, starting prenatally and continuing throughout the early years of their children's lives.
- Make finding, accessing, and using consultation and treatment services simpler and less stressful.
- Make Early Intervention services easier to find and get referred to and extend eligibility until kindergarten entry.
- Increase access to therapeutic and treatment services in the communities where families live.
- Address the policy and funding issues that get in the way of providers accepting a medical card. If the family is not eligible for Medicaid, affordable options for treatment need to be widely available.

*There are posters in hospitals that bullet symptoms of postpartum depression. Why not have posters for parents in pediatric offices about the symptoms of social-emotional issues? And, have a website where parents can get information. There is a national hotline for postpartum depression. Why not for this?*

## Provider Focus Groups

Twenty-one providers, including mental health consultants and child care providers, among others, participated in two focus groups, one in Chicago and one in Moline. Service providers were asked to share: their perspectives on the assumptions/mindsets they encounter in connection with social and emotional development; what they think works well in the ways in which Illinois supports healthy social and emotional development; and the extent to which they believe current services are meeting the need. Additionally, service providers were asked what was most crucial to include in the Action Plan and to identify changes that would most improve their day-to-day work with children and families.

### **What assumptions/mindsets do you encounter regarding social and emotional development in the course of your work and your interface with the community?**

Providers in the Chicago focus group talked about families and professionals whom they encounter in their work who believe that children are not affected by their social and emotional experiences and do not experience social and emotional problems like depression. Providers in the Moline focus group noted that parents might be concerned about the stigma associated with using mental health services and sometimes will remove children from services rather than experience that stigma.

Providers described early childhood professionals who are unaware of what constitutes healthy child development and what development looks like when it is going off track. It was observed that these same professionals are then less likely to notice developmental concerns or may be hesitant to make a referral because they are afraid of being wrong. Providers in both groups discussed the discomfort many early childhood providers experience in openly acknowledging and dealing with their own emotions, or the emotions of the children and families they serve. Providers observed this is particularly true when the emotions in question are negative. A service provider said:

*Sometimes it [not talking about emotions] is to protect the grown-ups and feeling like they should just move forward rather than talk about it. In the classroom, there is a feeling of wanting to protect the group in the classroom – that teachers would lose control. It's a wish for an easy answer.*

### **What works well in the ways in which Illinois currently supports healthy social and emotional development?**

Service providers identified public education and awareness activities; screening, mental health consultation and intervention services; parent education and support; and the state's early childhood champions, for example, active philanthropies, advocacy groups, and the infant mental health community, as evidence of what is working well.

It is interesting to note that service providers and families had different perceptions of how well outreach programs are working to get families help early and how well services are designed to intervene early. In both cases, service providers were much more positive than families about the scope and effectiveness of these efforts.

It was also interesting to note that service providers in the focus groups do perceive that a conversation about young children's social and emotional development and overall mental health is already underway in the state. They believe there is now strong support for a holistic approach to meeting the needs of young children and their families and that there are many champions making a difference, including the Irving Harris Foundation, Voices for Illinois Children, the Ounce of Prevention and the state's strong infant mental health community.

### **To what extent are services (in Illinois and/or your community) that support the healthy social and emotional development of young children meeting the need?**

- Service providers said the services that are in place are effective but that they are not available to all who need them. In the Chicago focus group, providers expressed concern that there no services in some parts of the Chicago area. One service provider noted:

*South-side minus 0%. Finding a clinician that would serve children under five through public aid or private insurance – no one will do it. The three and unders are harder to get services for due to the diagnosis and billing.*

# Findings from the System Scan

- Members of both focus groups talked extensively about the barriers to service experienced by families and children with a medical card. A related barrier was that the early childhood mental health treatment that is being provided in many cases does not translate into what needs to be documented to gain Medicaid reimbursement. Providers knew of clinicians willing to provide services but the document requirements made it prohibitive for those providers to do so. Members of both focus groups expressed strong beliefs about the way in which there is mismatch between the needs of young children and the medical model.
- Service providers said there are insufficient services for people of different ethnic backgrounds and language barriers for families who do not speak English. One service provider stated:

*It's a white middle-class framework.*

- Service providers said there are not enough early childhood services for children ages 0-5 and their families. Providers discussed how little is available beyond school-based services for children ages 3-5, and that while Early Intervention programs might offer social work services, the Early Intervention eligibility criteria can make it difficult for children to get access to services to address their social and emotional concerns. Service providers said more cross-sector team-work is needed to coordinate and provide services. They noted that the connections between systems like Early Intervention and programs for children ages 3-5 are not working adequately. Two service providers shared their concerns:

*Services for the 3-5 year old that clearly needs therapeutic work on a daily basis are non-existent.*

*The notion of a collaborative effort looks good on paper. An unintended consequence of programs relying on each other is that if one loses funding – both no longer work.*

- Much conversation took place over the need for all services for children ages 0-5 to be delivered with a focus on the family, rather than just the child. The need for more education of the mental health field was identified. Providers indicated that many mental health professionals do not understand the benefit of play therapy or family therapy because they do not work with young children. Some providers expressed the strongly held belief that no child under the age of 3 should be given a mental health diagnosis.

## **What would need to change for you to be able to say – “All children and families have access to the information, consultation and treatment they may need to experience healthy social and emotional development?”**

- Biases, mindsets, stereotypes and culture regarding early childhood mental health currently held by the public, parents and many service providers in the different sectors of the early childhood system would need to be eliminated.
- More parents, providers and even the business sector would need to be more actively on board with the vision.
- Sufficient resources for Caregiver Connections mental health consultants would be available to provide support for children, parents, teachers, and providers to attain competency.

*The bureaucracy is getting in the way of people who would be willing to provide services but the paperwork is just too much trouble.*

- Systems serving high-risk families – for example, the child welfare system, prisons, mental health services, and substance abuse programs – would see the importance of the parenting role and work collaboratively with the early childhood system to promote successful parenting.
- Early Intervention-like services would be available through age 5.
- Children under 5 years of age, their parents, and the whole family, would be able to access group therapy.
- Early childhood mental health professionals would receive greater compensation.
- More parents would have education about social and emotional health issues that would empower them in their parenting roles.

- Families would be able to choose their mental health providers, just as they can choose their child care providers.

*Parents have anxiety about bringing young kids in for treatment. The idea that social-emotional development is a good thing could have long term impact.*

### **What improvement or change would make the biggest difference in your own work on a daily basis?**

- Legislators would value and prioritize healthy social and emotional development.
- Family trauma would be an accepted diagnosis for documentation and billing.
- The stigma experienced by children with social-emotional concerns, and by their parents and teachers, would be lessened.
- There would be a referral network for children under age 5.
- More mental health treatment resources would be available in communities.
- On-site mental health consultants could work with the child, family and staff.
- Medicaid could be billed for early childhood mental health consultation.
- Pediatric practices would have child development specialists on staff – for example, they would use the approach taken by Healthy Steps.
- Training across the sectors of the early childhood system could create more knowledge about child development and early childhood, so that children with social and emotional concerns would be identified and properly helped by any professional they come into contact with.
- Parenting education in early childhood programs would be provided so that parents could learn about child development and understand more about how to get the additional resources they might need to help their children. One provider noted the following benefit of peer interaction:

*Parents feel effective because they can share their experiences with other parents.*

### **If you could tell the people who are creating the early childhood mental health Action Plan one thing that you think is critical to include in the plan – what would that one thing be?**

- All parents would be given basic child development education as a part of their participation in prenatal, prevention, intervention or treatment services.
- There would be increased capacity and ability for providers, teachers, and families to work together to meet family needs, as families identify them.
- Mental health treatment could be provided to both the parent and the child together.
- Service providers would have ongoing training on social and emotional needs and how to address them, including both their own and those of the children and families they serve.
- Individuals and organizations who serve infants and toddlers – i.e., hospitals, pediatricians, nurses, and child care teachers – would receive ongoing specialized training.
- The whole early childhood workforce in Illinois would be trained in a shared model of child and family development so everyone has the same basic knowledge and understanding.
- Eligibility for services would be as broad as possible to serve the maximum number of children.
- Early intervention-like services would be available for children up to the age of five.
- Funding would be sustainable and long-term, leading to more treatment, consultation and community education.
- All child care centers would have mental health consultation.

# Findings from the System Scan

## *Illinois Early Childhood Mental Health Survey*

In 2002, a report titled *Unmet Needs Project: A Research, Coalition Building and Policy Initiative on the Unmet Needs of Infants, Toddler and Families* was published in Illinois. It served as a catalyst for some of the successes noted earlier of this report. One of the sources of information for that report was a survey of early intervention, Child and Family Connections, public health, child care centers, and prevention program staff. The questions that formed the basis for that survey were used as the foundation for the survey that was developed and fielded in this assessment process in September 2014.

The 2014 survey was sent to more than 1,200 people who were identified as either directing or managing an early childhood program or programs or providing services in an early childhood program. The overall response rate for the survey was approximately 38% (463). While respondents were from a variety of early childhood programs, the most frequently cited programs were:

- Child care;
- Preschool for All;
- Prevention Initiative; and
- Head Start.

About 18% of the respondents were from mental health and approximately 66% of the respondents were directors and/or managers of these programs. Most respondents worked in programs serving 50 or more children and almost 20% were in programs serving more than 500 children.

Key responses included the following:

- Nearly 77% said staff members were prepared to *support social and emotional development* but only 49% said staff had the actual expertise and 10% said they did not know.
- Nearly 83% said that children they served exhibited social and emotional developmental concerns in the last year.
- Nearly 70% of programs who did serve a child with a social and emotional concern reported the child was able to participate in the regular program with some adaptations. The remaining children needed additional intervention outside of the typical program services.
- Just over 15% of respondents had to discontinue services to a child or ask a family to withdraw their child due to social and emotional concerns. The most frequently cited reasons for asking a family to withdraw a child were hitting, biting, self-harming behaviors, extreme aggression and excessive tantrums. Excessive tantrums were identified as the social and emotional concern most difficult for programs to address.
- Respondents indicated that the families served by their programs had many mental health concerns. The most frequently occurring concerns were:
  - o troubled parent child relationships;
  - o deep poverty;
  - o exposure to trauma;
  - o maternal/paternal depression; and
  - o parental substance abuse.
- Nearly 16% of respondents said that troubled parent-child relationships were the most difficult for their programs to deal with, followed by exposure to trauma, and deep poverty.
- 71% indicated family mental health concerns (versus child mental health concerns) were the most difficult for their program to address.

## Findings from the System Scan

- Respondents most commonly meet the social and emotional and mental health needs of children through using consultants with specialized training, like mental health consultants who work with program staff.
- When asked what was most needed to answer the social and emotional concerns of the children and families, respondents said more professionals to provide evaluation of and treatment for children and families, as well as regular and consistent mental health consultation.
- Nearly 77% of respondents indicated they experience challenges or barriers to accessing treatment for children with social and emotional concerns. The barriers that respondents indicated occur most frequently are: parents not consenting to services or treatment; treatment providers not accepting medical cards; and limited or no qualified treatment providers in the geographic area.
- Programs indicated the greatest areas of unmet need in their communities were supports and services for children with mild, moderate or severe social and emotional concerns and public understanding of the importance of social and emotional health and development.
- When asked what the most critical barriers are to the development of a more integrated and effective early childhood system, respondents identified:
  - o insufficient resources;
  - o gaps in services (not able to serve all families);
  - o services not reaching the most vulnerable children and families; and
  - o public officials not prioritizing investments in an integrated system.

**Action Plan Priorities:** Listed below are specific priorities respondents listed as most critical to include in the Action Plan.

1. Site-based and/or ongoing access to mental health consultation for all early childhood programs, teachers, home visitors, etc., provided by qualified individuals with specialized training in addressing the social and emotional concerns of young children.
2. More qualified mental health treatment providers in all geographic areas of Illinois who can effectively address the needs of young children, particularly 0-3 year old children, and their families.
3. Early childhood and mental health service capacity more equal to need; barriers to timely access to needed mental health services are substantially reduced or eliminated.
4. Regular, ongoing professional development opportunities for the early childhood workforce, across sectors, that specifically addresses, but is not limited to:
  - healthy social and emotional development and how to support it;
  - how to recognize when development is off-track and what to do/where to go for assistance;
  - childhood trauma identification and trauma-informed practices;
  - how to talk to and work with parents, as partners, in addressing the social and emotional concerns of their children; and
  - reflective supervision.
5. Increased public understanding regarding social and emotional health that leads to a reduction in the stigma associated with the need for mental health services currently being experienced by children, parents, early childhood and mental health staff.
6. Policy and funding reform such that:
  - families are able to access needed mental health treatment and therapeutic services with a medical card or, if not Medicaid eligible, at a cost that is affordable;

# Findings from the System Scan

- communities have an array of early childhood and mental health services that align with community needs and assets;
  - early childhood and mental health direct service providers are compensated such that they consider themselves valued professionals.
7. All social and emotional services and supports are provided to the families as a whole, adapted to their cultural community and in their own language.
  8. Parents have the information and education (confidence and competence) they need to:
    - recognize healthy social and emotional development;
    - understand the role they as parents play in that development;
    - what to do when development goes off track; and
    - how to work effectively, in partnership, with the early childhood and mental health programs and services that interact with their family.

## *Advice from Five States*

The Irving Harris Foundation has a long history of national investment in early childhood, child and family policy and infant mental health. To provide some of the benefit of that investment to this report, the Foundation identified five states that have achieved significant impact from initiatives designed to ensure that significant percentages of young children and their families have access to the prevention, intervention and/or treatment services they needed to experience healthy social and emotional development. Mental health leaders in Arizona, Colorado, Connecticut, Louisiana, and Minnesota were interviewed with the goal of learning from their expertise and experience in the creation of the Illinois Action Plan. Listed below is a breakdown of their advice and lessons learned.

### **Systems Approaches**

- Figure out what the systems are and then assess them to understand how to best connect people and fill in the gaps.
- Link mental health consultation with initiatives like QRIS/ExceleRate Illinois, child care health consultation, or Part C of IDEA to create a larger quality improvement/technical assistance initiative, accessible through a single helpline for service providers across sectors.
- Identify goal areas to serve as a framework for gauging progress and current conditions. Embed goal areas into the larger early childhood system framework so that all stakeholders understand early childhood mental health in that context.
- Ask for a commitment of all involved to consistently highlight where their work spans the early childhood systems framework and to build shared knowledge about gaps, resources and where opportunities lie across the sectors of the early childhood system.

### **Governance**

- Consider identifying an Early Childhood Mental Health Director to be housed inside the Governor's Office of Early Childhood Development. The funding for this position in Colorado was seeded by a private foundation.
- Identify a cadre of leaders who will be a consistent, trusted source of information on early childhood mental health; position them where decisions are being made.
- Identify who "gets" early childhood mental health inside the state agency responsible for adult and adolescent services. You need someone who understands that, when parents have mental illness, it affect the development of their children.



### **Messaging and Advocacy**

- Have one consistent message. In Colorado, the message was: Comprehensive services that focus on health, promotion and prevention, and take the family context into account.
- Conduct a public perceptions survey related to your goals, and use social marketing to systematically target more positive perceptions.
- Consider developing an inside-outside strategy to push the agenda. Both play important roles in making change. Determine who the inside partner is in Illinois.
- Cultivate champions; devote time and effort to broaden the base of support and advocacy.
- Identify other funding partners to help support the services and advocacy necessary to lead change.
- Start the systems conversation with a budget because to influence policy, the budget is the place to start. Construct and propose a budget to identify what is being spent in Illinois for children in each sector of the early childhood system. Show not just what is being spent on social and emotional health but paint a picture of that spending, in the context of all other aspects of the budget.
- A visual dramatically accelerates the conversation.
- Educate people so they understand what early childhood mental health really means, e.g., it is not a baby on the psychotherapy couch.
- Use data to engage stakeholders, build their knowledge and demonstrate collective impact.

### **Common Vision, Definitions, Goals and Approaches across Early Childhood Mental Health Programs**

- Reach consensus on definitions, integration, and coordination of the early childhood mental health systems, services and supports.
- Identify a common vision and direction and then commit to it for the long term.
- Have an operational definition of early childhood mental health so everyone knows what success looks like and data is standardized.

Hold a gathering of the state government staff responsible for public health, child care, child welfare, and Medicaid. Provide them with the operational definition and have them think about how it all will now need to work. To create the operational definition, gather community individuals and groups and find out what the levels of buy-in are. Bring the local and state groups together to talk about policy and funding.

# What We Heard: Priorities for the Action Plan

Through each of the assessment activities reported on in this document, stakeholders made suggestions for the Action Plan. Through a thematic analysis of those recommendations, 12 potential priority areas of work were identified and are detailed below.

## 1. **Shared Vision**

- Define a set of shared outcomes to measure progress, impact and success of the integration of early childhood mental health into the comprehensive early childhood system.
- Develop and commit to a set of values dependent on equitable, evidence-based, trauma-informed, strengths-based practices. In addition, these practices build family resiliency, have a whole child-whole family focus and assume both a shared responsibility and accountability for all children, and that the parent's voice will be heard at decision-making tables.
- Agree to shared definitions and common language for key terms like social and emotional health, early childhood mental health and system integration, so that stakeholders can "see" and understand what is being sought.

## 2. **Equity**

- Build and honor authentic partnerships with diverse stakeholders to systematically address issues of culture, race, disparities, and discontinuities of care.
- Embed cultural awareness and sensitivity in all sectors of the early childhood system.
- Create equal access to information, referral, and services for families in which English is their second language.

## 3. **Parent Leadership and Voice**

Use an early childhood system-wide approach to ensure and enable parent leadership and voice in regard to social and emotional concerns at all system levels – child and family, community, and state.

## 4. **Public Education**

- Shift the mindsets of the general public, parents, service providers, and the business sector to align with the shared vision by increasing awareness and understanding of what social and emotional health is, why it matters, how to know when it's not on track, and the benefits of gaining assistance with healthy social and emotional development.
- Reduce the stigma families face in seeking assistance for their children with social and emotional concerns.
- Involve parents as collaborative partners in the development and implementation of public education targeted at parents.

## 5. **Parent Education and Outreach**

- Make it easier for families in Illinois to find out about child development broadly, and social and emotional development in particular, including how to promote social and emotional health, how to recognize when development goes off track, and whom to call for help by consolidating this information into one website that provides one number to call. Work with parents as key advisors and collaborative partners.
- Systematize parent educational offerings related to social and emotional development across all sectors of the early childhood system, beginning prenatally and continuing to kindergarten entry.
- Offer specialized education for specific populations of parents whose children are more likely to experience social and emotional concerns, i.e., teen moms and dads, foster parents.

# What We Heard: Priorities for the Action Plan

## 6. **Workforce Development**

- Teach service providers to be more encouraging, empathetic and respectful toward the families they work with.
- Define shared standards and expectations for “Early Childhood Mental Health Practitioners” across systems.
- Use a shared model of healthy development as the basis for professional development to assure that service providers in all sectors of the early childhood system have the same basic knowledge and understanding.
- Develop a systemic strategy for pre-service education, from community colleges to graduate programs, to embed required content on social and emotional development, trauma, toxic stress, and relationship-based approaches.
- Provide ongoing required (and optional) in-service learning opportunities across all sectors of the early childhood system, from basic through advanced, with content on child development, social and emotional development, trauma, and toxic stress, and relationship-based approaches. Content should also address how to recognize when development is off track and what to do/where to go for assistance; how to talk to and work with parents, as partners, in addressing the social and emotional concerns of their children; and reflective supervision.
- Provide service providers and organizations that work with infants and toddlers (i.e., hospitals, pediatricians, nurses, and child care teachers) with ongoing specialized training.
- Increase the availability of reflective supervision as a workforce support within and across the sectors of the early childhood system.
- Invest in best practice approaches for in-service learning opportunities that use inter-professional approaches (peer learning communities, job embedded learning, etc.) that increase integration and alignment of the system and workforce.
- Use the early childhood mental health credentialing process as the designation threshold for some positions and incentivize agencies to hire credentialed staff.

## 7. **Mental Health Consultation**

- Systematize how Illinois implements Mental Health Consultation in the comprehensive early childhood system through the identification of a consistent model, core knowledge and competencies, and defined, sustainable, cross-system funding (e.g. Medicaid and other funding sources).
- Make mental health consultation a core component of every early childhood program with large early childhood programs having mental health consultants on-site.

## 8. **Mental Health Treatment for Children Ages 0-5**

Approach the resolution of the myriad of issues that prevent access to mental health treatment systemically. A systemic solution should address: access for families with a medical card, availability of treatment providers, availability of therapeutic settings, community response systems, community-based treatment options, how the Affordable Care Act and parity could be used to expand access, where community mental health fits in, philosophy, diagnostic and billing issues related to serving children vs. families, and issues related to diagnosis for very young children.

## 9. **Integration of Social and Emotional Health into Sectors of the Early Childhood System**

### *Early Intervention*

- Conduct a study to determine the feasibility of providing early intervention-like services for children up to age 5.
- Make improvements to Early Intervention (Part C of IDEA) and improve and strengthen its connections to other sectors of the early childhood system.

# What We Heard: Priorities for the Action Plan

## *Health*

- Shift mindsets and approaches regarding developmental guidance by pediatricians to parents to increase earlier referral to specialized assessment and evaluation.
- Explore the potential for integration of child development assistance into pediatric practices.
- Make intentional linkages with primary care where it matters most in the programs provided through each sector of the early childhood system.

## *Early Learning and Care*

- Build an intentional focus on social and emotional health in the Innovation Zones and QRIS (now known as ExceleRate Illinois) by defining social and emotional health as a core component of quality.

## *Referral and Screening*

- Increase integration of screening (broadly defined) within and across systems for both adults and children.
- Have more effective information and referral targeted to service providers who need assistance with addressing the developmental concerns of the children and families they are serving.

## 10. **State Government Leadership for Integration of Social and Emotional Health**

- Add an early childhood mental health leader to the Inter-Agency Team led by the Governor's Office of Early Childhood Development.
- Support the Inter-Agency Team to develop a consistent approach to the development of state agency programs and pilots that increases system alignment and integration.
- Form effective, collaborative partnerships between mental health and other sectors of the early childhood system.
- Formalize Division of Mental Health leadership and commitment to early childhood mental health.
- Formalize commitments to strengthen alignment and integration between mental health and other sectors of the early childhood system through memorandums of understanding or interagency agreements.
- Enforce applicable laws related to ensuring the legal rights and mandates for some services for high-risk children and families.
- Prioritize ways of conducting and organizing the work of the Action Plan to give recognition and reward to outcomes associated with systems integration and alignment.
- Consider how different theories of change or system requirements (i.e., Life Course from Title V or the Head Start requirements on mental health) could be adopted to enhance systems alignment and integration.
- Examine existing links between core early childhood programs, like Child and Family Connections and DCFS, and take steps to strengthen and/or develop depending on need.
- Shift the mindsets within systems serving high-risk families – child welfare, prisons, mental health, substance abuse, etc. – to recognize many of their customers are parenting adults, and as parents, have needs to be addressed in concert with the early childhood system.

## What We Heard: Priorities for the Action Plan



### 11. Early Childhood Mental Health System Capacity Building

- Map current early childhood mental health system capacity, with a goal of defining the adequacy of existing social and emotional promotion/prevention, intervention and treatment in light of defined need. Assessment would include, but not be limited to: funding levels, policy, workforce development, workforce compensation, etc. Use data to define unmet need, taking into account attributes like scope, scale, duration, geography, English as a second language, etc. *(This work will need to be conducted in alignment with recommendation #9.)*
- Develop a long-term funding and advocacy strategy based on the system capacity vs. need report.

### 12. Governance and Implementation of the Action Plan

- Determine what would be needed for the Illinois Children's Mental Health Partnership to lead the implementation of the Action Plan.
- Build on the foundation of governance established through leadership of the Governor's Office of Early Childhood Development, the Early Learning Council and the Children's Mental Health Partnership to support effective implementation of the Action Plan.

Define clear roles, expectations and shared accountabilities for implementation of the Action Plan, and use committees, work groups, etc. in service to those functions.

**The Illinois Action Plan to Integrate Early Childhood Mental Health into Child- and Family-Serving Systems is made possible through the generous support of the Irving Harris Foundation.**



The Irving Harris Foundation's strategic investments and field leadership in early childhood aim to improve the likelihood that all children receive equal access to comprehensive, high quality care in nurturing environments from birth to ensure their successful development and school readiness. The Foundation intentionally focuses on integrating early childhood mental health into child- and family-serving systems.