LIVINGSTON COUNTY CHILDREN'S NETWORK

Local Evaluation Report

2011-2015

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EXECUTIVE SUMMARY

The Livingston County Children's Network (LCCN) is comprised of entities committed to implementing an inter-connected systems, public health approach to fostering social, emotional, behavioral, academic and physical health for all children ages zero to eighteen. We envision that families all across Livingston County will utilize and value a comprehensive continuum of services to promote children's social and emotional development which will, in turn, effectively reduce at-risk behaviors and strengthen relationships.

In 2011, the LCCN reported that 424 children had received therapy at our community mental health center, Institute for Human Resources (IHR), in a twelve-month period. According to our local needs assessment, community members perceived the system of care to be inadequate to meet the already identified mental health needs of the community. What's more, based on statistical projections in line with national data, we predicted that at least 1,000 of our estimated 9,500 children were in need of treatment for diagnosable conditions.

The community realized that the long-term success of our children relied on a preventive approach to decrease the frequency and intensity of mental health needs. We developed a plan to pool resources across agencies to deliver four tiers, or levels, of support to match the level of need. Tier I supports, which are intended for all children and adolescents, are designed to promote our children's development. Universal screening aims to identify children whose developmental trajectory is askew and get them back on track preventing the emergence of mental health disorders. Over time, these efforts will decrease the demand for Tier III treatments for children with disorders and Tier IV intensive family supports.

The team determined that successful implementation of the four-tiered public health model would depend on increasing the capacity, accessibility, and coordination of the system of care. In addition, due to the heavy preponderance of rick factors in children's lives, it required a concerted effort to promote protective factors such as school engagement and adult-child relationships to reduce risk behaviors and mental health problems. The local evaluation plan was intended to answer the following questions in an iterative fashion such that the data collected informed community stakeholders at each stage of implementation.

- Are we doing what we proposed to do?
- Are we on-target to accomplish our goals & objectives?
- Are there other important things we didn't plan for initially that must be taken into account in order to achieve our short-term outcomes?

The comprehensive narrative document which follows is being updated annually; it describes the data collection process for each of the community goals, challenges encountered both in data collection and in implementation, changes in important metrics identified by community stakeholders, and a discussion of the findings in an ever-changing socio-political context. Specific metrics comprise a "community scorecard" that is being presented at our annual community summit and widely disseminated. In addition to analyses of local process and outcomes, the program evaluation team has conducted some formal studies that are contributing to the literature on children's mental health service delivery in rural settings and will be valuable in on-going efforts to secure support for the maintenance of the system of care.

Research originally centered around the use of the Positive Action curriculum in schools; a large amount of archival data has accumulated which has allowed us to understand our youth and the relationship between various risk behaviors of concern in the community (e.g., self-injury/suicidal thoughts, body image/eating disorders, and substance use), beliefs about/acts of aggression, psychological/adaptive functioning, school climate, reading/math scores, and school attendance. The cross-site cohort data collection has also afforded the opportunity to track specific variables in over 100 at-risk children. Currently, the program evaluation team is studying teachers' readiness to implement Positive Action and the improvements in juvenile justice outcomes over the last few years.

In summary, the Livingston County Children's Network is well on its way to fulfilling its articulated vision. This progress is in large part due to steadfast commitment to our collective goals. The capacity of the system of care has been expanded by matching children, adolescents, and their families with the intensity of supports needed. Coordination of the system has been greatly enhanced by individuals who serve as liaisons in each of the major sectors (education, mental health, medical, juvenile justice). The types of services, the number of providers, and the diversity of settings in which services are delivered have all increased. For example, 94% of elementary school children have access to social-emotional skill-building lessons. This last year, 11,556 screenings were conducted and as many as 70-80% of those with positive screens were able to receive early intervention to get them back on track. More parents of 0-5 year olds and 6-18 year olds have accessed parenting consultation and dyadic treatment with increases of 183% and 57% respectively. The number of children and adolescents treated for mental health conditions within our community mental health center has increased almost three-fold. Finally, our overall positive screen rate has decreased from 16% to 9% suggesting that, across the board, our combined efforts are having a positive global effect. In summary, every piece of data suggests the system of care and the children within the system of care are improving.

PROJECT OVERVIEW

Livingston County is the fourth largest county in Illinois, spanning 1,034 square miles of geography. The population is ~40,000 with slightly over 50% of the population living in rural areas. Pontiac, the county seat, is home to the only hospital, mental health center, and health department. Many of the outlying villages are more than 35 miles from Pontiac. According to the US Census Bureau (2008), the citizens are 93% White, 5% Black, & 2% Other, and ~9-10,000 of these individuals fall within the 0-18 age range. The median household income in 2008 was $47,442 (compared to the state median of $54,131), and only 13% of residents reported a bachelor's degree or higher in comparison to 26% in the state. The percentage of high school graduates is also below that of the state average. While only 21% of the population under 21 was enrolled in Medicaid compared to 29% in the state, the ratio of enrollees to physician vendors is 134:1 in comparison to the ratio for the state of 82:1 (IPLAN Data System, 2002). Fourteen percent of babies are born to mothers under the age of 20 and 55% are born to single mothers. An average of 13 reports of child abuse and neglect per 1,000 children are made each year in comparison to 8 per thousand in the state (Illinois Kids Count—Voice for IL Children) with approximately 1.3 cases per 1,000 indicated for sexual abuse compared to .8 in the state (DCFS Annual Reports). The hospitalization rate for alcohol-dependence (IPLAN Data System) and reports of domestic violence are also higher than expected (Illinois State Police, Annual Uniform Crime Reports). These statistics paint a picture of the landscape within which children of Livingston County grow and develop.

During the initial needs assessment, stakeholders identified a number of metrics that were particularly of concern and important to the community. We predicted that successfully implementing the four-tiered public health model to address children's mental health would ultimately bring about measurable gains. We articulated four goals with subsequent objectives and strategies to be implemented across inter-connected systems. The program evaluation team was charged with monitoring whether all providers were making the changes as agreed and whether or not these changes were bringing about the desired effect. The data was intended to be used to inform course adjustments over the life of the grant. The universal implementation of the evidence-based social-emotional learning curriculum, Positive Action, in all the county's schools was viewed as incredibly ambitious and likely very important to the overall success of the model. The program evaluation team devised a formal quasi-experimental study design to evaluate the added benefit of the curriculum over all the other components of the model. The longitudinal design and the wealth of data collected has provided the opportunity to explore several variables in our rural population as well.

In Year 3, the program evaluation team was able to compile a large document describing the community's progress toward the attainment of its four goals and objectives; an updated version is attached. It also assisted in updating a "community scorecard" that is being used in a variety of venues to engage various constituent groups in the overall vision of the LCCN. There were also several changes in the program evaluation. First, there was a shift from collecting self-, teacher-, and parent-report data in schools where considerable "data collection fatigue" had been observed. Rather than focusing exclusively on the outcomes of Positive Action, the team focused its attention on understanding the process and barriers to implementing the curriculum. On several occasions, community stakeholders were puzzling over a question and asked the program evaluation team to see if they could find answers within the data set. For example, the presiding judge has become increasingly concerned about truancy. The program evaluation team was able to provide information about children in the county who have poor attendance and improved efforts by the local truancy board to address this problem. The program evaluation team has begun studying outcomes of the new diversion and treatment strategies being implemented in the juvenile court system. Finally, in year four, the team has been discussing data gathering mechanisms that can be maintained by local stakeholders once the grant funding for local evaluation concludes.

Goal 1. Increase capacity of system of care

Objectives:

- Increase workforce to meet needs
- Increase skills of current personnel
- Fill identified service gaps
- Identify funding sources

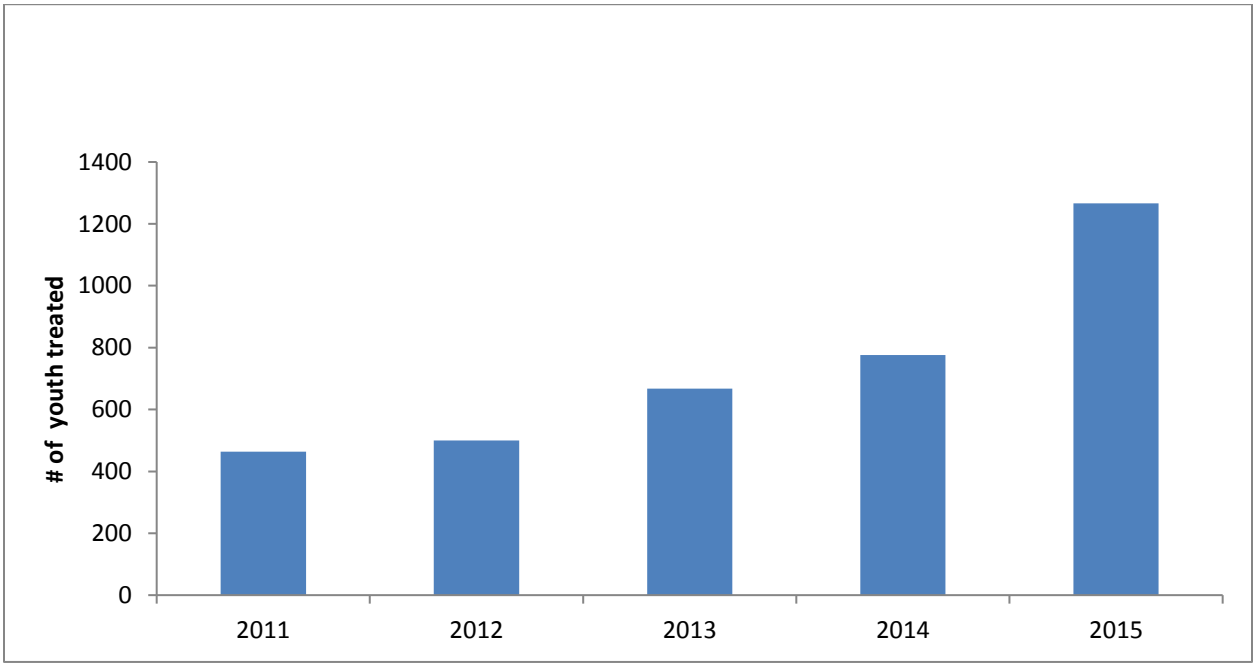
Methodology:

- NTI Annual Gap Analysis (# of providers vs. need for providers)
- Wait time for psychiatry
- Service Activity Log
- Percentage of children screened during doctor visit
- Follow-up services provided to court-involved youth
- Frequency Counts: # of children served by IHR, psychiatrist, Resource Link Care Coordinator, Developmental Interventionist, Family Resource Developer, Family Support Specialist and Comprehensive Inter-disciplinary Assessment team; average # of Positive Action lessons; # of families receiving dyadic/family systems treatment; # of professionals receiving training

SUMMARY: Similar to other rural communities, recruitment and retention of highly-skilled providers is an on-going challenge. The entities have found engaging with institutions of higher education to provide pre-service learning opportunities to be a highly effective strategy that has allowed for on-going infusion of new knowledge and much low-cost service provision. Providing opportunities for part-time employment and flexible schedules has also allowed partners to retain employees who are looking for work-life balance. For example, the community has retained several professional child psychologists who are competent to provide comprehensive inter-disciplinary assessments, a previously-identified service gap. Continuing professional development is sometimes a challenge. Innovative methods of accessing training such as group staffing of complicated cases and an on-line book group have been used to incorporate training into clinicians' days and limit the impact on revenue. In rural communities, all employees need to be generalists first; yet, some providers have received additional training to address specific identified gaps such as dyadic treatments for young children and evidence-based strategies to resolve trauma. Members of the Executive Council have developed a sustainability plan which focuses on each entity's plans to maintain human resources necessary to maintain the system of care.

In 2011, the Livingston County Children's Network reported that 424 children had received therapy at our community mental health center, Institute for Human Resources (IHR), in a twelve-month period. According to our local needs assessment, community members perceived the system of care to be inadequate to meet the already identified mental health needs of the community. What's more, based on statistical projections in line with national data, we predicted that at least 1,000 of our estimated 9500 children were in need of treatment for diagnosable conditions. **In 2015, 1266 children and adolescents were served by IHR, approximately 13% of 0-18 year olds in the county. This dramatic increase represents the expanded capacity of the mental health center to serve children and adolescents. It also reflects a smooth and seamless referral process as well as families' increased willingness and ability to access available care.**

The community realized that the long-term success of our children relied on a preventive approach to decrease the frequency and intensity of mental health needs. We developed a plan to pool resources across agencies to deliver four tiers, or levels, of support to match the level of need. Tier I supports which are intended for all children and adolescents are designed to promote our children's positive development. Universal screening aims to identify children whose developmental trajectory is askew and get them back on track preventing the emergence of mental health disorders. Beyond screening for social-emotional concerns, we have been systematically adding universal prevention programming in county schools. At the close of 2015, 94% of our K-8 graders have teachers trained to deliver instruction in social-emotional learning. Also, 97% of all 0-18 year olds were screened, and our local data suggests that 70-80% of those with positive screens received follow-up services in schools. Over time, these efforts are expected to decrease the demand for Tier III treatments for children with disorders and Tier IV intensive family supports.



Four objectives were articulated to increase the capacity of our system of care.

A. Increase workforce to meet needs

Each year in late fall, Executive Directors of all entities have come together in a group to complete the "sustainability matrix" provided by NTI that monitors the FTE of human resources across a large number of professions, in terms of the expressed need as well as the personnel in place.

In 2010, when we started implementation, we were down at least one FTE each in medical providers, school-based providers, and community mental health center therapists. In addition to substantial turn-over in providers in all three sectors, we had a number of positions that were lost as a result of Reductions in Force or left vacant without recruiting due to economic hardships faced by the agencies. This was a tough place to start with implementation because we were asking all existing providers to continue performing their current duties, make changes to the way they do business, and even add tasks! There was also much trepidation about the unknown amount of new referrals that could potentially flood the system once universal

screening was fully implemented. Since 2013, all the OSF medical practices and IHR have been fully staffed. The specific disciplines we are monitoring appear below.

Child Psychiatrists: One child psychiatrist is contracted by IHR, our community mental health center, to provide services on-site two days per month. On two additional days, he provides services to patients at IHR via tele-health (video/audio). When OSF implemented psychiatry tele-consultation through the Resource Link program, they agreed to contract with the same psychiatrist (even though he is out-of-network) so that there would be continuity of care if the family was subsequently referred to IHR. There is also another OSF child psychiatrist that provides some tele-consultation to medical providers when this psychiatrist is not available. The intent of Resource Link is to assist primary care doctors in managing psychopharmacological interventions for many of their patients. When, through tele-consultation, the doctors agree that a referral to IHR is warranted, the primary care physicians are likely to have better communication with the psychiatrist and be more amenable to resuming responsibility for the child's treatment once he or she is stabilized. In addition to the increase in time and access to the child psychiatrist, the community now has a full-time psychiatric nurse employed through IHR who can treat adolescents. **During the baseline year, the psychiatrist treated 112 children and youth. During 2012 and 2013, he treated 120-130 children and adolescents, and in 2014, that number jumped to 159! In addition, we have decreased the wait-time for a first appointment from six to three months.**

Therapists: The community mental health center employs 13.5 FTE therapists, which is 2.5 FTE more than in 2010. One full-time therapist was originally completely funded and is now partially-funded on the LCCN grant to provide services to children, adolescents, and their parents in community settings. Four therapists have left the agency since 2010 and all have been replaced; this represents a 30% turnover in staff. This level of turnover requires thoughtful orientation and routine training on LCCN protocols. Two of the therapists who left the unit served for a time in the role of the full-time community-based child and adolescent therapist, a person who was easily recognized as a face of the LCCN initiative. After losing two individuals in this role, the Executive Director of IHR began to allocate a portion of multiple therapists' time to community settings such as homes, doctors' offices, schools, and churches. The remaining therapists serve all age groups. In 2014-2015, while all community mental health therapist positions remained filled, several providers were out on leave. Some of these same therapists serve on the crisis team for SASS or provide substance abuse treatment. IHR trains two .5 FTE master's level clinical/counseling psychology interns each year. Although we have enough cases to warrant employing more therapists, the ratio of clients with Medicaid to those with insurance is such that we cannot financially sustain more providers. **Despite the turnover in personnel, there has been a steady and remarkable increase in the number of children and adolescents receiving treatment since the LCCN plan has been implemented.**

	2011	2012	2013	2014	2015
# of children/adolescents served	**464**	**500**	**667**	**776**	**1266**

Child Psychologists: Since 2010, we have had two dually-credentialed psychologists leave the community. We currently have five people (3.8 FTE) who are doctoral-level school psychologists and two of them are clinically-licensed with the remaining two accruing post-doctoral hours and likely to be licensed within the next 12-months. Of this total, .70 FTE, which includes our full-time Project Manager, is funded by the grant. The community is committed to keeping several licensed psychologists employed for the following reasons:

- They can supervise doctoral interns who provide inexpensive, but high-quality services; there are currently 5 people (4.6 FTE) training in the community. Pre-service training has been a tremendous recruitment tool with approximately one out of four trainees choosing to stay in the community.
    - The grant currently funds 2.2 FTE and the sustainability plan will include generating on-going funding for trainees.
        - On average, post-grant funding, it would cost approximately $6,000 per year (stipend, benefits, and mileage) to have an additional day per week of therapy provided by a doctoral intern in a high school. In turn, that intern would provide individual or group therapy to approximately 15-20 students and provide 340 hours of mental health service (therapy 48%; consultation to administrators, teachers, and parents 7%; clinical documentation, coordination, and supervision associated with screening, therapy, and crisis intervention 40%).
        - A doctoral intern providing one day per week of integrated behavioral health in primary care costs approximately $6,000 and serves an average of 200 patients. Two-thirds of patients served are children, adolescents, and parents. Approximately 40% time is devoted to direct service to patients, 40% providing consultation to medical providers, and 20% to clinical documentation, coordination, and supervision.
- They provide leadership in the delivery of clinical services, can function across sectors, and have specialized training in systems-change.
- They can conduct psychological assessments. Prior to the grant, all children requiring psychological assessment were sent out-of-county. One licensed psychologist, employed by the special education cooperative, is contracted by the community mental health center so that assessment services can be billed to third-party payors. The licensed psychologist participates in the Comprehensive Inter-disciplinary Assessment team which staffs the most mystifying Tier IV cases and takes the lead on assessments when they are warranted.

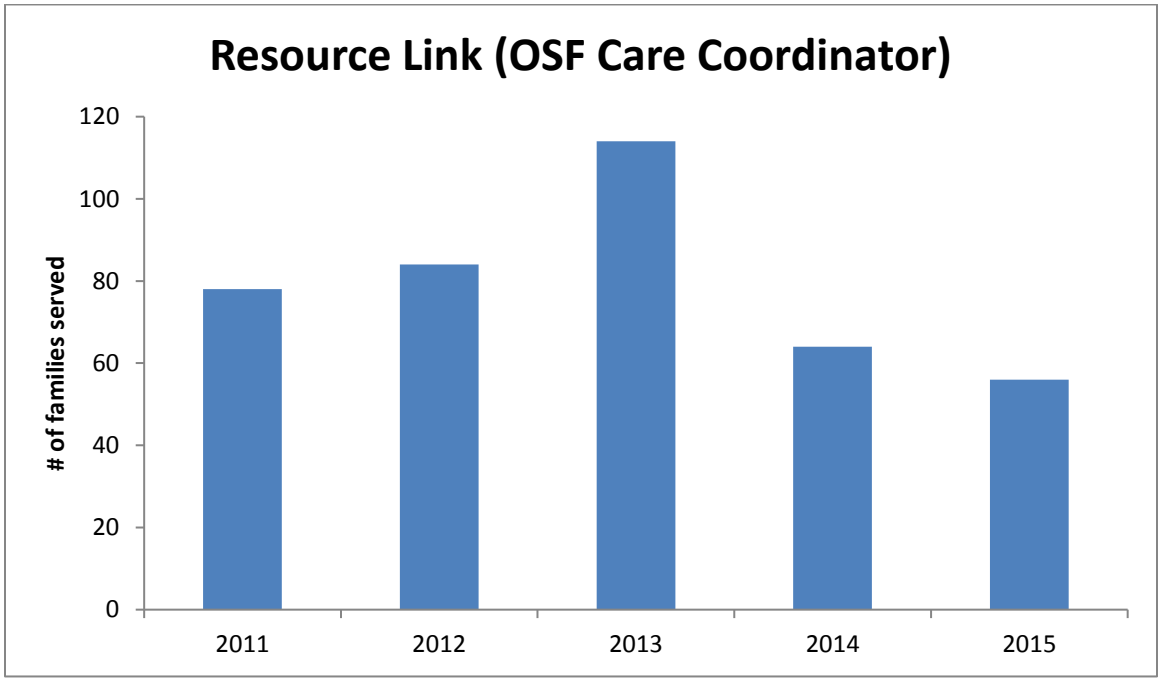
School Psychologists/School Social Workers: The special education cooperative and the two largest school districts employ a total of 17 FTE school psychologists and social workers plus the 4.6 FTE doctoral-level psychologists already counted above. Since 2010, there has been a 1.0 FTE increase due to a vacant position being filled. With all the increased responsibilities for Tier I, II, and III services, ideally we would be able to add at least 2.0 FTE in this category; however, the maintenance of several trainee positions to assist with implementation partially meets this need and ensures access to a pool of high quality applicants for any vacancies. Just prior to the 2014-2015 school year, LCSSU received the resignation of one school psychologist; two part-time school psychologists were contracted to fill in; however, the full-time position continues to be posted.

Case Managers: Our model has several different individuals who might fall in this category and we are monitoring the function of these positions as described elsewhere in this report. Not mentioned is a slight increase in FTE for home-visiting and case management support for at-risk mothers through a different health department grant. **In addition to the individuals described below, the Project Manager, a school psychologist at LCSSU, and the Tier IV Facilitator, the clinical director at IHR, with some LCCN grant funding, serve as point people for the educational and mental health sectors, respectively.**

1) Resource Link Care Coordinator: Just prior to the LCCN grant implementation, OSF created a grant-funded position entitled, “Care Coordinator” to serve in the medical sector. The individual, a social worker who had previously been employed by St. James

Hospital, served another county as well and was charged with case management for patients referred by any doctor (OSF and Non-OSF) needing therapy. Following referral, she met with the family to understand the child's needs and then facilitated follow-up with IHR or another provider of their choosing. She then continued to follow the case until the family was regularly attending appointments. Her responsibilities also included facilitating the consultations between primary care and child psychiatry. She coordinated the calls and typed and disseminated a summary of the plan. Since we have begun universal screening in doctors' offices, her role has increased. All positive screens from primary care for 6-18 year olds come to her. She often makes a referral to the school psychologist or school social worker at the child's school for Tier II follow-up. Some positive screens require or prefer referral to a non-school provider. The Care Coordinator is an active member of the CIA team, communicating information, recommendations, and questions to and from medical providers before and after each staffing. OSF has assumed full responsibility for funding this position which has served incrementally more children each year. In 2014, however, there was a dramatic decrease in the number of families being served by Resource Link in Livingston County. The reason for the decrease is a change in the largest pediatric practice in the county; the new physician in the practice is very comfortable with managing mental health concerns in primary care. This practice alone referred 50 fewer patients in 2014 as compared to 2013. The county now has therapists embedded in all the rural OSF practices and the large Reynold Street practice in Pontiac which may or may not have had an impact on the number of referrals to Resource Link. In addition, the LCCN has utilized the Care Coordinator in other ways that are not reflected in her care coordinator figures: to connect families with a medical home and to serve on the Comprehensive Inter-disciplinary Assessment Team.

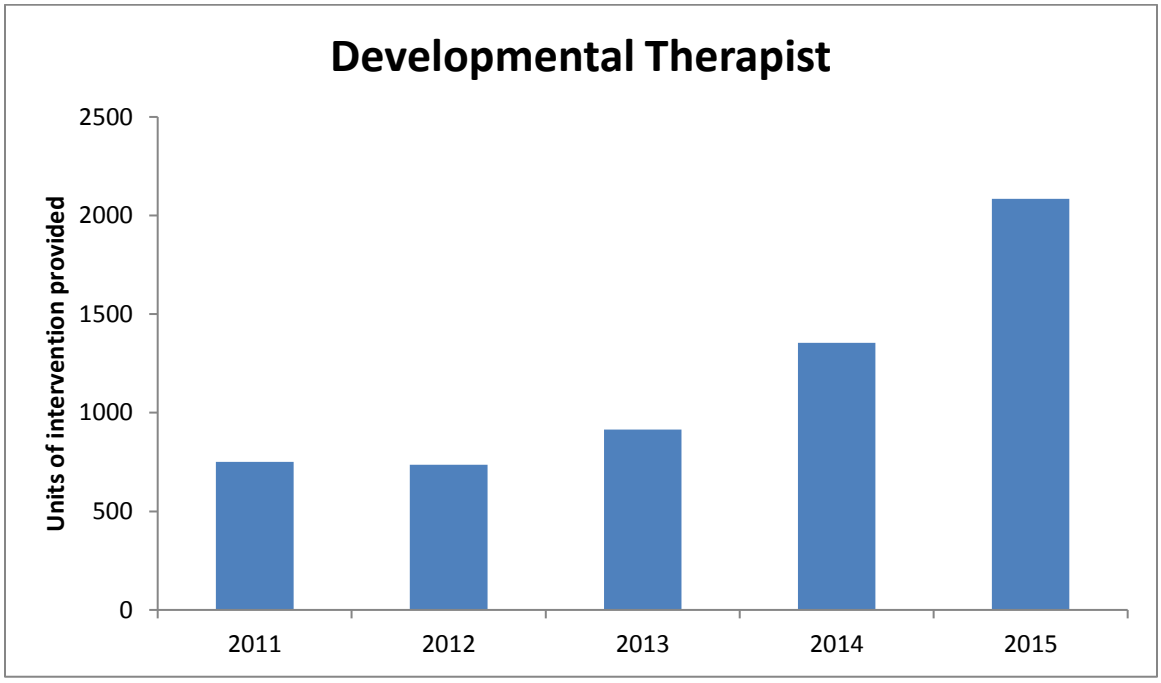
	2011	2012	2013	2014	2015
# of Families Served	**78**	**84**	**114**	**64**	**56**



2) Developmental Therapist: One full-time developmental therapist provided the bulk of developmental screening for 0-3 population in the county prior to the grant; the program, which is housed in the Rehabilitation Department at OSF St. James Hospital, is funded in large-part by the Mental Health Board. The program provides children in Livingston County birth through three years of age the following services; identification of children at risk of developmental delays, identification and referral of children with developmental delays, developmental education, developmental stimulation, and environmental enrichment. Children at risk for delays are afforded an opportunity to interact with children with and without developmental delays and to learn preschool readiness skill instruction. Services are provided in the child's home to foster growth and education in the natural environment unless the family requests services be rendered at the hospital clinic or another setting. A developmental playgroup is offered in a variety of settings in the county for social development and a transition group is provided for children two and one half through three years of age in an instructional setting. All positive screens from primary care for 0-5 year olds come to the developmental therapist for case management. Positive screens for 3-5 year olds are typically referred to the special education cooperative (LCSSU) or District 429 for Tier II or Tier III follow-up. After reviewing the data and speaking with the parents of 0-3 year olds, the developmental therapist frequently moves forward with a global assessment and begins early intervention with no delay. She is also conducting a parent-child attachment-building group. The Mental Health Board funds services to children with <30% delay while children with greater delays are funded through the state early intervention contract. As her caseload has increased, she has taken on some trainees and referred some children with more narrow problems to specific disciplines such as occupational therapy or speech pathology.

Below are data on her Tier II and assessment services, which have remained stable and while Early Intervention Services have increased by 84%. The enormous increase in the amount of intervention being provided within the OSF Early Intervention program has led to conversations about increasing capacity. The community is exploring possible mechanisms to increase the amount of services available to 0-3 year olds with social-emotional needs and their parents. There have been other changes in the socio-political landscape that are influencing service delivery in this age group. A couple years ago the Child and Family Connections contract was rebid and there have been a number of problems within the system of care since the contract landed in Champaign. Children are being referred for assessments to out-of-county providers and youngsters in the system are not receiving services in the coordinated and seamless manner provided by the Livingston County Children's Network. School providers are consistently reporting missing or delayed reports. Other concerns on the horizon involve proposed changes in criteria for Early Intervention services and funding.

	2012	2013	2014	2015
Infant-Toddler Enrichment Program	**12**	**10**	**11**	**10**
Infant-Toddler Play Group	**24**	**22**	**18**	**27**
Referred to Early Intervention (0-3)	**17**	**22**	**34**	**32**
Referred to School District (3-5)	**13**	**22**	**11**	**8**
Global Developmental Evaluations	**17**	**19**	**18**	**10**
Early Intervention Units	**736**	**917**	**1354**	**2084**



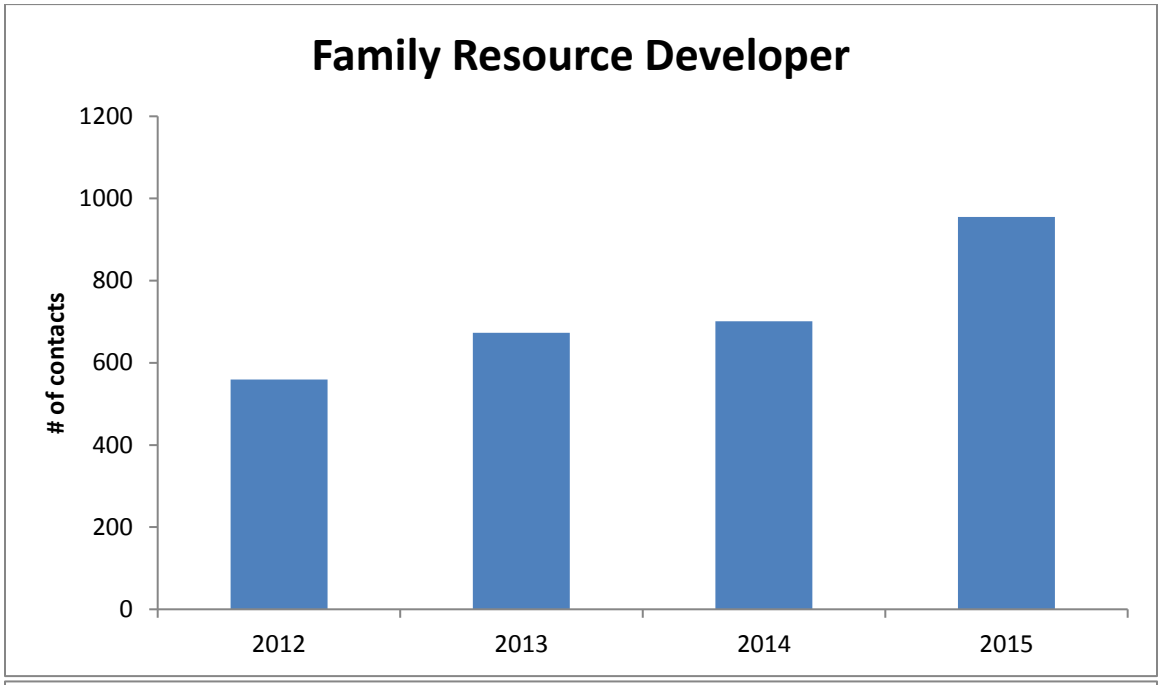
3) Family Support Specialist (FSS): Prior to the grant, the individual who is now serving in this role, a bachelor's level social worker, was funded by the Livingston County Youth Commission and the Mental Health Board through several funding streams. When funding for some of those programs was cut, the community seized the opportunity to develop her role and utilize her skills in the juvenile court system (.6 FTE); she is currently LCCN grant funded. The presiding judge added language to the pre-trial paperwork that required all families to meet with the Family Support Specialist for screening and referral. A big part of her job is to facilitate communication across providers, serve on the CIA, and support families in navigating the various systems serving them. In addition to providing case management for families with many risk factors (i.e. homelessness, DCFS involvement, unemployment, substance abuse, domestic violence), she is involved in the initial stages of developing a juvenile mental health court. Her remaining FTE continues to be funded by the 708 and 377 boards and involves participation in adult mental health court and serving individuals with developmental disabilities. Our sustainability plan will include on-going funding for this role. The FSS is providing intensive supports to these highest need youth. In 2014, the scope of her work increased to include screening of youth being served by the ACHIEVE Center (educationally at-risk youth) and those on probation without court involvement. Data regarding youth outcomes are provided on p. 19-20.

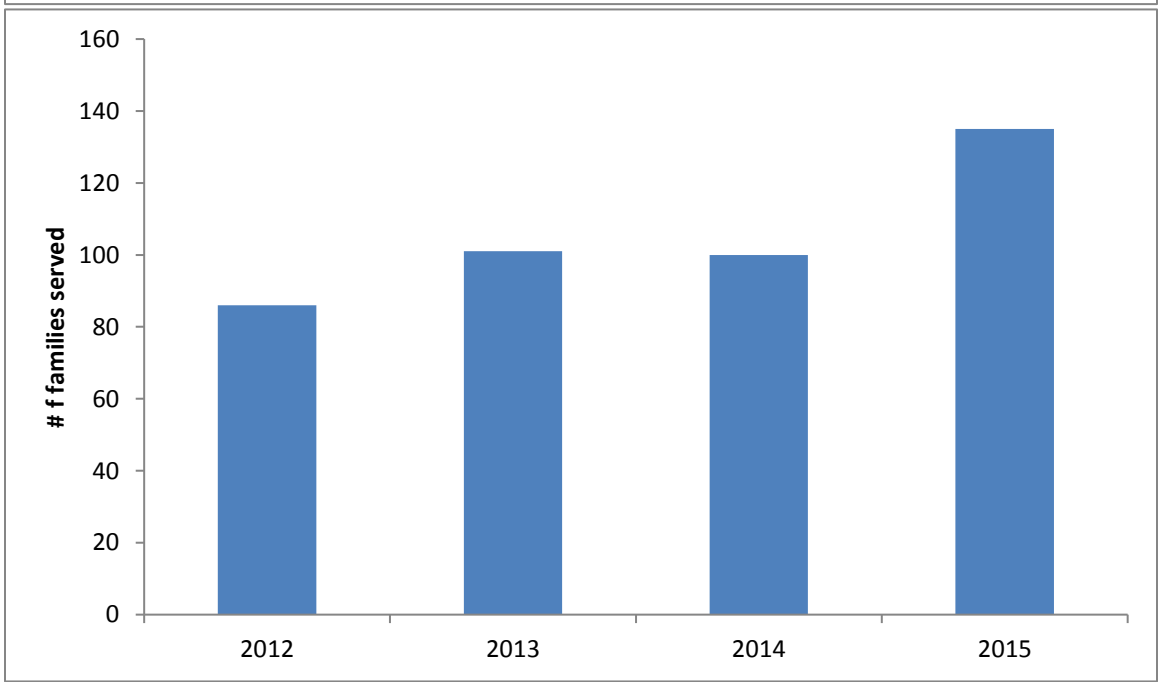
	2012	2013	2014	2015
# of New Families Served	**54**	**5**	**20**	**4**

4) Family Resource Developer: We have one individual who provides parenting and in-home supports to parents of children in SASS. As a result of the needs identified in the CIA and in the self-contained programs for children with emotional and behavioral disorders, we increased her time from .6 to .8 FTE in 2014 and finally 1.0FTE in fall of 2015. When not working with families individually, she conducts parent training groups for those mandated by DCFS to attend. She also provides foster parent training and

serves as an educational advocate. The position will be maintained by a braiding of funding streams..

	2012	2013	2014	2015
# of Contacts	**599**	**673**	**701**	**955**
Families Served	**86**	**101**	**100**	**135**





Our focus has been on increasing therapy and case management resources. We have successfully retained some employees through innovatively braiding funding streams and

assignments and by accommodating the providers' need for part-time rather than full-time participation in the workforce. Many of the positions seem to be self-sustaining with the exception of funding our Project Manager and a portion of our trainees. However, our data suggests that training pre-service practitioners is an inexpensive way to increase FTE to meet the demand for services in the schools as well as a good way to recruit to fill inevitable vacancies. As we prepare for our sustainability plan, we are collecting additional data to share with stakeholders articulating what funding one trainee actually buys the community in terms of clients served.

In 2015, an estimated 97% of the 0-18 population was screened, which is an increase over 93% in 2014. Currently staffing is adequate, but not sufficient to serve those needing some level of follow-up services. We have employed strategies to increase the effectiveness of services. In addition, we have implemented universal interventions and early interventions which are intended, over time, to reduce the number of children needing treatment for disorders such that the need for services can be effectively met with current levels of human resources.

B. Increase skills of current personnel

Our implementation plan requires all adults working with children to be prepared to play a role in their healthy development, consistent with the "it takes a village" philosophy. In essence, providers and even the institutions within which they work were challenged to redefine their professional identity to include various aspects of health promotion. Engaging all professionals in this endeavor to create a seamless and cohesive web of supports required people to perform tasks for which they may never have received formal training. Thus, we determined to provide the necessary training and follow-up coaching. The following are all the personnel groups who have participated in training and associated data collection.

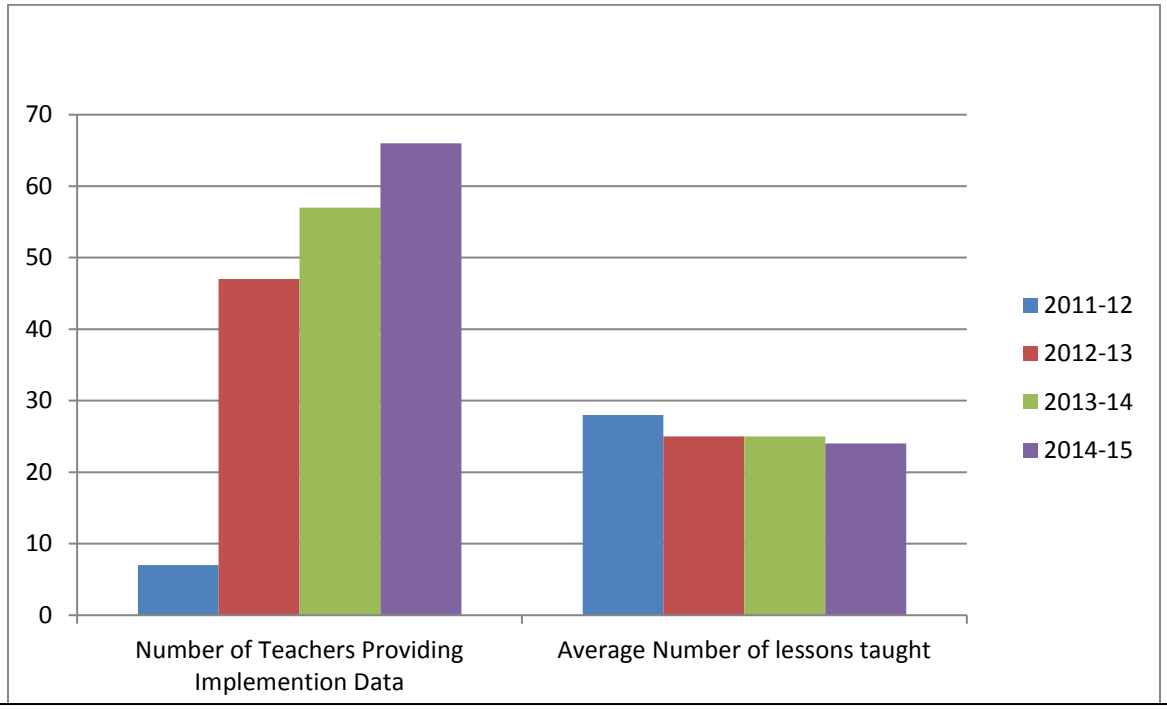
Teachers: Children and adolescents in the community were perceived to be growing up with insufficient social-emotional skills. Social and Emotional Learning (SEL) refers to interpersonal functioning and self-regulation skill development of children in grades K-12 (Elias, 2006). Because of growing awareness of the relation between SEL interventions and positive academic outcomes (Durlak et al., 2011), communities at various levels are encouraging delivery of SEL programs within schools (Domitrovich, Durlak, Goren, & Weissberg, 2013).

An evidence-based classroom curriculum to teach these skills was selected from a field of four by a parent-teacher advisory board. Subsequently, PK-5th grade teachers, selected middle school teachers, and many administrators in all Livingston County schools have received training on completing the screener and delivering Positive Action, a social-emotional learning curriculum. The Project Manager and all school psychologists and social workers at LCSSU have also been trained as Positive Action trainers. Each year, new teachers attend a one-day training hosted by LCSSU. Administrators can recommend teachers to attend a booster training as well.

Teachers voluntarily submit "implementation checklists" upon which they indicate which lessons they have used and which components of those lessons. In Years Two and Three, building-level Social-Emotional Learning Champions distributed and collected checklists from individual teachers to whom they provided coaching; each year a few more teachers submit their data. **Teachers, on average, completed just about the same number of lessons per classroom; however, there remains variability across teachers.**

	2011-2012	2012-2013	2013-2014	2014-2015

# of PK-4th teachers providing data	**7**	**47**	**57**	**66**
Average number of lessons taught	**28**	**25**	**25**	**24**
Standard deviation	**18**	**22**	**26**	**23**
# of 5-8th teachers providing data			**51**	**53**
Average number of lessons taught			**18**	**17**
Standard deviation			**13**	**8**



*(As of 2013-2014 data suggests as many as 4650 out of 5000 K-8th graders have access to the curriculum.)

In the Spring of 2013, we conducted a survey of implementers to explore barriers. The survey suggested that 70% of teachers completing the survey felt that the curriculum met students SEL needs well. Sixty-eight percent reported that students seem to enjoy the curriculum, but only 23% found teaching the lessons enjoyable. Some teachers (27%) reported that they preferred a narrower curriculum that had been delivered by social workers in the past; while another 39% claimed they just did not have enough time to fit in the lessons. Fifty-one percent reported occasionally seeing students using the skills they have learned in Positive Action. Ultimately, 56% said they would continue with the curriculum after the grant but many of them would only do so if their principals continued to prioritize it.

Three strategies were executed in response. First, the expectation was conveyed by administrators that less enthusiastic teachers would deliver the core 25 lessons of the 140 in the curriculum such that children would receive at least one lesson per week. Second, each building principal was asked to select an SEL champion who would receive a small stipend to coach his/her colleagues, to promote school-wide promotion of Positive Action, and to be a liaison to the Project Manager. And third, the SEL champions and all administrators were invited to a training by the author of the curriculum, which is now being used with five million children in the United States.

Currently, there is a wide range of "buy-in." In the largest district, Positive Action is delivered to nearly every student nearly every day. We have learned that administrator enthusiasm and peer coaching, or on-going support for the use of new skills, is critical to the success of this piece of the plan.

Because the curriculum is provided by classroom teachers, effective implementation depends on teachers' willingness to adopt and embrace the role of SEL instructor. We decided it would be important to better understand how teachers' attitudes about school-based SEL have influenced their behavioral intentions with respect to implementation.
The transtheoretical model proposes that behavior change involves movement through a series of stages, beginning with precontemplation (not thinking about change or that change is necessary); contemplation (recognizing a need for change); preparation (preparing for action); action (taking steps to change behavior); and maintenance (working to maintain a change that has already occurred) (Prochaska, DiClemente, & Norcross, 1992). When applied to teacher attitudes about SEL learning standards, the transtheoretical model may be helpful in understanding how likely teachers are to implement SEL curricula in their classrooms.
An online survey was used to assess teacher attitudes regarding SEL and their self-assessment of their stages of change. Sixty teachers completed the survey during the 2013-2014 school year. Teacher reported on their attitudes about the following SEL learning standards.
Additionally teachers rated their readiness to change their roles to include implementing an SEL curriculum. For the purposes of this study the stages of change assessed included Precontemplation, Contemplation/Preparation, Action, and Maintenance.
We found:

- Teacher's ratings for the Precontemplation stage were negatively associated with favorable attitudes towards SEL learning standards.
- In contrast, there was some evidence that teacher ratings for Contemplation/Preparation were associated with positive attitudes about SEL learning standards.
- Finally, strong positive relations were found between teacher ratings of the Action and Maintenance stages of change and attitudes about SEL learning standards.

These results suggest that as teachers move through the stages of change, their attitudes towards SEL learning standards become more positive. Unfavorable attitudes towards SEL are prominent among teachers high in precontemplation; teachers who are thinking about and preparing to change have attitudes towards SEL that are moderately favorable; and teachers high in action and maintenance report favorable attitudes regarding SEL learning standards. Future research should seek to better understand associations between teachers' stages of change and their overt SEL implementation behavior.

In Spring of 2014, 66% of teachers surveyed were in the Action or Maintenance stages and 61% reported using the curriculum at least one time weekly. Data collected in 2015 were very similar to 2014. With the additional data points collected, we will be able to look more closely at teachers' perceptions of their students' social emotional needs over time as well as their views of their own readiness to support those aspects of child development. These data will be analyzed and shared in 2016.

Medical Providers: Staff from all eleven OSF practices participated in a half-day training by EDOPC on administering and scoring the screening measures and providing anticipatory guidance. A "black belt" from OSF and the nurse educator worked with each practice to develop an individualized process map for integrating screening and the subsequent referral process into the work flow. The top-down administrative support for universal screening has been strong and extremely effective in the roll out. We began with the four practices with the most pediatric

patients and the most willingness and slowly added practices until August 2013 such that all 11 practices became engaged.

Each quarter, the following data are pulled from the Electronic Medical Record (EMR): number of patients seen (0-5 and 6-18); number of visits with completed screen, percentage of visits with a completed screen, number of referrals, patient zip code, and number of screens completed during the year (0, 1, 2, or 3). **The percentage of 0-5 year olds screened during a visit has consistently been around 96% while the percentage for 6-18 year olds has been about 91% with the percentage being higher during the back-to-school physicals and lower during other visits throughout the year**. As expected, 6-18 year olds typically received zero or one screen. This past year, as recommended by the American Academy of Pediatrics and consistent with our plan, 33% of 0-5 year olds received 3 screens and 15% received 2 screens; these numbers helped us subtract off duplicates so that we could be more confident in stating the total number of children screened (the actual number of screens completed was greater than the number of children in the community). The data reflecting "number of referrals made" is very helpful because this is the only indication we can get from the EMR that the child screened positive. There may be a small percentage of children with a positive screen for whom a referral is not made, but we have cautioned against this during the training process. Data collected from the Developmental Therapist (0-5) and the Resource Link Care Coordinator (6-18), whose roles are described above, should match the EMR. When they have not, we have been able to go back and investigate glitches in the referral process. These checks and balances were helpful in making sure that screening is happening, that it is being done accurately, and that no zip code is being systematically overlooked.

There are seven non-OSF practices in the county. They are either part of large healthcare systems in nearby counties or independently owned and operated offices. In April 2013, all seven practices were invited to an informational dinner (multiple phone calls, postal mailings and several e-mails). None agreed to attend and the event was cancelled. A Panopto podcast was developed describing the opportunities for grant-supported activities and disseminated by e-mail to the practices. In addition, a series of phone calls and e-mails were made to the office staff attempting to set up appointments to answer any questions about the video. Several office staff responded favorably to having watched the video. In September 2013, the medical sector (OSF) took the lead in hosting the community Summit and once again invitations went out to each of the practices. Ultimately, several office staff of three physicians attended and expressed interest about learning more; these are the non-OSF providers who have the largest pediatric populations. Since that time, two of those practices were provided with screening materials and training. In 2014, one non-OSF practice began implementing screening and follow-up referral. The second chose to implement policies consistent with a large healthcare system in a neighboring county. Without an overarching administrative structure, it has been difficult to communicate with the general and family practice doctors. We have learned that the medical office staff play a large role in the process of systems change. We have learned that much revenue is lost in order for training to take place and for a new process to go to scale and this must be taken into consideration. As a result, the portion of patients that are pediatric may have influenced the responsiveness of the providers to implementing the various components proposed as well as the existing infrastructure for implementing the many new initiatives being required within the changing healthcare environment.

School social workers/school psychologists:
School psychologists and social workers (SP/SW) were trained in Positive Action and screening alongside teachers. Then, they received training and on-going support during monthly staff meetings on how to follow-up on positive screens. At the start of the grant period, SP/SW often

went into classrooms to deliver social-emotional curricula; the new plan proposed that teachers take over this role and SP/SW provide Tier II supports in the form of small groups. Thus, they needed to have evidence-based resources for this purpose. In addition, much of the individual counseling provided to children with special education IEP's seemed to be long-term supportive counseling of a maintenance nature. They needed evidence-based materials to actively address mental health functioning. The SP/SW assisted in selecting Tier II and Tier III curricula for common referral concerns and familiarized themselves with the manuals individually and in small groups. Some individuals went to external trainings by the publishers and came back and shared what they had learned with their peers. The intention was that they would progress monitor the child's symptom improvement and these data would guide treatment. To date, the only SP/SW actually gathering these data routinely are the trainees who maintain actual mental health files that are signed by their licensed supervisors. It is unclear how religiously SP/SW deliver the curriculum; however they do tend to regularly draw from these curricula, as evidenced by the high demand placed on them in the LCSSU library. In 2015-2016, all SP/SW will begin using an online progress monitoring instrument for their individual therapy cases.

Approximately half of the SP/SW employed by LCSSU and the two largest districts consistently attend a voluntary group clinical supervision time during which more challenging cases are presented. This has been highly valued by those who attend as a form of continuing professional development. While Tier II services are primarily skill-building in nature, this group engages in case conceptualization and treatment planning around Tier III cases. On multiple occasions, the group, which tends to think about systems-interventions as well as those for individual students, has drafted informal policies around ethical or high-risk scenarios. For example, they researched strategies for managing dual relationships, which are common in a small rural community where many of these providers live and work. Another example has to do with evaluating self-injury or suicidal risk and breaking client confidentiality. In 2013-2014, the group has enthusiastically responded to the idea of engaging in a "book group" with non-school providers around treatment of children with trauma histories. The online book group participation never really got re-established in the fall of 2014 although providers anecdotally report using the activities in the book and their knowledge from the book with clients. In 2015, we often referred to the book during our Tier IV staffings.

IHR Therapists: A major shift in the service model at IHR involves parent engagement in treatment. In some cases, as is the case in the schools, individual child and adolescent therapy is accompanied by parent consultation. In other cases, however, the target of treatment is the parent-child dyad or the family system. While, in the past, parents would often drop their children off for treatment and head to Walmart for the hour; this practice has stopped. During 2012, 262 families received dyadic or family systems treatment and that number has held steady at 247 families in 2013. We contracted with NTI to conduct several distance learning sessions with the IHR therapists during their regularly-scheduled clinical staffing time. NTI provided some readings in advance on interventions that were dyadic (i.e. Theraplay, Dyadic Developmental Psychotherapy) and then provided a webinar presentation; the clinicians could see the PowerPoint slides and hear the presenter. Technical difficulties prevented it from being as informative as expected. The training encouraged heightened awareness of interventions and some research. Some practical ideas were given as well as reinforcement of what clinicians were already doing. In the long run, though, if they were going to implement any of the selected treatments, they felt they would need to experience a more in-depth training. Nonetheless, the trainings facilitated the groups' thoughts about parental participation in the treatment process.

Several of the IHR therapists participate in each CIA meeting as they present and discuss their Tier IV cases. As data have been collected on the Tier IV cases that have been staffed, it has

become clear that there is a pattern. All of the cases have complicated trauma, attachment, and loss histories. The CIA meetings have been a great opportunity for continuing professional development, and those who participate are eager to be a part of the "book group" over the next few months. The plan has been for everyone to read a portion on their own, dialogue via the internet with providers in other sectors, and talk about the content in the context of current cases while in their own respective group supervision sessions.

In 2014, several individuals received specialized training in trauma-informed and attachment-informed treatments (3=Eye Movement Desensitization and Reprocessing, 1=Theraplay, 8=Trust-Based Relationship Intervention). In 2015, therapists began using biofeedback technology at IHR and in primary care practices and began progress monitoring therapy cases electronically.

Parent Coaching Medical Providers and IHR Therapists: The single most commonly and consistently reported concern across the community has been that of ineffective parenting. Although IHR has always offered a group parent training curriculum that some individuals are mandated by the courts to attend, very few individuals ever participated in it despite free materials, babysitting, food, convenient location, etc. Our implementation plan required a bold and comprehensive strategy to address this identified need. One program, Triple P or Positive Parenting Program, offered a public health approach that seemed to be a good fit. In particular, the idea of providing Tier II parent support in doctors' offices made sense; children almost always have their parents with them when at the doctor and very frequently parents seek their medical provider's advice about social, emotional, or behavioral concerns for their children. We began exploring the model and spoke with medical providers who used Level Three Triple P. They reported that they were definitely pleased that they received the training and were using it in their offices although they found that they typically could only deliver 1-2 twenty-minute sessions rather than four as the model suggests. Mental health therapists, given the shift described above to include parents in treatment, were also identified as appropriate for this training. Twenty individuals (half medical and half mental health) participated in a multi-day training in the Spring of 2011. Since that time, 19 of 20 individuals have been accredited by Triple P. Unfortunately, implementation of the curriculum appears to have been relatively unsuccessful.

We surveyed the providers in the Spring of 2013 and received responses from doctors, mid-level providers, nurses, and mental health counselors who had been trained; over half responded. Eighty-three percent said they used Triple P Parent Coaching with 1-24% of their patients and 90% reported using the Tipsheets with this same percentage. Over 80% of the time, they reported using the curriculum in a single session with no follow-up visits. In nine percent of cases, providers reported that lack of confidence with the curriculum and too few child patients were barriers to implementation. Most providers listed issues with time and money. Over half of providers (54%) reported that the scheduled visit was too short to incorporate Triple P and 73% reported that the curriculum had not been effectively integrated into the work flow. In the comment section providers went on to say that, although they felt the tip sheets and time spent coaching parents was valuable, there were many barriers to implementation. In addition to those listed in the survey, they added inability or lack of knowledge of how to bill for Triple P; the prohibitive cost of training and tipsheets, and lack of administrative support as barriers to implementation.

The IHR therapists continue to use the DVD and hand out the tip sheets with evidence-based strategies for parents, but they strongly believe that most parents who tend to come to IHR require a more intensive parenting intervention than just a few fifteen-minute conversations.

Medical providers have discovered just what the physician champions reported. The curriculum is almost too intensive for them to integrate an unexpected request for parenting help into the busy work flow. Even if they can start a conversation and provide a tipsheet, parents do not return for more parenting help. Basically, we feel like we chose to split the difference between the two groups and ended up with a level of intensity that was not appropriate for either one. This past year we have considered numerous options associated with continued training and implementation of Triple P. As of March 2014, we decided not to pursue roll out of this curriculum to additional venues.

At the tail end of 2014, we disseminated a technology mini-grant request for proposals. Providers in schools, community mental health, obstetrics, and the courts secured devices to systematically utilize technology to facilitate parents' access to parenting resources. OSF has already launched The Newborn Channel as a Tier I intervention and we are working to stimulate increased utilization of expectant and new parents across entry points.

In summary, we have engaged adults across sectors in the responsibility of nurturing children's mental health. In turn, we have provided training that has led to additional kinds and levels of services being available in natural settings such as schools and doctors' offices. Lastly, we have shifted some treatments upstream allowing the therapists and school psychologists/social workers to focus their energies on children and families with the highest needs.

C. Fill identified service gaps

Aside from the prevention and early intervention service and training needs already outlined above, community members and mental health providers reported that the most glaring service gaps were for the highest need families. Historically, children with the most complex needs were referred out of the county for psychological assessments, more restrictive educational, day treatment, or residential programming, and treatment for attachment problems and complex trauma, especially that of a sexual nature. We continue to grapple with serving this high-need population as funding streams continue to be reduced.

Comprehensive inter-disciplinary assessments. Prior to the grant there were four kinds of assessment occurring: 1) global developmental assessments for 0-3 year olds, 2) trans-disciplinary play-based assessments for 3-5 year olds, 3) school-based assessments for special educational planning for 6-18 year olds, 3) intake mental health assessments at the community mental health center, and 4) CANS in the court system. There was no process in place to thoroughly gather data from all sectors to inform treatment planning for the highest need clients. In October of 2011, we began developing and piloting a process called the Comprehensive Inter-disciplinary Assessment (CIA) team. The team is comprised of representatives from each of the main sectors (medical, school, mental health, DCFS, and court) as well as specific providers who rotate on depending on the target client.

In July 2013, we conducted a survey of providers who had participated in the CIA. Respondents rated the following statements on a 5-point Likert scale. In 2015, we repeated the survey and the average ratings occur side-by-side below. Generally speaking, they were very similar across the two data points.

2013/2015

3.9/4.1	How happy were you with the process of staffing a child with the Comprehensive Inter-disciplinary Assessment (CIA) team?
3.9/3.7	How pleased were you with the results?

4.0/4.4	How likely are you to initiate staffing a child or to encourage someone else you know to do so?
4.3/3.44	If you have presented one of your own cases, how well have the staffings increased your clinical effectiveness with the identified client/family?
4.0/3.56	How helpful was participating in the staffing in enhancing your work with other clients?
4.0/3.8	How much do you believe that participating in the CIA process has been or could serve as an effective means of continuing professional development?

Comments about the helpfulness of the process included the following:

- Candid discussion about the child's situation and the possible barriers for success.
- Collaboration. The ability to problem-solve together and take action without having to wait to hear back from each other.
- I loved sitting around with a group of professionals and problems solving the cases. All of the people sitting around the table were empowering and professional. In the past I have participated in similar programs and it was very disempowering.
- Having people there from various disciplines was very useful in obtaining information about possible services, and how to access those services.
- The gathering of the minds, and being provided with the most up-to-date mental health information and getting new ideas. It also helps learning who the other agencies that are providing services.

Suggestions for improvement included the following:

- Knowing how this process worked before coming to a meeting. Clearer expectations for what should be presented and how to prepare.
- Ideas for referrals for specialized treatment/ evaluation if appropriate
- More structure for the meetings, e.g., first up is the IHR therapist for a 5 minute summary, then the school rep for 10 minutes, etc. We gained valuable information, however, it probably could be attained in less time.
- The barriers to service were quite difficult to overcome in some cases, so we spent a lot of time analyzing the problem(s) but saw little positive results from it.
- It isn't always clear who everyone is and what their role is.

In 2013, we instituted more structure in the staffing process and identified point people to synthesize data prior to each meeting. We also developed an explanatory sheet for participants initiating a referral. In 2015, we again revised our referral process and added table tents with names/agencies of team members.

In 2015, we staffed 10 new cases bringing the total number of cases staffed since inception to 40. Two of these cases required the collection of additional formal assessment data resulting in a comprehensive psychological report. Following completion of the first report, a family successfully accessed an appropriate specialized residential treatment program. The second report resulted in connecting a family with appropriate academic and social-emotional supports. Many of those staffed on the CIA also appear in the data below for court-involved youth.

Case Management for Court-Involved Youth. The community suspected that many youth ending up in the court system were those who had fallen through the cracks. These youth were suspected to have experienced barriers to accessing care; in many cases due to an overwhelming number of family risk factors and or parental resistance. By adding the Family

Support Specialist to the pre-trial paperwork, the community aimed to more effectively connect both the family and the youth to needed services. To date, this resource appears to be having a remarkably positive influence.

The data are remarkably positive. In 2013, we were interested in gathering input from stakeholders that might guide our pursuit of future funding for the position. Providers associated with the courts, probation, DCFS, IHR, SASS, and schools were surveyed regarding their perceptions of the FSS's role and performance. All respondents endorsed items indicating that the FSS increases the quality and effectiveness of the system of care and helps to engage difficult families. The comments provided suggest that the FSS is in a unique position to access and communicate helpful information that in turn facilitates work with families across sectors. Seventy percent indicated that her job likely saves them time, but they were unable to quantify this report. One hundred percent of respondents either agreed or strongly agreed with the following statements:

- The FSS made sure that I had the information I needed to provide services to the child and family.
- If I encountered problems in engaging the family, the FSS was available to assist me.
- The FSS has effectively connected families with necessary and appropriate services.
- I am satisfied with the services provided by the FSS.

In 2012, 54 youth were screened; their outcomes were followed over the course of the last four years and the data are included side-by-side in the first column. While probation has been successfully terminated for 57% of youth, it has been surprising to see how many are ultimately placed in DCFS care (19%) and an additional 15% were eventually sentenced to Illinois Department of Juvenile Justice. There was an astounding drop in the number of youth entering the court system with smaller percentages ordered to DCFS guardianship and/or IDJJ in subsequent years.

Youth screened in 2012

	Yr 1	Yr 2	Yr 3	Yr 4
Number screened	**54**			
Positive screens	**40 (74%)**			
% agreeing to MH services	**33 (83%)**			
% followed thru with MH services	**25 (78%)**			
Ordered into DCFS guardianship	**6**	**3**	**1**	**0 (19%)**
Probation successfully terminated	**0**	**12**	**19**	**0 (57%)**
Probation unsuccessfully terminated	**0**	**5**	**10**	**2 (32%)**
Petition to Revoke Probation	**9**	**10**	**1**	**7**
Second Petition to Revoke Probation	**0**	**6**	**2**	**0**
Sentenced to IDJJ	**1**	**3**	**4**	**0 (15%)**

Youth Screened in 2013

	Yr 1	Yr 2	Yr3
Number screened	**5**		
Positive screens	**4 (80%)**		
% agreeing to MH services	**4 (100%)**		

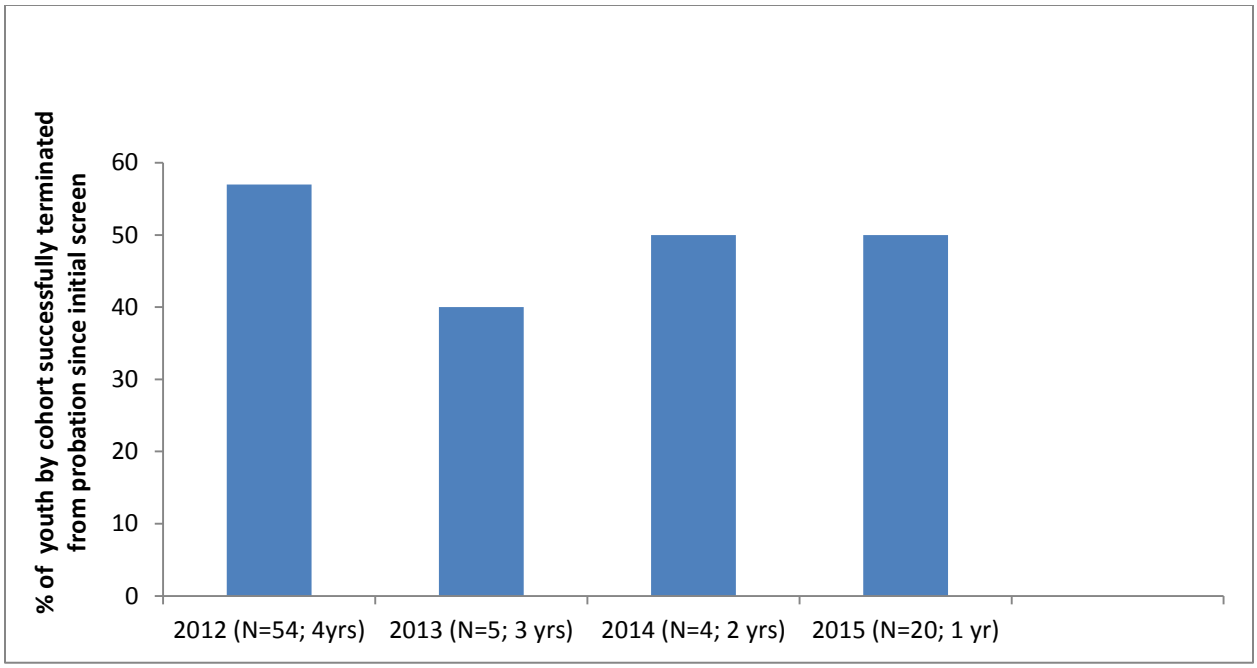
% followed thru with MH services	**2 (50%)**		
Ordered into DCFS guardianship	**0**	**0**	**0**
Probation successfully terminated	**0**	**2**	**0 (40%)**
Probation unsuccessfully terminated	**1**	**1**	**0 (40%)**
Petition to Revoke Probation	**3**	**0**	**0**
Second Petition to Revoke Probation	**0**	**1**	**0**
Sentenced to IDJJ	**0**	**0**	**0**

Youth Screened in 2014

	Yr 1	**Yr 2**
Number screened	**20**	
Positive screens	**12 (60%)**	
% agreeing to MH services	**12 (100%)**	
% followed thru with MH services	**12 (100%)**	
Ordered into DCFS guardianship	**0**	**2 (10%)**
Probation successfully terminated	**3**	**7 (50%)**
Probation unsuccessfully terminated	**2**	**2 (20%)**
Petition to Revoke Probation	**3**	**5**
Second Petition to Revoke Probation	**0**	**0**
Sentenced to IDJJ	**0**	**1 (5%)**

Youth Screened in 2015

	Yr 1
Number screened	**4**
Positive screens	**2 (50%)**
% agreeing to MH services	**2 (100%)**
% followed thru with MH services	**2 (100%)**
Ordered into DCFS guardianship	**0**
Probation successfully terminated	**2 (50%)**
Probation unsuccessfully terminated	**1 (25%)**
Petition to Revoke Probation	**0**
Second Petition to Revoke Probation	**0**
Sentenced to IDJJ	**0**



Beginning in 2015, the program evaluation team has begun conducting an analysis of the juvenile court and probation files to determine factors that lead to successful outcomes for youth.

Educational and Family Supports for Tier IV Youth. In our community, many of the children with the most needs are served through the LCSSU programs for children with Emotional or Behavioral Disorders. Many of these children have histories of psychiatric hospitalization. In fact, there is a good deal of overlap between children referred to the CIA and those attending these programs. In 2014 we staffed many students using the CIA process and improved the coordination of services across sectors and provided services of the Family Resource Developer to prevent further deterioration of child and family functioning. In fall of 2014, the programs implemented a Restorative Justice model in hopes of interrupting the coercive cycle. The teachers, almost all whom were new to LCSSU, were invited to participate in the attachment book group.

D. Identify Funding Sources

Additional information about the various strategies to generate long-term sustainability can be found in our annual sustainability report. Generally speaking, the first step was to explore re-aligning job and entity role definition such that there is little duplication of services. Activities that require less training have been moved upstream leaving the most highly trained practitioners to provide the most intensive services. Many of these activities required “start-up” costs that have now been decreased and assumed by the various implementing agencies.

We are also piloting different positions that braid resources across sectors. We have various models being piloted that provide integrated care and co-located care in community settings and capitalize on local contributions from schools, mental health board, hospital, and third-party payors.

We continue to seek external funds. Our project director monitors funding opportunities daily and forwards them to relevant Executive Council members. Grants are likely to continue to benefit the community for specific components of the initiative.

We continue to advocate for changes in the larger system of children's mental health care in Illinois. We hope to communicate with state agencies and legislators about the unique needs of rural communities and innovative ways to braid funding across sectors. In 2015, we were invited to participate with the Sargent Shriver National Center on Poverty Law in a collaborative policy initiative with other communities attempting comprehensive inter-disciplinary efforts to improve children's mental health.

We have pursued several action items to move towards sustainability. Members of the LCCN Executive Council submitted a proposal to the Livingston County Commission on Children and Youth requesting to be adopted as a separate cost center within this pre-existing 501c3. We developed and disseminated a "community scorecard" to consistently communicate the progress of the LCCN to stakeholders each year and presented it at our Annual Summit in November. In 2015 we engaged natural supports, parents, and youth in raising awareness of children's mental health through a walk and plan to continue similar outreach events in conjunction with children's mental health awareness week in May.

After removing funds associated with program evaluation and grant administration, the grant has provided approximately $60 per child per year. The members of the Executive Council drafted a Sustainability Plan outlining what each entity has committed to contribute to the on-going maintenance of the system of care post-grant funding.

Goal 2. Increase accessibility of services

Objectives:

- Identify barriers to utilization
- Decrease stigma barrier
- Decrease financial barrier
- Decrease transportation barrier
- Increase awareness of services & how to access them

Methodology:

- Frequency Count: # of families assisted with securing Medicaid/Health Insurance; special education students on Medicaid, clients served in community settings
- List of barriers reported by parents during case management
- Cohort parents' self-reports of stigma, personality & parenting

SUMMARY: The community has successfully increased access to services. In schools, 94% of elementary children are in classrooms with a teacher trained in Positive Action and equipped with the evidence-based curriculum. Implementation continues to vary; however, 66% of teachers report being in the Action or Maintenance stage in their readiness to adopt their new role as instructors of social-emotional learning. Students receive an average of 25 lessons per year which is considered by the publisher to be the bronze level of fidelity.

The community mental health center, Institute for Human Resources, served nearly three times as many children and adolescents in 2015 than in 2011 (1266 vs. 464). More parents of 0-5 year olds and 6-18 year olds have accessed parent consultation and support with increases of 183% and 57% respectively. Since our DHS office closed, the Livingston County Health Department has helped more families access Medicaid and other health insurance. The number of special education students on Medicaid has increased from 470 in 2011 to 651 in 2015. Increased access to services is due in part to the community's efforts to place providers in natural settings such as home, church, doctors' office, library, park, and school to overcome stigma, finances, and transportation. For example, there are part-time clinicians in six primary care practices. Therapists employed by schools, mental health center, courts, and primary care now have tablets to assist clients in accessing on-line resources.

We know that we can have the highest quality services and plenty of providers and still not make a difference for children who are struggling if adults in their lives are not able, or choose not, to access supports when they are needed. The literature on rural health describes numerous barriers faced by families living in sparsely populated regions, and we have drawn ideas from many of these resources as well as reflecting on lessons learned in the community with previous efforts to support the provision of health services.

A. Identify barriers to utilization

During intake, the case managers described above ask families about any anticipated barriers to treatment utilization and these data are gathered by the Project Director quarterly. No one has mentioned stigma directly, but the literature suggests it is often a large barrier in rural areas. People who have accessed medical care and the Resource Link Care Coordinator do not report barriers to services; they may state that they don't want the schools to know their child's problems (i.e. stigma) or report a prior bad experience with IHR as reasons for not pursuing

treatment in the community. It appears that many families with more means go to cities outside the county where there is more variety of specialty care providers. In the 0-5 population, the most common population to report concerns about accessing services are families who face language barriers or are not US citizens. Families in the court system, though, typically list many stressors associated with basic survival that have prevented them from accessing Tier I, II, and III level services. Many children reside with individuals who are not their guardians which makes securing parental consent for services challenging. Other barriers include lack of housing, phone, transportation, income, physical safety, and natural supports. With no homeless shelter, it is difficult to stabilize these families and meet basic needs. As we identify and attempt to treat the mental health needs of many of these traditionally underserved families, we are generating additional referrals for other community resources. It has at times felt as if we are overwhelming these social services and charitable organizations as the extent of the needs in the community becomes more apparent.

As part of the longitudinal cross-site study of children ages 2.5-19 years with positive screens, we have assessed parents' perceptions of stigma. Baseline data, from 61 parents, suggest that parents' own perceptions are remarkably positive for personal feelings, thoughts, and behaviors regarding mental illness. In contrast, their perceptions of how others respond to someone with mental illness were significantly different from, and more negative than, their own feelings, thoughts, and behaviors. Also, the more negatively they viewed their own family member with mental health concerns, the more negatively they perceived others to view individuals with mental health concerns. Parents with more agreeable personalities tended to be less negative in their thoughts and behavior and feel closer to their family member with mental health concerns. In contrast, parents who were more emotionally unstable and more likely to experience unpleasant emotions, such as anxiety, sadness, anger, were more likely to have negative thoughts and feelings toward their own family member. These respondents may not be representative of all parents in the community as they are 1) parents of children with positive screens, and 2) parents who chose to participate in longitudinal data collection. A small sample of parents have completed the measures at multiple points over time. So far, the parents' self-reported stigma and their perceptions of others' stigma regarding mental health has not changed. This lack of change may be due to the small sample size, which does not provide inadequate statistical power to detect effects, or due to the relatively brief period of time that the perceptions have been monitored. One would expect that perceptions such as these would likely be extremely slow to change.

We wanted to better understand the role that stigma plays in the lives of Livingston County youth. Stigma by association (SBA) represents the process through which the companions of stigmatized persons are discredited (Pryor, Reeder, & Monroe, 2012). In other words, SBA refers to the extent that students who have a friend or family member with a mental health problem feel disrespected as well. Previous research has found cognitive, affective, and behavioral components of SBA to be strongly related to perceived public stigma (i.e., perceived societal reactions) and to predict poorer psychological well-being across various stigmatizing conditions (Pryor, Boss, Reeder, Stutterheim, Willems, & McClelland, 2012; van der Sanden, Remko, Bos, Stutterheim, Pryor, & Kok, 2013). In addition, physical and psychological complaints have been reported as symptoms of psychological distress caused by SBA (e.g., irritability, insomnia, fatigue, as well as neck and shoulder pain; Angermeyer, Liebelt, & Matschinger, 2001). Thus, we expected SBA to be associated with more symptoms reported on the Pediatric Symptom Checklist in our high school students who reported knowing someone with a mental health problem.

We were interested in exploring the role of perceptions of public stigma and stigma by association as predictors of psychological symptoms among our high-school students. We analyzed self-report data from 160 high school students from 5 schools in Livingston county, with 94 students (59%) who knew someone with a stigmatizing condition (e.g., ADHD, depression, anxiety, or Autism Spectrum Disorder). Correlational analyses revealed that, not only was public stigma positively associated with psychological symptoms, but SBA perceptions among students who knew someone with a mental health problem were also correlated with psychological symptoms.

We were also interested in understanding how students' perceptions of school climate might relate to their experience of stigma and their functioning. Previous research has consistently linked school climate to important student outcomes. The National School Climate Council (NSCC, 2015) defined school climate as the quality and character of school life, including students' perceptions regarding the social, emotional, and academic environment of their school. Positive perceptions of school climate are associated with reduced levels of emotional and behavioral problems and improved psychological well-being (Kasen, Johnson, & Cohen, 1990; Kuperminc, Leadbeater, Emmons, & Blatt, 1997; Kuperminc, Leadbeater, & Blatt, 2001; McEvoy & Welker, 2000). Virtanen and colleagues (2009) found that lack of trust and reduced opportunities for participation were associated with youth-reported depression and physical and psychological symptoms.

Within our sample of 160 high school students, overall school climate, as well as several subscales of school climate (i.e., Safety and Relationships) were negatively associated with psychological distress. In other words, students who reported less positive views of their safety and relationships in school reported more psychological distress. And, students who reported more social support reported somewhat less stigma by association. Students who reported more public stigma felt less safety.

The findings highlight the importance of decreasing stigma in schools, particularly feelings of public stigma. The findings also indicate that increasing feelings of safety (i.e., safety from physical harm, verbal abuse, and teasing) and positive relationships (specifically student-to-student relationships) in the school setting is critical to protecting students from the effects of public stigma on psychological functioning.

Another barrier to accessing services is school attendance. Members of the community have been concerned about truancy. In 2014, we analyzed data provided by parents and teachers of 198 children in grades Pre-K through 5th grade. We discovered correlations between children's poor attendance and other concerns. Teachers identified a connection between poor attendance and children's academic functioning (e.g., learning problems, attention problems, study skills) while parent ratings identified an association between poor attendance and externalizing behavior (e.g., hyperactivity and "acting out").These findings highlight the importance of developing school environments that address both the academic and the social-emotional health of children with poor attendance and provide support to parents who may be overwhelmed by their children's externalizing behaviors.

B. Decrease barriers

In 2010, community members complained about the wait to get a therapy appointment. Through increasing the number of providers and reorganizing therapists' schedules at IHR (our community mental health center), there are four open intake slots daily and time of referral to first appointment is now a matter of days. Appointment times for psychiatric services have been

greatly reduced, as described above, such that a new appointment can be secured within three months.

Financial barriers, in terms of the cost of treatment, have been greatly reduced or eliminated by providing therapy in natural settings and utilizing local funds from the Livingston County Mental Health Board or Livingston County Special Services Unit. Since February 2013, we have been designated a Health Service Provider Shortage Area (HPSA) in the area of mental health, and, although we do not know the overall outcome of new state and federal policies, we may have additional mechanisms to support the provision of services through the Affordable Care Act and innovative billing options associated with rural health care. Medicaid enrollment in our community is a confusing matter. Although we have a very high Medicaid population-to-provider ratio in comparison to other communities in Illinois, it appears that many of our residents who would likely be eligible for Medicaid are not enrolled. Our DHS office closed in August 2012 and since that time families have had to drive to Bloomington to be served. Each quarter, our Health Department has provided assistance to families wishing to enroll in Medicaid (see chart below). The numbers of families have increased over 40% from year one to year two. During the fourth quarter of year two, the Health Department began providing in-person assistance for the insurance marketplace and engaged 36 additional individuals during through this service. During 2015, only nine families total were enrolled during the first two quarters of the year.

	2012	2013	2014	2015
# of Families Served	**28**	**40 (+36 Marketplace)**	**51**	**9**

The Health Department staff report nearly insurmountable barriers for many families attempting to enroll at a distance, many of which are perceived to be due to the inadequate staffing and resources in the DHS office. However, the special education cooperative has seen a steady increase in numbers of special education children on Medicaid suggesting that these families, at least, are continuing to successfully renew their enrollment.

	2011	2012	2013	2014	2015
# of Medicaid-enrolled Special Education Children	**470**	**490**	**580**	**653**	**651**

According to the latest Livingston County Health Department Community Needs Assessment & Community Health Plan (2015-2020), 92.4% of Livingston County residents have health insurance (public/private) compared to 87.1% of Illinois. Livingston County had 34.0% of public health insurance compared to 28.9% for Illinois.

The number one strategy that we have implemented to decrease all barriers (stigma, transportation, funding, child care) is to offer services in community settings. School-based providers employed by LCSSU provide group and individual therapy to students and these services are funded by the cooperative. IHR therapists are embedded in all five of the rural OSF practices as co-located providers and these sessions are fully funded through a fee for service contract with our own mental health board. IHR therapists are now also providing additional part-time therapy services in three high schools.

	2012	2013	2014
Total # of IHR clients served in community settings	**440**	**643**	**911**
# of child/adolescent served in community settings	**190**	**243**	**434**

The Clinical Director at IHR has been encouraging clinicians to connect with families by telephone in between sessions to facilitate progress. In 2013, we saw a decrease from 67 cases

to 37 cases engaging in tele-therapy. We plan to continue this practice but also explore other avenues of communication. As we look forward to the remainder of year three and anticipate further addressing barriers to care in year four, we have identified a number of ways to utilize technology to increase consumer access. OSF Healthcare System is implementing the Newborn Channel which provides web links to clips of information about positive parenting practices and child development. As we explore parenting programs for older children, we are finding many resources available in a similar format. Practitioners across sectors require devices to utilize in their offices to connect patients with these resources. In addition, many evidence-based treatments are now being delivered online, with guidance by clinicians, during and between therapy sessions. Lastly, efforts to progress monitor therapy outcomes have not gained traction. Therapists report that they would like to administer progress-monitoring tools on a tablet which could score the measure and provide immediate feedback to clients. The data would then be uploaded to their respective entities so that patterns in the aggregate data could be explored.

In summary, we have attempted to address barriers such as stigma, finances, and transportation by infusing mental health services in other natural settings. While these strategies appear to be increasing the number and types of assistance that are being utilized, moving forward we plan to explore more fully how technology can connect youth and their parents to needed supports.

C. Increase awareness of services and how to access them

The biggest focus in the early years has been on developing awareness among providers in all sectors of what services are available and how to successfully make appropriate referrals. We have made huge strides in this area. Having fully informed “case manager” positions in each sector has also facilitated access as well as navigation of the system.

Each quarter, members of the Leadership Team report various avenues by which they have raised awareness within the community. These activities include presentations to various constituent groups. We have provided news releases, radio interviews, and newsletters. We have distributed promotional items directing individuals to our website, which is very informative. Finally, in the fall of 2013, we hosted our first annual Community Summit. We informed attendees about our process to date and 16 individuals representing the full continuum of care each spoke about their role. We ended with some stories about lives that have been changed as a result of the community’s efforts. Slides and audio of the entire presentation is available through a link on our website. In addition, we hope to engage parents and youth in promoting these priorities in our community. To date, much of what we have accomplished has been TO and FOR youth, and we are interested to learn more about our youth’s interests around promoting mental health. For example, recently, the teens at Pontiac Township High School created a YouTube video to promote acceptance of classmates with cognitive impairments. Prairie Central High School students created a mental health awareness video.

In the fall of 2014 and 2015, we hosted Community Summits during which we presented our “community scorecard” that shares progress on metrics important to the community. Short promotional videos were shot at each Community Summit and are being used by stakeholders to increase awareness and buy-in. We conducted a walk for children’s mental health and other activities in May 2015 to coincide with National Children’s Mental Health Awareness Week. Youth staff of Operation Snowball played a large role in the success of the walk in the elementary schools. We distributed T-shirts that continue to be worn regularly in the schools.

Goal 3. Increase coordination of services

Objectives:

- Promote linkages to the medical home
- Increase likelihood of successful transition from one setting/provider to another
- Increase collaboration between providers serving same clients
- Utilize data to evaluate process & outcomes

Methodology:

- Percentage of pre-school students with medical homes in-county, in practices with implementing provider, out-of-county.
- Frequency Counts: # of families connected to medical home, physicians utilizing tele-consultation, patients in emergency room without medical home, crisis calls/SASS screens/psychiatric hospitalizations, emergency room visits, graduation rates, juvenile police reports

SUMMARY: As seen above, families all across the community are accessing services at greater rates than ever before owing in part to the "care coordinator" individuals in each of the sectors (education, medical, mental health, and juvenile justice). The Comprehensive Inter-disciplinary Assessment team has staffed a total of 40 of our highest need families, planning and providing cohesive and seamless treatment.

We have been monitoring the percentage of preschool children with an identified medical home; the percentage has bounced between 1-6%. We are also monitoring the number of children and adolescents in the Emergency Department without an identified physician; these percentages are very similar suggesting that the population utilizing this setting for medical care may not be substantially more likely to lack a medical home. Each year, the Resource Link coordinator has provided assistance to families needing a medical provider and that number has remained consistent and low (6-9). The number of visits to the Emergency Room has fluctuated between 2200-2500 over the last three years; there was a substantial drop this year (1571).

A. Promote linkages to the medical home

Whenever children enter special education or start mental health treatment their parents are asked to identify the child's medical provider. If one is not provided, the provider requests a release of information and makes a referral to the Resource Link Care Coordinator who helps establish a connection for the family with a medical practice. The Care Coordinator, in turn, connects the child's medical home to other providers in schools, mental health, and psychiatry. Each quarter, she reports the number of referrals. In 2015, Resource Link postcards will be provided to all families at school registration who do not list a primary care provider.

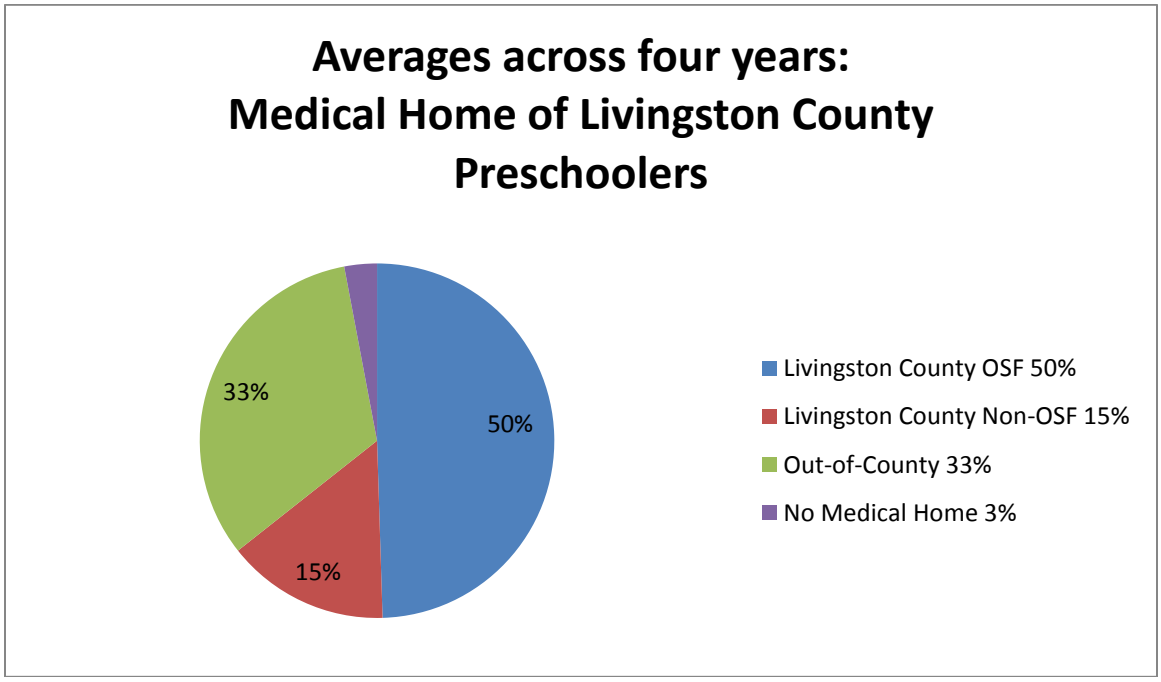
	2012	2013	2014	2015
# of Families connected to Medical Home	**6**	**9**	**8**	**10**
# of PCP Seeking Psychiatric Tele-consultation	**Unk**	**19**	**22**	**22**

This year, we chose to look closely at the data for pediatric patients who visited the Emergency Department. The generally held assumption is that families without medical homes utilize the Emergency Department more frequently than do others. In 2014, 4.8% of all pediatric *visits* in the emergency room were by families who did not provide the name of a primary care physician.

Of the *patients*, 5.8% had no medical home. In 2015, these numbers were 5.4% and 5.9% respectively. These two figures suggest that the overall percentage of pediatric patients in the emergency room without a primary care provider is fairly stable and probably similar to the percentage in the population that attends pre-school screenings.

At the trans-disciplinary play-based screenings, experienced by a vast majority of 3-5 year olds in the county, the facilitator records the names of medical providers and submits them on a quarterly basis to the Project Director. These data haves allowed us to get a snapshot of where children get their medical care. These data are particularly important when we think about our universal components, such as screening or parenting resources, reaching all families. We discovered that one-third of our children have a doctor outside of Livingston County and may not receive an annual screening in that setting. Also, for example, if The Newborn Channel is prescribed for families going through the birthing process with an OSF doctor then it is likely that at least the 11-17% of families who have chosen a non-OSF provider in Livingston County will miss out on this Tier I parenting intervention (although OSF has made it available to additional families through Early Intervention and the Health Department).

	LC OSF	LC Non-OSF	Out-of-County	No Medical Home
2012	**51%**	**16%**	**31%**	**2%**
2013	**41%**	**17%**	**36%**	**6%**
2014	**59%**	**14%**	**26%**	**1%**
2015	**48%**	**11%**	**37%**	**4%**



B. Increase transition and collaboration between providers

Three changes have been made that have helped us meet our objective, to increase transition and collaboration between providers.

- The LCCN has developed a set of universal LCCN forms as well as flow-charts that have facilitated a much more seamless journey across and through the system of care.

- "Case manager" positions in each of the sectors utilize these forms and monitor the effectiveness of the communication protocols between providers.
- For the highest-need families, the CIA meets face-to-face to develop cohesive and coordinated treatment plans for all children in a given household.

At the start of the grant, it was suspected that distribution of providers' time might shift as the plan was implemented. In November 2011, we chose to look closely at one sector. The LCSSU school psychologists and school social workers were asked to log their time for two weeks to establish a baseline measure of time spent across various duties in their job descriptions. We anticipated that time spent in consultation with school personnel would increase as they provided support to teachers around Tier I and consultation with parents, medical providers, and mental health therapists would increase as the system of care became more seamless. We were completely taken by surprise by the number of hours that social workers were spending in communication with medical providers, an average of 2-3 hours each per week, in an effort to remove barriers to learning. Social workers were even, on occasion, authorized by parents to take children to medical appointments. Examples include securing treatment for severe eczema, inhaler for asthma, eye glasses, pain associated with decaying teeth, and side-effects associated with psychotropic medication. This communication with the medical home is only possible if the social worker can secure a signed release of information. We are considering whether to ask parents to sign a release at school registration.

C. Utilize data to evaluate process and outcome

Early in the planning process, the community determined that there would never be enough resources to serve all children with mental health concerns in the county if we continued with a model that focused our energy on treating our highest need children. Rather, we needed a public health approach that provided all children 0-18 with supports commensurate with their needs. At Tier I, we implemented strategies that would promote the well-being of children and families. Subsequent to universal screening, we utilized Tier II evidence-based strategies to support children and parents so that they could get back on track. For children who had already developed disorders, we provided Tier III, individual therapy, in accessible venues. And finally, for our highest need situations, children and their families are receiving intensive and frequent supports from multiple agencies to restore the family system to health. We have a graphic of a triangle which should fit nicely over the four levels of treatment such that most children (85%) need only our Tier I. Perhaps as many as 10% might fall in the at-risk or Tier II level, leaving only about 5% of children in Tiers III and IV. Mid-way through the launch of these services, we have more of an hour-glass design. In other words, while we are effectively serving most of the children in our Tier I, we also already have a large percentage of children who have pretty significant mental health needs. Over time, we are monitoring the distribution of children at each level of need and are gauging our success by shifting the balance to more children served in Tier I and Tier II and fewer children requiring individual therapy or intensive family systems interventions.

Generally speaking, we are trying to evaluate both the process and the outcome of each change in our system of care. In year one, as part of a doctoral dissertation, we explored several aspects associated with implementation in the schools. Elementary schools were invited to participate in three different pieces of LCCN implementation: Positive Action, universal BESS screening, and an evidence-based Tier II small group intervention for children with positive screens. Of the 13 eligible schools, four schools chose no additional supports, four schools implemented one component, two schools implemented three components, and three schools implemented all three. Results of this study indicated that the only school-level characteristic that was strongly and significantly positively correlated with that decision was average class

size. Schools with larger classes were more likely to implement more prevention components. Schools that served student populations with higher needs, as indicated by lower instructional expenditure, higher percent low income, higher mobility rate, and higher student to teacher ratios, demonstrated weak to moderate relations with the number of prevention components implemented; however, these relations were not statistically significant. Furthermore, schools with a greater percentage of students with elevated scores on the screening measure were not more likely to implement more components as was hypothesized. Other interesting statistically significant findings were that schools with low income students experienced higher rates of mobility and truancy, and schools with higher mobility rates had more children receiving special education services.

A second area studied in year one was treatment integrity associated with the Tier II curriculum, Strong Start, which was delivered by school psychologists and school social workers. Treatment integrity varied widely from 52-89% across the seven practitioner groups. The first threat to treatment integrity was that the lessons were designed to be 45 minutes in length so they were adapted to accommodate the shortened time allotments for the group, which were an average of 24-35 minutes. Some practitioners simply did not stick to the script and integrated other activities from other curricula. Others found that behavior management difficulties arose when small groups of children with positive screens were formed. The end result was that the average student receiving the curriculum received only slightly over half the time recommended. Nonetheless, while there were no gains evident on the BESS screener or a measure of emotion knowledge, there were statistically positive gains on AIMSweb early literacy scores for treatment adherence and treatment dosage. **In other words, if practitioners used the social-emotional learning curriculum as it was intended, children experienced reading gains, AND the more of the curriculum the children received, the greater the influence on their reading scores. These local data provides strong support, consistent with research in the literature, that social-emotional interventions often have an astounding influence on academic performance.**

Similar to the processes encouraged in the schools, IHR has an interest in more closely monitoring child and adolescent therapy outcomes. Each quarter, the clinical director reports on the number of children whose progress is being monitored on the Ohio Scales, which was required by DHS at the start of the grant and thus we originally chose not to add another. However, we are considering adding a measure of the therapeutic alliance because progress monitoring is of great interest to the Executive Director of IHR as a predictor for outcomes. We plan to utilize technology beginning in the latter part of Tier III to administer the Youth Outcome Questionnaire at 90 day intervals.

We have consistently tried to promote the practice of systematically monitoring client progress. In year four, by utilizing tablets, practitioners were not only be able to regularly graph client gains using the Youth Outcome Questionnaire, but they were also able to immediately share this information with clients which, research suggests, can be beneficial. In addition, with signed release, they will be able to share these graphs with other providers also serving the same child. Over time, we will be able to look at patterns in the data, which can guide allocation of community resources to certain types of training or treatment modalities.

We are interested in comparing several metrics included in our Livingston County Health Department IPLAN. In the Community Needs Assessment & Community Health Plan (2015-2020), it is reported that Livingston County's health outcome rankings hover

around 50th (out of 102 counties) Our Health Factors ranking increased to 27 in 2016 from a low of 68 in 2012 (previous report was at 50). For health behaviors Livingston County is now ranked 40th where it was at 93 in the 2010 report.

- **Our ranking for "social & emotional factors" dropped from 26th to 49th (and specifically single-parent households tripled from 9% to 27%). Children in poverty increased from 14% to 17%. This category includes education, employment income, social support, and community safety.**
- **Our "clinical care" improved to 6th in the state from 37th in the previous report. This category reflects citizen's access to care and quality of care, which has been a goal of this initiative. Only 10% are considered uninsured in the county.**
- **There are currently 1220:1 mental health providers in Livingston County compared to 560:1 for the state.**
- **Births to mothers under the age of 20 decreased from 14.4% in 2000 to 7.9% in 2011 (compared to 8.2% for Illinois).**
  Child abuse and neglect rates per 1000 were twice the state average in 2011 (17.5 compared to 8.0). In 2012; however, indicated cases of sexual abuse, which were previously also twice the state average, dropped to .7 compared to .67 for Illinois.

- **Crimes against children appear to be slowly dropping in general from an average of 167 per year (2002-2007) to 97 (2011).**
- **Domestic violence is also decreasing with an average of 537 crimes per year (2002-2007) to 176 in 2011.**
- **Motor vehicle fatalities, which have averaged approximately 10 per year for approximately the last 20 years, dropped to 2 in 2013.**

Below are data that are being collected annually and shared with the Leadership Team as an impetus for many course adjustments as described throughout this report.

There are several types of data that each sector has identified for monitoring. Many of these are variables that are not likely to have had noticeable changes so far but will be part of the long-range progress monitoring of the children's mental health system of care.

CRISIS CALLS and PSYCHIATRIC HOSPITAL ADMISSIONS (0-18 yr olds)
SASS Screens and hospitalizations have held fairly steady over the last four years with an average of 86 screens and 34 hospitalizations. The LCCN is designed to proactively and comprehensively address the needs of our youth so that fewer will require these intensive services over time; however, we are pleased that youth who need this level of service are able to access it and receive appropriate care. These data represent incidents rather than individuals.

	2012	2013	2014	2015
Crisis Calls	46	45		
SASS Screens	83	89	81	89
Psychiatric Hospital Admissions	33	42	23	36

EMERGENCY DEPARTMENT VISITS
We are tracking the numbers of visits to the Emergency Room. The hope is that children and adolescents health and mental health needs will be addressed in a more preventive fashion

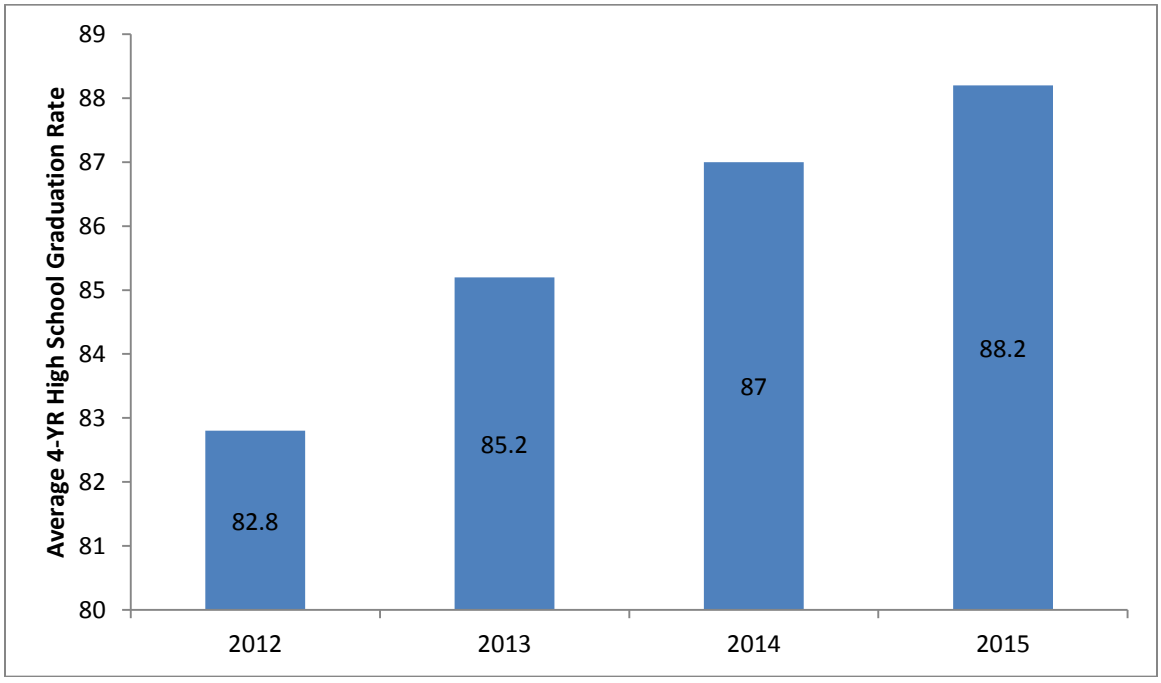
such that these numbers decrease over time. **In 2015, there was a substantial drop in the number of visits in comparison to the three previous years**. These data represent incidents rather than individuals.

	2012	2013	2014	2015
MH-related Visits	55	88	45	61
Total Visits	2273	2854	2490	1571

GRADUATION RATES

Overall, the county's high school graduation rate is gradually increasing! For students requiring an additional year to accrue the necessary credits, the graduation rate is also improving from 84.6% in 2012 to 88.5% in 2015.

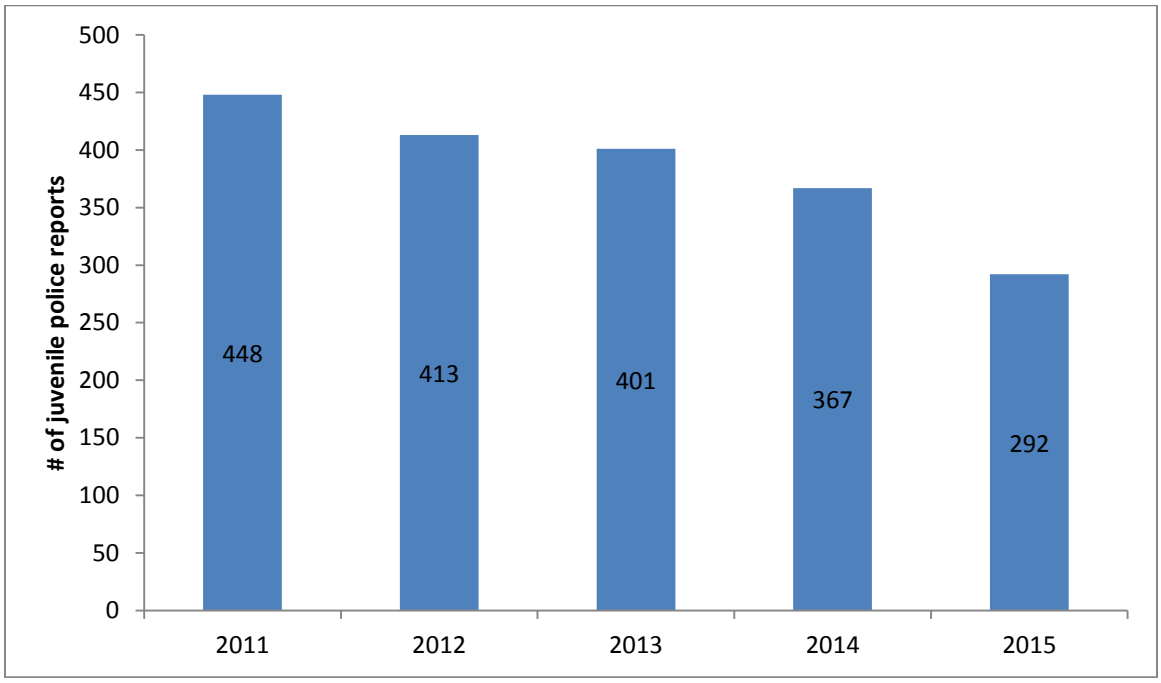
	2012	2013	2014	2015
Dwight				
4-yr	92	79	90	88
5-yr	84	92	80	92
Flanagan-Cornell				
4-yr	83	93	80	91
5-yr	92	83	93	82
Pontiac				
4-yr	87	82	76	86
5-yr	82	88	85	78
Prairie Central				
4-yr	80	90	87	86
5-yr	80	83	88	88
Tri-Point				
4-yr	69	83	92	92
5-yr	80	74	88	94
Woodland				
4-yr	86	84	97	86
5-yr	90	86	100	97



JUVENILE POLICE REPORTS

Probation saw a dramatic drop in average monthly caseloads from 103-104 in years 2011, 2012, and 2013, to only 67 and 78 in 2014 and 2015 respectively. Additionally, a review of juvenile police reports shows a slow but steady drop since the first year of the grant such that 35% fewer youth were arrested in 2015 than in 2011. We believe that these data reflect a decrease in law-breaking behaviors as a result of our prevention and early intervention strategies.

	2011	2012	2013	2014	2015
Juvenile Police Reports	**448**	**413**	**401**	**367**	**292**



Goal 4. Decrease rates of risk behaviors and frequency & severity of mental disorders

Objectives

- Promote child & adolescent social- emotional skill development
- Nurture protective factors (e.g., adult-child relationships & school engagement)
- Identify and support at-risk children & adolescents

Methodology

- Youth self-report of risky behaviors, beliefs/acts of aggression, psychological functioning, perceptions of school climate
- Parent & teacher ratings of children's psychological functioning
- School archival attendance and discipline data
- Frequency counts: # of children screened, # and percent positive, Tier II & III services in schools

SUMMARY: There were 11,556 screenings conducted in 2015 on our 9,500 0-18 year olds. It is expected that very young children be screened more than once per year, and we suspect some youth may be screened in more than one setting (e.g., primary care and schools); thus, it is difficult to accurately state the number of youth screened; estimates range as high as 97%. The percentage of positive screens continued to drop from 17% in 2012 to 9% in 2015. In parallel, juvenile police reports have dropped by 35% over the same time period. These outcomes suggest that the prevention and early intervention efforts are having a positive impact. Ninety-four percent of children in PK-8th grade are in classrooms with a teacher trained in Positive Action and equipped with the curriculum. Of children who screen positive, 70-80% receives group or individual services in schools. High school graduation rates are on a steady climb from 82.8% in 2012 to 88.2% in 2015.

We are collecting several sets of longitudinal data to determine whether we are improving rates of risk behaviors and mental health. The following are baseline data collected for children whose parents gave active consent for participation over multiple years. In the summer of 2014, we compiled data collected during the 2013-2014 year. So far, we have been able to collect baseline data from quite a few children, their parents, and their teachers. The data are consistent with the concerns expressed by adults in our initial needs assessment. The findings have helped us understand, as a community of providers, just how pervasive the concerns are and think about what kinds of resources we need to allocate to different concerns.

Student Self-Reported Risky Behavior Among 7th and 8th Graders (Fall 2012): **Many junior high students report engaging in what could be considered risky behaviors. They also report higher than expected levels of "sensation seeking," which means they choose to do some potentially dangerous behaviors for the thrill of it. Given that the county has consistently had two to four times the state average for fatal accidents, this risk-taking behavior could be a characteristic of our culture that we wish to attend to. Consistent with our original needs assessment, youth appear to have concerns when it comes to body image and violence/bullying.**

- 75% ride bikes and never wear a helmet (71% 2011)
- 45% roller blade and never wear a helmet (same as 2011)
- 40% report that they do not always wear a seatbelt (38% in 2011)

- 43% report that they have or might have ridden in a car driven by someone who had been drinking alcohol
- 7% report that they have tried cigarettes and 13% have tried more than a few sips of alcohol
- 32% perceive themselves to be overweight, 41% are trying to lose weight using methods including fasting (13%), diet pills (3%), laxatives (4%)
- 37% report watching 3 or more hours of television per day, and 22% report video game/computer use for 3 or more hours per day (not including school work)
- 41% have been in a physical fight (5.4% have required medical attention due to injuries from a fight), and 32% have carried a weapon
- 56% have been bullied on school property, 34% have been cyber-bullied

Self-Reported Problem Behaviors Among 5th-8th graders (Early Winter 2012; 224 children): **Any of the areas below that have a total of more than 15% of respondents in the clinical or at-risk ranges suggests that youth are reporting higher than expected levels of concern in comparison with a national sample. Of particular concern and interest are students' relationships with teachers and attitudes toward school, which are known to serve as protective factors for youth. Many of the elevations map on to the original needs assessment. Regardless, though, in terms of the data guiding our allocating sufficient resources for treatment, if we assume that only 12% of our population of children endorses symptoms of depression (one of our lower numbers), that translates to 780 of our school-age youth!**

- **4.9% reported attitudes towards school in the clinical range; an additional 11.2% reported attitudes in the at-risk range (16.1% total)**
- **5.5% reported attitudes towards teachers in the clinically significant range; an additional 12.3% reported attitudes in the at-risk range (17.7% total)**
- **4.6% reported clinically significant school problems; an additional 13.2% reported school problems in the at-risk range (17.8% total)**
- **5.5% reported clinically significant sensation-seeking; an additional 15.5% in the at-risk range (20.9% total) (adolescents only)**
- **8.6% reported clinically significant levels of atypicality; an additional 8.6% reported at-risk levels of atypicality (17.2% total)**
- **7.2% reported clinically significant problems related to locus of control; an additional 10.3% reported at-risk levels (17.5% total)**
- 4.5% reported clinically significant levels of social stress; 10% reported at-risk levels (14.5% total)
- **7% reported clinically significant anxiety symptoms; 10.2% reported at-risk levels (17.2% total)**
- 6.3% reported clinically significant depression symptoms; 5.9% reported at-risk levels (12.2% total)
- 5.9% reported clinically significant sense of inadequacy; 8.1% were at-risk regarding sense of inadequacy (14% total)
- 6.3% reported clinically significant levels of somatization; 8.9% were a-risk (15.2% total)
- 6.1% reported clinically significant levels of internalizing symptoms; 8.4% were at-risk (14.5% total)
- **5% reported clinically significant attention problems; 13.1% reported at-risk levels of attention problems (18.1% total)**

- **6.8% reported clinically significant levels of hyperactivity; 13.2% reported at-risk levels of hyperactivity (20.1% total)**
- **6% were in the clinical range for inattention; 12% were in the at-risk range (18% total)**
- 5.1% were in the clinical range for the emotional symptoms index; 8.4% were at-risk (13.6% total)

Self-Reported Deficits in Adaptive Behaviors Among 5th-8th graders (Early Winter 2012; 224 children): **Consistent with adults' perceptions in 2010, a substantial portion of our youth reported poor relationships with their parents.**

- **6.0% reported clinically significant deficits in their relationships with their parents; 15.3% were at-risk (21.3% total).**
- 4.1% reported clinically significant deficits in their interpersonal relationships; 7.7% were at-risk (12.7% total)
- 4.9% reported clinically significant self-esteem deficits; 9.4% were at-risk regarding self-esteem (14.3% total)
- 10.9% reported clinically significant deficits in self-reliance; 2.3% were at-risk regarding self-reliance (13.2% total)
- 10.2% reported clinically significant personal adjustment deficits; 5.6% reported personal adjustment in the at-risk range (15.8% total)

Teacher-Reported Problem Behaviors Among Elementary Students (Spring 2012; 140 children): **Teachers of our younger students reported that more students than expected experience somatic complaints. In other words, they report physical ailments such as headaches or stomachaches that are often associated with internal emotional distress.**

- 5.7% in the clinical range for attention problems, plus an additional 5.7% at risk
- 2.1% in the clinical range for aggression, plus an additional 7.9% at risk
- 3.6% in the clinical range for conduct problems, plus an additional 7.3% at risk
- 3.6% in the clinical range for externalizing problems, plus an additional 8.6% at risk
- 2.9% in the clinical range for anxiety, plus an additional 5.7% at risk
- 2.9% in the clinical range for depression, plus an additional 6.4% at risk
- **4.3% in the clinical range for somatization, plus an additional 15.7% at risk**
- 6.4% in the clinical range for internalizing problems, plus an additional 2.1% at risk
- None in the clinical range, 2.9% at-risk for atypicality
- 2.9% in the clinical range for withdrawal, plus an additional 10.7% at risk
- Less than 1% in the clinical range for attention problems, but 17.1% at risk (17.8% total)
- 1.4% in the clinical range for behavioral symptoms index, plus 5% at risk

Teacher-Reported Deficits in Adaptive Behavior (Spring 2012; 140 children)

- Less than 1% in the clinical range due to low adaptability; 10.7% at risk (11.4% total)
- 2.9% in the clinical range for low social skills, plus 7.9% at risk (10.7% total)
- Less than 1% in the clinical range for functional communication problems, plus 10% at risk (10.7% total)
- Less than 1% in the clinical range for low adaptive skills, but 7.1 % are at risk (7.9% total)

Parent-Reported Problem Behaviors Among Elementary Students (Spring 2012) – 80 children: **Consistent with teacher reports, parents reported high levels of attention problems and hyperactivity in youth.**

- **5% reported clinical levels of hyperactivity; an additional 11.3% at-risk (16.3% total)**
- **2.5% reported clinical levels of aggression; an additional 15% at-risk (17.5% total)**
- 4.4% reported clinical levels of conduct problems; an additional 7.4% at-risk (11.8% total)
- 5% reported clinical levels of externalizing symptoms; an additional 6.3% at-risk (11.3% total)
- 3.8% reported clinical levels of anxiety; an additional 11.2% at-risk (15% total)
- **1.3% reported clinical levels of depression; an additional 16.2% at-risk (17.5% total)**
- None reported clinical levels of somatization but 7.5% reported at-risk levels
- 3.8% reported clinical levels of internalizing symptoms; an additiona; 7.5% at-risk (11.35 total)
- 2.5% reported clinical levels of atypicality; an additional 3.8% at-risk (6.3% total)
- **2.5% reported clinical levels of withdrawal; an additional 13.8% at-risk (16.3% total)**
- **6.3% reported clinical levels of attention problems; an additional 22.4% at-risk (28.7% total)**
- 3.8% reported clinical levels of behavioral symptoms (BSI); an additional 8.7% at-risk (12.5% total)

Parent-Reported Deficits in Adaptive Behavior (Spring 2012) – based on 80 children

- **1.3% reported clinically significant deficits in their child's adaptability, with another 16.2% reporting at-risk deficits (17.5% total)**
- **2.5% reported clinically significant social skills deficits in their children, with another 22.5% reporting at-risk levels of social skills (25% total)**
- 1.5% reported clinically significant deficits in their child's leadership skills, with another 8.8% reporting at-risk levels of leadership skills (10.3% total)
- 1.3% reported clinically significant deficits in their child's activities of daily living with an additional 10% at risk in this area (11.3% total)
- 2.5% reported clinically significant deficits in their children's functional communication with an additional 8.8% reporting at-risk levels of functional communication (11.3% total)
- 2.5% reported clinically significant deficits in their children's adaptive skills, with an additional 10% reporting at-risk levels of adaptive skills (12.5% total)

Self-Reported Aggressive Behaviors (Winter 2012) - **255 Middle Schools self-reported aggressive behaviors exhibited during the previous seven days. These rates are surprisingly high and yet consistent with adults' concerns.**

- 69% Got angry very easily with someone
- 46% Said things about other kids to make other students laugh
- 44% Fought back when someone hit first
- 44% Angry most of the day
- 41% Teased students to make them angry
- 32% Pushed or shoved other students

- 31% Called other students bad names
- 30% Slapped or kicked someone
- 24% Threatened to hurt or hit someone
- 18% Got into a physical fight because angry
- 11% Encouraged other students to fight

Year One outcomes for the Tier II Curriculum. In year one, K-2 children with positive screens in some schools were provided with a Tier II curriculum, Strong Start, in small pull-out groups. The children were not randomly assigned to this treatment; rather their inclusion depended upon parent consent, willingness of the school psychologist or social worker assigned to the building, and school administrator choice. The children who received the Strong Start curriculum were compared with children who were receiving the school's de facto social-emotional supports, which included individual counseling, Positive Action and Second Step. **The children receiving Strong Start (in its first year and at half the recommended dosage) did not do statistically better on any of the follow-up measures; however, the good news is that children in all the different conditions showed statistically significant improvements on the BESS screener as well as a measure of emotional knowledge suggesting that the efforts, across the board, to improve children's functioning were successful.** Going forward, school psychologists and school social workers have chosen from a wider variety of Tier II evidence-based curricula rather than limiting themselves to the Strong Kids curriculum.

Following year two, we asked school psychologists and school social workers to administer a follow-up post-test to Tier II students served throughout the year. Unfortunately, they only secured data from the 55 students, about half of those assigned to Tier II, who were still receiving services at year's end (while the remainder had "graduated"). Of these 55 students, all continued to screen "at-risk;" we concluded that the data validated the adults perceptions that the youth continued to be in need of supports and each child was staffed by teacher, parent, and provider to determine whether Tier II was appropriate when the child returned to school in the fall or whether a Tier III intervention should be implemented. In addition, many of these students continuing to display elevations were referred to IHR for therapy during the summer months.

A. Promote child/adolescent social- emotional skill development

In early 2010, an advisory group comprised of parents, teachers, clinical supports, and administrators, were asked to consider four evidence-based universal social-emotional learning curricula. The group was encouraged to reach a consensus around which curriculum would be the best choice for our county. The group chose Positive Action, which has very strong research-base. In fact, the curriculum, which teaches children how to make positive choices they can feel good about, has been shown to dramatically reduce risk factors that are of concern in the community, such as grade retention, drug/alcohol/tobacco use, violence, bullying, discipline referrals, truancy, and aggression. For example, the curriculum has reduced voluntary sexual activity by 83% in some samples; this intervention is more effective than most programs specifically designed to decrease early pregnancy! The advisory group was particularly impressed with the comprehensive nature of the curriculum and its strong history of improving students' academic outcomes on state tests, by over 20% in the area of reading and 50% in the area of math in previous samples. **During the 2014-2015 school year, 18 of 19 schools were trained and equipped with Positive Action!**

We have been implementing evidence-based Tier I and Tier II strategies in the schools as well as generalizing programming to Boys and Girls Clubs during the summer, and home-visiting for 3-5 year olds. All of these practices are intended to promote children's functioning. We are anxious to see whether our efforts over time are really making a difference.

In the first year, we attempted to determine whether the Positive Action curriculum provided any added benefit above and beyond all the other new supports being implemented. To examine the effectiveness of Positive Action, we randomly assigned some grades in some buildings to serve as wait-group controls for the first year so that we could compare functioning between children who had the curriculum and those who did not. The Positive Action sample included 225 children from 22 PK-4th grade classrooms in five schools; the control group had 197 children from 25 PK-4th grade classrooms in four schools. At Time 1 (before the intervention), despite the random assignment, children in Positive Action classrooms (PreK-4) were rated by teachers as having higher scores (i.e., worse) on the Behavioral Symptoms Index (i.e., externalizing and internalizing symptoms) than did children in control classrooms. At the end of the school year, there was no evidence of a difference between these groups with internalizing symptoms (i.e. anxiety, depression) accounting for most of this difference in Time 1 scores. Also, at Time 1, children in Positive Action classrooms were rated lower in Adaptability (i.e., worse) relative to their counterparts in control classrooms. Again, there was no evidence of a difference between groups at the end of the year's implementation of Positive Action. **These data suggest that Positive Action helped those children catch up with their peers by ameliorating symptoms, which is consistent with Tier 1 Prevention goals and expectations.**

B. Nurture protective factors

Our initial needs assessment suggested that children were lacking some protective factors. Specifically, concerns were raised about their positive relationships with their teachers and their parents. School engagement and positive parenting are both ways to improve children's resilience and outcomes. Throughout the last couple years we have made efforts to improve school climate and parenting by launching Positive Action, Triple P, and the Newborn Channel. We are monitoring children's self-reported experiences of their relationships with their parents, their teachers, and their school climate. Using our baseline data, we have been able to examine relationships between these protective factors and some of the risk behaviors.

School climate can serve as a protective factor for children and increase the likelihood that they will be resilient and avoid engaging in risk behaviors. We decided to look closely at our baseline data to learn about the relationship between children's self-reported perceptions of climate in their schools with their self-reported functioning and risk behaviors. The first study used information from 338 middle school students (grades 5-8) at four middle schools and focused on children's adjustment. We found that students' perceived sense of school community as well as their perceived autonomy and influence were associated with fewer school problems, emotional problems, and internalizing problems, as well as better personal adjustment. Their sense of school community (but not perceived autonomy and influence) was also related to fewer inattention/hyperactivity problems. Investing energy in creating positive school climates will clearly have an influence on child functioning.

The second study looked at the relations among school climate, functioning, and some risk behaviors. In this study responses from 254 middle school students (grades 5-8) in four schools were examined. Similar to the first study, there were significant correlations between school climate and student adjustment. Specifically, students' sense of community was related to lower

levels of anxiety, depression, and aggression. Students' autonomy and influence, as measured by the school climate scale, were related to lower depression and (marginally) lower anxiety, but there was no evidence that it was related to aggression. Students who used alcohol had less positive sense of school community and (marginally) perceived less autonomy and influence at school. Efforts to foster a positive school climate should focus on fostering positive relationships among students and teachers as well as encouraging students to actively make decisions.

The last study involved 232 middle school students (grades 5-8) at four middle schools and looked at school climate in relation to beliefs about and acts of aggression. The majority (87%) of students in this sample reported engaging in at least one aggressive behavior in the past week. Aggressive behaviors that were most frequently endorsed included: getting angry easily with someone, saying things about peers to make others laugh, fighting back when someone else hit first, feeling angry most of the day, and teasing students to make them angry. Both students' aggressive beliefs and the negativity of their perceptions of school climate predicted acts of aggressive behavior.

Many youth are at risk for having low academic performance, dropping out of school, experiencing mental health concerns, and engaging in risky behavior. Youth in rural areas are at a higher risk for experiencing these concerns due to having a lack of supports and services (e.g., Beebe-Frankenberger, 2008; Rural Education, 2011). There is a strong need to identify protective factors that improve outcomes for youth, especially in rural areas. One powerful protective factor for youth is experiencing a positive school climate. Research has consistently demonstrated relations between school climate and students' functioning (e.g., Brand et al., 2003; Kasen et al., 1998; LaRusso & Selman, 2011; Shirley & Cornell, 2012; Suldo et al., 2012). Past research with mixed urban, suburban, and rural samples has suggested that all five dimensions of school climate are related negatively to students' risky behaviors. In 2014, we examined whether this holds true for a solely rural population. **In our sample of 260 high school students, only the Relationships dimension of school climate related negatively to risky behaviors.** The aspects of school climate that are important for influencing risky behaviors may vary based on a school's urbanicity, and the present results suggest that it may be particularly important to build and strengthen relationships in rural schools.

Only a few studies have examined longitudinal relations between school climate and student outcomes (e.g., Kuperminc et al., 2001; Shochet et al., 2006; Way et al., 2007). More longitudinal studies are needed to further investigate the protective nature of positive school climate on middle school students' development to inform prevention and intervention strategies, especially in rural communities. In 2014, we examined the longitudinal effects of school climate (i.e., sense of community, school and classroom supportiveness, and autonomy/influence) on students' social-emotional functioning (i.e., internalizing problems and personal adjustment), risky behavior (i.e., fighting, carrying weapons, smoking, and drinking alcohol), and academic performance (i.e., CBM reading and math scores). Measures were completed by 530 middle school students at five time points across two years.

We found that:

- More positive school climate perceptions were related to higher math scores, less risky behavior (fighting, weapon carrying, alcohol use, smoking), fewer internalizing problems, and better personal adjustment.

- Climate perceptions became more negative over time as did their internalizing problems, aggressive behavior and beliefs, and risky behavior, which is consistent with previous research (e.g., Kuperminc et al., 2001; Way et al., 2007).
- Climate perceptions predicted future risky behavior (fighting and smoking).
- Quadratic effects were observed between climate perceptions and internalizing problems, personal adjustment, alcohol use, and cigarette use, such that problems started increasing during 7th grade.

Results have the following implications:

- Students who feel supported and involved in decision-making at school have better academic, behavioral, and social-emotional outcomes.
- Schools should continually assess the perceived climate to identify at-risk students and to improve school contexts and practices.
- Schools should create climates aligned to students' developmental needs. For example, special attention to social-emotional needs of students before and during seventh grade is important.
- School climate improvement is a universal (Tier I) prevention strategy for improving students' functioning.

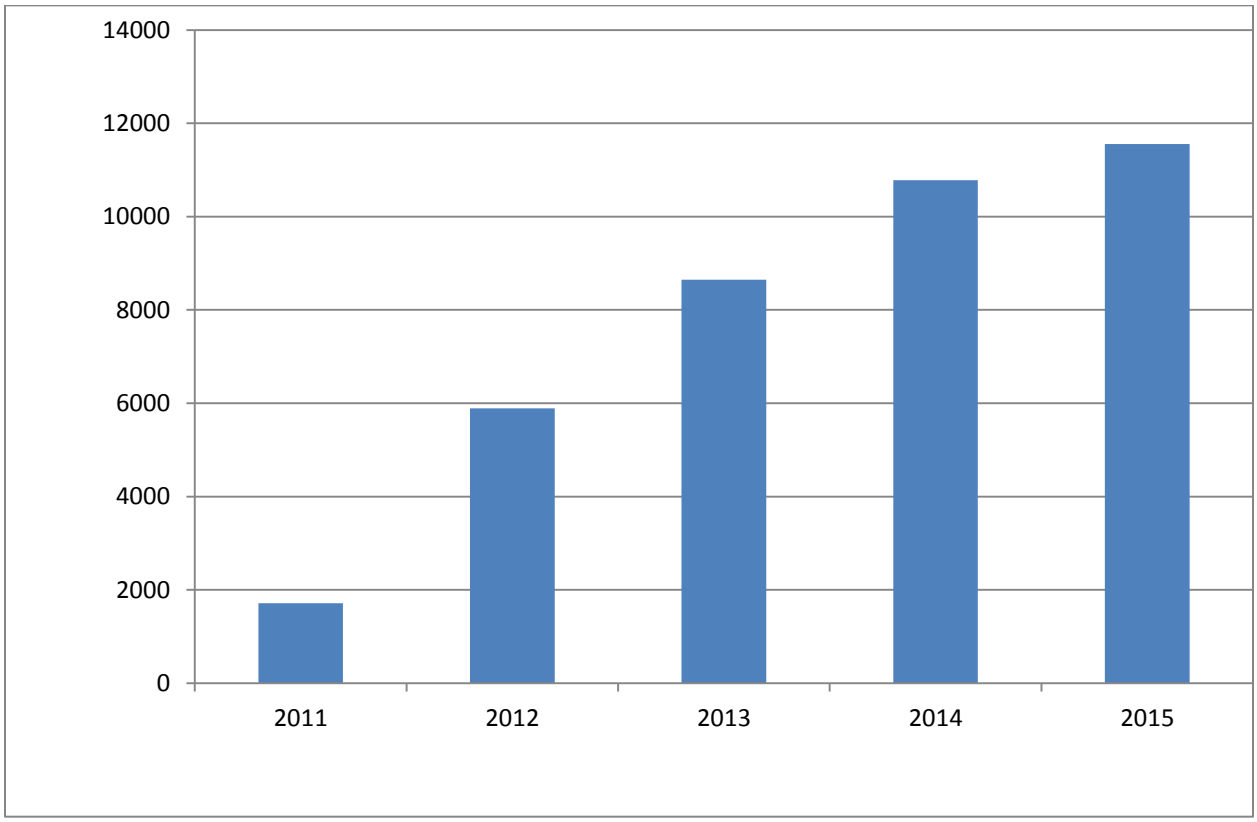
C. Identify at-risk children

The community agreed that it is important to find children who need services as early as possible in the progression of a developmental or mental health problem. Before children are born, their mothers are screened during prenatal visits to their doctor or the health department and follow-up services are offered for positive screens for substance use, depression, or domestic violence. We are not specifically tracking data on these positive screens or follow through with treatment; however, the health department consistently serves approximately 50 families through the Healthy Families program and an additional 30 in 2013 through the Better Births program, which casts a wider net for families who are a little bit lower risk. In the 0-3 age group, the settings where most screens occur are the health department or the child's medical doctor's office and Tier II follow-up occurs in the Infant-Toddler Enrichment program through OSF (partially funded by the 708 board). In the 3-5 age group, most screens occur in the form of Trans-disciplinary Play-based Screenings conducted by LCSSU. Follow-up Tier II is encouraged in the form of structured preschool experiences, At-risk Pre-K, or Head Start.

The screening process in schools was new for the community. We knew it would be important for the measure to be conducted universally at least once per year. Once this decision was made, school districts informed parents of the new practice in their handbooks and on websites. Each year in the fall, parents have the opportunity to opt-out of screening, but very few parents have done so. Most parents have expressed support for the practice and appreciation that the school is considering their child's social-emotional needs. Originally, we had intended to use a multi-gated process whereby the teacher would complete the screening form on the child and then we would get parental consent for a parent report and a child self-report. As it turned out, it often took 1-2 months for the follow-up to the screening and to get children connected with Tier II supports. Therefore, the follow-up to the first positive screen is a phone call discussing the

results with the parent and getting consent to provide the service if the parent concurs that support would be beneficial. In many cases, the classroom teachers prefer to be the one to make this call and have this conversation with parents; however, in other cases the school psychologists or school social workers do. As one can imagine, connecting by telephone and getting paperwork home and back signed to school can sometimes take some time and persistence. Some schools send home letters to all parents to let them know their child's screening results weather positive or negative.

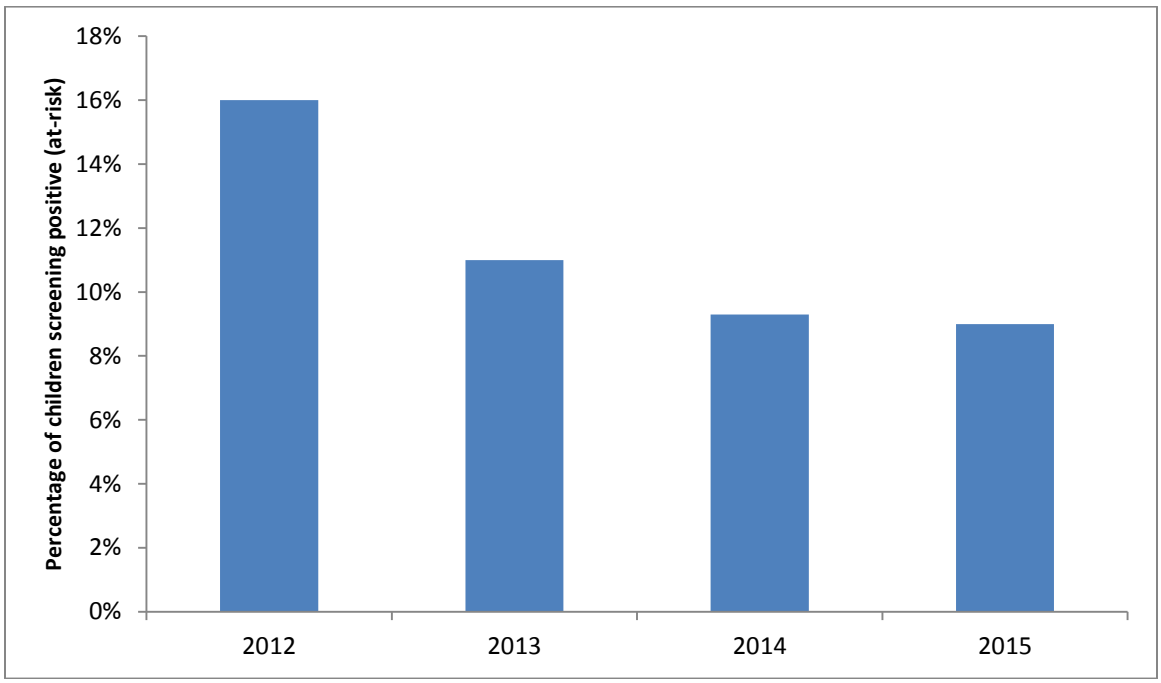
For grade school students, teachers complete the Behavioral and Emotional Screening System, otherwise known as the BESS (in schools), or parents complete the Pediatric Symptom Checklist, otherwise known as the PSC (in doctors' offices), and positive screens are recommended for Tier II skill-building groups in the schools. In the junior high, students complete a self-report BESS in addition to the teacher-report BESS. In the six high schools, all ninth grade students are screened with two schools also screening older grades using the self-report PSC. Junior high and high school students also have the opportunity to complete the PSC in their doctor's office or the juvenile court in addition to the parent report. **In Year four, the community collectively completed 10,000 more screenings over baseline and, adjusting figures for duplicated screens, this total suggests an increase from 18% to approximately 97% of the total population of children 0-18. Some students in grades 10-12 in three high schools represent the last known group of unscreened 0-18 year olds.**



Perhaps even more exciting than expanding our universal screening process is the percentage of positive screens. Despite increasing the number of children screened, the percentage of positive screens stayed steady at 9%. This decrease in positive screens

suggests that prevention and early intervention is successfully decreasing the number of children across the county in need of services.

	Baseline	2012	2013	2014	2015
Total number of Screens 0-18	**1713**	**5887**	**8648**	**10783**	**11556**
Estimated number of children	**1713**	**5256**	**7385**	**8852**	**9191**
Estimated percent of total pop.	**18%**	**55%**	**78%**	**93%**	**97%**
% of positive screens	**unk.**	**16%**	**11%**	**9%**	**9%**



D. Provide support for at-risk

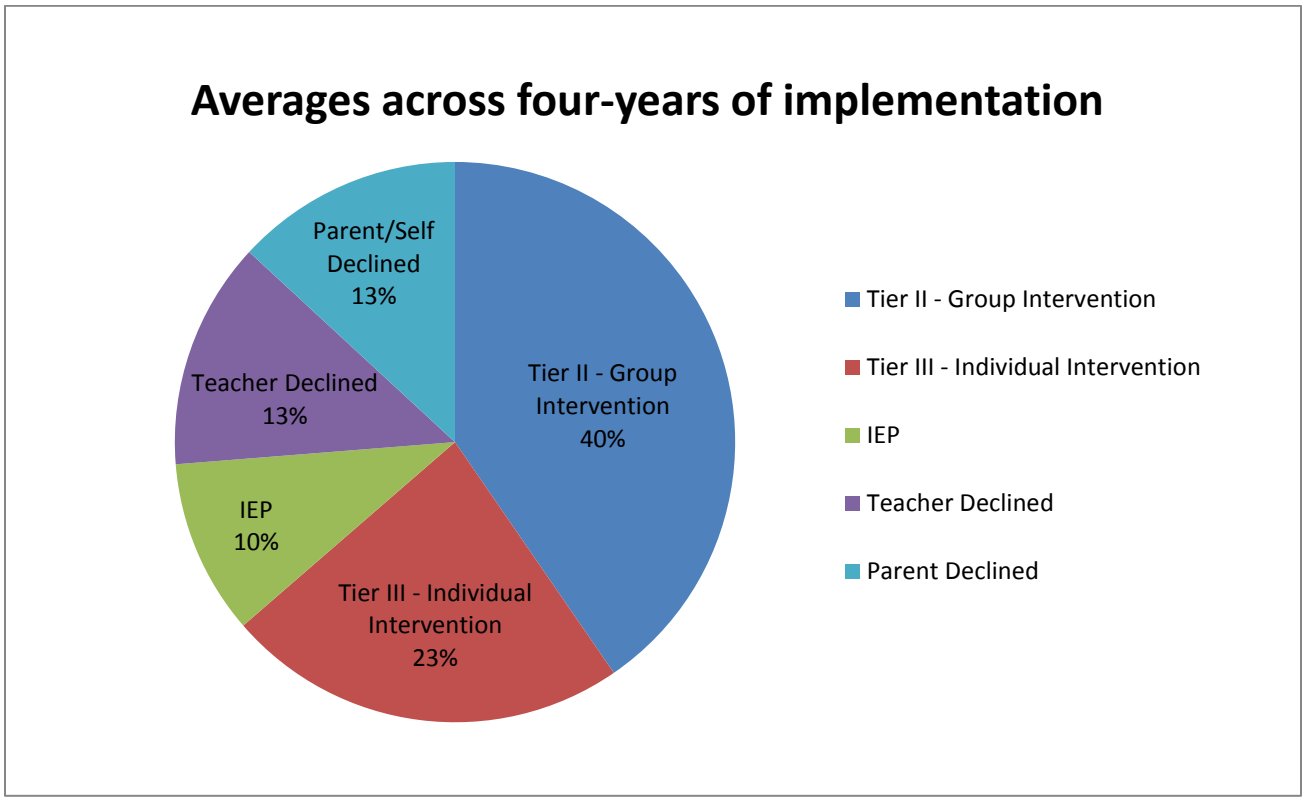
An extremely important component of the continuum of services is to provide support for the children who are identified as at-risk for mental health concerns through the screening process. Prior to the grant's initiation, there was a well-developed system for 0-5 year olds to be screened and funneled into Tier II or Tier III services as appropriate. As a result, we are monitoring this process, but no new services have been developed.

Screening and Tier II services are completely new in the 6 to18 age range. Some of the 6 to18 year old children who screen positive each year are already receiving services primarily as a result of teacher or parent referral. When screening data are reviewed by school psychologists, school social workers, and administrators, the team considers whether the current type and level of service needs to be changed to meet the child's needs. Screening is intended to identify children who are AT-RISK of developing a problem, not just those about whom adults are already concerned. As a result, sometimes elevations are a bit of a surprise and either the parent or the teacher expresses desire to delay or avoid services. There may be actions taken on the part of the parent or the teacher to support the student, but these are not reflected in the Tier II numbers. Also, sometimes a teacher, as a result of a high positive screen rate, will request additional classroom-based social-emotional support or instruction, and these numbers may also not be reflected in the official Tier II count. The following chart depicts the total number

of positive screens in the schools. **Not all schools report their follow-up information; thus, we have data on 63% of positive screens in 2014.**

Over the course of the four years of implementation the statistics are fairly steady despite the increasing number of youth screened each year. About 10% of youth who screen positive are already receiving social-emotional supports as part of special education services. Approximately 40% of positive screens receive group interventions while about 23% receive individual interventions. On average 13% of youth do not receive services in schools because their teachers suggest alternatives and another 13% do not receive follow-up services because they or their parents decline the opportunity.

	2012-2013	2013-2014	2014-2015	2015-2016
Positive school-based screens K-12	384	456	838	679
# for whom we have follow-up data	210 (55%)	298 (65%)	335 (40%)	430 (63%)
# already receiving services on an IEP	15 (7%)	62 (21%)	16 (5%)	47 (11%)
# received Tier II group intervention	99 (47%)	117 (39%)	115 (34%)	147 (34%)
# received Tier III individual intervention	48 (23%)	61 (21%)	67 (20%)	114 (27%)
# moved out of school following + screen			36 (11%)	1
# teachers declined to pursue services	24 (11%)	46 (15%)	50 (15%)	53 (12%)
# parent/self declined permission	24 (11%)	12 (4%)	67 (20%)	68 (16%)



Conclusion

The Livingston County Children's Network is well on its way to fulfilling its articulated vision that families all across Livingston County will utilize and value a comprehensive continuum of services to promote children's social and emotional development which will, in turn, effectively reduce at-risk behaviors and strengthen relationships. This progress is in large part due to steadfast commitment to our collective goals. The capacity of the system of care has been expanded by matching children, adolescents, and their families with the intensity of supports needed. Coordination of the system has been greatly enhanced by individuals who serve as liaisons in each of the major sectors (i.e., education, mental health, medical, and juvenile justice). The types of services, the number of providers, and the diversity of settings in which services are delivered have all increased. For example, 94% of elementary school children have access to social-emotional skill-building lessons. Last year 11,556 screenings of 0-18 year olds occurred and as many as 70-80% of those with positive screens were able to receive early intervention to get them back on track. The number of children and adolescents treated for mental health conditions within our community mental health center has increased almost three-fold over baseline. Finally, our overall positive screen rate has decreased from 16% to 9% suggesting that, across the board, our combined efforts are having a positive global effect. **In summary, every piece of data suggests that the system of care and the children within the system of care are improving.**