Empowering Minds

Transforming Lives

Child and Adolescent Psychiatric Services

McHenry County Mental Health Board

June 2017

Prepared by Smart Policy Works, a division of Health & Disability Advocates

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Executive Summary

Problem

McHenry County currently has no providers with available inpatient beds for children and adolescents requiring crisis-level behavioral health inpatient stays. Parents and caregivers seeking access to this level of care are limited to providers outside of McHenry County. There is a general perception that this absence places a burden on McHenry County residents. It also presents added complexity when the McHenry Mental Health Board (MCMHB) attempts to support consistent and quality care to children and adolescents.

MCMHB has heard from parents, providers, and stakeholders that child and adolescent inpatient beds are needed to bolster care delivery in the county system. Additionally, MCMHB also sees opportunity in meeting unmet needs by increasing the number of providers providing lower intensity services thereby bolstering interventions before individuals reach crisis-level need.

Recommendations

Smart Policy Works (SPW) survey results (See Appendix A), stakeholder feedback, and analysis of demo- graphic and claims data makes clear that the development of one specific type of service cannot alone address the behavioral health and substance abuse needs of children and adolescents in McHenry County. As such, while we agree that a lack of inpatient beds demonstrates a clear gap in the service continuum, SPW believes that strengthening wrap around services, that is services on the less intensive end of the spectrum, will help prevent newly evident mental health incidents from escalating to crisis level, which obviates some of the need for a child and adolescent psychiatrist or local inpatient facilities.

SPW's comments regarding present gaps in care are not meant to criticize the Board's funding priorities. The Board and its leadership deserve much credit for devoting resources to begin addressing a perceived problem in the community. It is our recommendation, based on the Board's input, that the Mental Health Board focus funding and resources on three main areas: Day Programs, School-based programs, and transportation.

Analysis of Psychiatric Services for Children and Adolescents

I. Problem Statement and Data Sources

Problem Statement

McHenry County currently has no providers with available inpatient beds for children and adolescents requiring crisis-level behavioral health inpatient stays. Parents and caregivers seeking access to this level of care are limited to providers outside of McHenry County. There is a perception that this absence places a burden on McHenry County residents and presents added complexity when attempting to provide a consistent and quality care to children and adolescents.

MCMHB has heard from parents, providers, and stakeholders that child and adolescent inpatient beds are needed to bolster care delivery in the county system. Additionally, MCMHB also sees opportunity in meeting unmet needs by increasing the number of providers providing lower intensity services thereby bolstering interventions before individuals reach crisis-level need.

Two core challenges exist to increasing the psychiatric services available for children and adolescents: 1) the extra training required for a child psychiatrist in addition to the four years of medical school and three years of general psychiatry, and 2) the reimbursement rate fails to reflect the extra time required for a psychiatrist to interview parents, teachers, and other interested persons familiar with a child's behavior. "You always have to deal with a parent or caretaker – it doubles the interview time, but the reimbursement rate is the same as if you're evaluating an adult."[1]

The lack of funding for psychiatric leadership grants is a key reason why 86 percent of Community Based Health Association's (CBHA's) membership has either reduced or eliminated psychiatric services since the budget impasse.[2] Only 2-4% of medical school graduates are entering psychiatry and the current population is aging (55% are age 55 or older).[3] American Academy of Child and Adolescent Psychiatrists (AACAP), which gauges the number of practitioners in the field at about 7,000. AACAP found there was, on average, only one child psychiatrist for every 15,000 youths under 18. The U.S. Bureau of Health Professions projects there will be about 8,300 child psychiatrists in 2020, only two-thirds of the estimated 12,600 needed.

[1] Interview with key informant
[2] Community Based Health Association – May 2016
[3] NIMH, 2011

The purpose of this assessment is to evaluate the current environment of child and adolescent psychiatric services in McHenry County to help answer whether more inpatient services are needed, or whether alternate opportunities can meet the community's needs. This report will provide an analysis of the need, the challenges present in supporting development of services, and methods in which the County could address the concerns raised by the community.

Data Sources

Smart Policy Works, a division of Health and Disability Advocates, has used multiple sources of data and information to inform this report.

Data sources include:

- U.S. Census Bureau's QuickFacts
- American Community Survey (ACS)
- U.S. Department of Health & Human Service's reports on the Health Insurance Marketplace
- Provider and Stakeholder Interview
- U.S. Centers for Disease Control
- Self-reports on health and risk behaviors among youth (Illinois Youth Survey, 2016)
- County Health Rankings & Roadmaps
- Youth Assessment and Screening Instrument
- NAMI Mental Illness Facts and Numbers
- FY16 BH DRGS 18 and Under by Zip Facility
- Person in Need Feedback Survey 2017 Report
- Wait List Info – Capacity Mgmt Form 7-19-16
- Phone conversations with stakeholders from Centegra, Rosecrance, and McHenry County Mental Health Board Members
- McHenry County Mental Health Board Strategic Plan for System Improvement, April 2017
- McHenry County Healthy Community 2016/2017 Survey Findings
- McHenry County Healthy Community 2016/2017 Focus Group Findings
- Illinois State Police, Illinois Uniform Crime Reports
- ACA Enrollment: Data extracted from Illinois Healthcare and Family Services Enterprise Data Warehouse
- Comparative Health Care and Hospital Data Report (COMPdata)
- Heartland Alliance, Social Impact Research Center. Confronting homelessness in McHenry County: Strategic plan to end homelessness 2016-2018
- Community Behavioral Healthcare Association
- McHenry County Network Council Survey Responses

II. The Development, Mission and Role of McHenry County Mental Health Board

McHenry County Mental Health Board Development and Mission

The Mental Health Board (MHB) is a special purpose unit of the county government that's regulated through Illinois House Bill 708, also known as the Community Mental Health Act (the Act). The MHB is responsible for making sure that the duties and responsibilities of the Community Mental Health Act are fulfilled.

The Act specifically mandates that each Community Mental Health Board in the state:

- Review and evaluate community mental health services and facilities
- Plan for programs of community mental health services and facilities
- Consult with others regarding the most efficient delivery of services
- Appropriate funds to maintain mental health services and facilities

The mission of the Board is to provide leadership to ensure the prevention and treatment of mental illness, developmental disabilities and substance abuse by identifying, planning, coordinating, fostering development, and contracting for quality services for all citizens of McHenry County, Illinois.

The vision of the Board is that all McHenry County residents experience optimal mental wellness through access to an integrated system of behavioral healthcare services of excellent quality, representing a recovery and resiliency-focused, consumer-driven, culturally inclusive, and community-based continuum of care.

The MHB considers the special needs of adults, children, and adolescents in planning for an effective countywide service delivery system. For children with severe emotional disturbances, the goal is to provide family-focused services that consider the needs of the child and family. Special emphasis is placed on provision of services that are sensitive to the needs of adolescents transitioning to adult-hood. In planning services for adults with behavioral health issues, the goal is to focus on individual recovery through person-centered care. For developmental disabilities, the MHB and the development disabilities community back a person focused and centered system of supports that allow for full integration in community life.[4]

McHenry County Mental Health Board Role

The Mental Health Board was established after McHenry County voters passed a referendum in 1967 to levy an annual tax for the purpose of "...providing community mental health facilities and

[4] McHenry County Mental Health Board Three Year Plan, 2012-2014

services..." The Community Mental Health Act mandates that the Mental Health Board administer mental health funds, collected through an annual tax levy.

In accordance with the Community Mental Health Act, the MHB distributes levied funds through a yearly application process to organizations that treat and educate county residents affected by mental illness, substance abuse, and other populations in need of behavioral health care.

The MHB is directed and led by a nine-member board of community representatives. These representatives are appointed by the County Board.

The McHenry County Mental Health Board sees its role in a larger context, however, than that presented in the Act. The Board realizes that it exists at the will of the community as expressed by passing the referendum. The Board therefore is mandated to assure, on behalf of the community, that those in need of mental health, developmental disability or substance abuse services will have those services available to them. To accomplish this task the Board must continuously engage in policy development focused on their governance of all access, quality and cost concerns for their constituency's behavioral healthcare needs.

The MHB sees this report as a means to fulfill its overall mission, vision, and role in the community.

III. Analysis of the Children and Adolescents who may Require Psychiatric Services

To determine how many youths may require psychiatric services or intensive mental health intervention, the first part of this section presents the known data and information on this population. The remainder of this section reviews the number of children who have risk factors that could require services with no intervention. It will specifically address the following risk factors: poverty, single-headed households, school delinquency, and involvement in the juvenile justice system, ability to maintain satisfactory relationships with peers and adults, consistently failing grades, repeated truancy, instances of being bullied, and violence toward others.

Although this report focuses primarily on SASS eligibility criteria, data throughout the report points out where additional needs exist when broadening the definition of need. For ex- ample, in the discussion about functional capacity, this report makes note of school social workers' estimates of how many students would benefit from case management services but do not quality for SASS.

McHenry County Youth Population

- **75,216 under 18 yrs. old**
- **16,579 under 5 yrs. old**
- **58,637 school age (approx.)**

McHenry County Youth Population

Approximately 25% of the population of McHenry County is 18 years of age or younger (24.5%). This percentage is slightly higher than the Illinois youth population (23%) and the national population (22.9%). Specifically, there are 75,216 residents under the age of 18, 16,579

residents are under the age of 5, so the approximate number of school age residents in the county equals 58,637.[5]

Children Hospitalized

The Comparative Health Care and Hospital Data Report (COMPdata) managed by the Illinois Hospital Association indicates that in Fiscal Year 2016, 358 children under 18 years old who lived in McHenry County comprised the 555 total cases that were discharged from inpatient services.[6] Nearly a third (110) of the children had multiple admissions during the fiscal year.[7] Of those multiple admissions children, the average number of admissions per year were 2.79 with 21 patients experiencing four or more admission (14 children had 4 admissions, 4 had 5 admissions, 3 had 6 admissions, and 1 had 7 admissions).[8] The average age of the youth treated in inpatient services is 14 years old.[9] The average length of stay per admission is 8.13 days.[10]

Child Hospitalizations, 2016

- **358 Children under 18 were discharged from inpatient services**
- **Nearly one third had multiple admissions during the year**
- **The average length of stay for each admission was 8.13 days**

By age, 79% of the 358 cases are between the ages of 13 and 18 years. The highest proportion (16%) are 15 years of age, with slight decreases in subsequent years. There are 20 cases, ages 8 and younger.[11]

From July 2013 to September 2016, the average number of crisis assessments for SASS per month is 51.86, or almost two every day.[12] According to one SASS program manager, 129 children were involved in the SASS programing based on psychiatric needs and 121 of those children were rescreened into the program more than once.[13] Since April of 2016, 35 children had two or more admissions, but this number does not include partial hospitalizations so the number would be greater.[14]

Specific Diagnoses

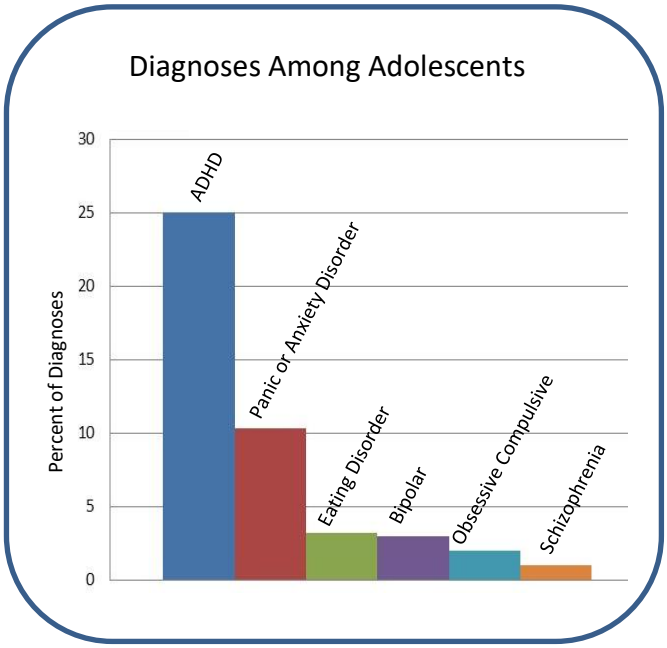
Adolescents with ADHD make up about 25% of the youth population in McHenry County.[15] About 10.3% of the youth population has been diagnosed with panic or anxiety disorder,[16] and about 3.2%

[5] 2015 Census date from Census Quickfacts
[6] FY16 BH DRGS 18 and Under by Zip Facility 10 11 16
[7] Id.
[8] Id.
[9] Id.
[10] Id.
[11] McHenry County Mental Health Board 2017 Strategic Plan for System Improvement at Page 8
[12] Youth screened SASS stats
[13] Conversation with key informant
[14] Id.
[15] McHenry County Healthy Community Study https://www.co.mchenry.il.us/home/showdocument?id=30455
[16] Id.

of the population has been diagnosed with an eating disorder. Bipolar disorder has been diagnosed in about 3% of the youth population, obsessive compulsive disorder is at about 2%, and schizophrenia is at less than 1%.[17] The primary diagnosis for approximately half the inpatient cases sent out of the county was psychosis (275 cases).[18]

Risk Behaviors of Suicide or Harm to Others

Understanding the prevalence of depression and suicidality among youth is important since both are correlated or precursors to psychotic hospitalizations. Suicide is the third leading cause of death for children ages 15 to 24 years old.[19] Further, more than 90% of those who die by suicide had one or more mental disorders.[20]



In 2016, the Illinois Youth Survey asked students in the 10th and 12th grades about suicidal thoughts. When asked if they had seriously considered suicide in the prior 12-month period, 18% of 10th graders and 15% of 12th graders reported they had.

According to the Illinois Youth Survey (IYS), 1-5%, or 580 to 2,900, of students were involved in a physical fight three time or more during the last 12 months.[21] In addition, 4-8% of students, or 2,320 to 4,640, brought a weapon like a handgun or knife to school at least once in the last 12 months.[22] Further, according to the Juvenile Detention Facility's 2016 report, 72 (36.5%) of the juveniles had a severe violent history and 97 (49.3%) had a medium to high risk of aggression.[23]

Behavioral/Emotional Symptoms of Depression, Anxiety and Substance abuse

In 2016, the Illinois Youth Survey asked students in the 8th, 10th, and 12th grades about whether or not they had felt sad or hopeless most days for two weeks or more in a row that stopped them from

[17] Advocate Health Executive Summary of McHenry County Report 2010 https://www.advocatehealth.com/documents/subsites/hope/McHenry-2010-Exe-Summary.pdf
[18] McHenry County Mental Health Board 2017 Strategic Plan for System Improvement at Page 8
[19] NAMI Mental Illness Facts and Numbers
[20] Id.
[21] Illinois Youth Survey, McHenry County 2016 at Page 39
[22] Id.
[23] YASI Full Assessment Risk Factors 01/01/2016 – 12/31/2016

doing some usual activities. A slightly greater proportion of 8th grade students experienced depression (35%) than did 10th (33%) or 12th graders (31%).

According to the Illinois Youth Survey, in McHenry County, alcohol is the most frequently used substance, with 34% of 8th graders, 44% of 10th graders, and 64% of 12th graders consuming within the last twelve months and 18% of 8th graders, 22% of 10th graders, and 43% of 12th graders consuming alcohol within the last 30 days.

A review of the county youth's grades, truancy, and attending school under the influence yielded the following results. According to the Illinois Youth Survey for McHenry County, approximately 1-2% of students, 580 to 1,160, have failing grades.[24] Approximately 3-4% of students, 162 to 1,740 to 2,320, missed more than 30 days of school during the school year.[25] Approximately 1-6% of students, 580 to 3,480, attended school at least once while under the influence of drugs or alcohol.[26]

Juvenile Justice

According to a state report from the Youth Assessment Screening Instrument that surveyed all 197 minors in McHenry County's juvenile delinquency program in 2016, over 50% of juveniles had elevated risks for mental health and substance abuse. In addition, 100 youth in McHenry County's juvenile delinquency program were high risk requiring intervention for mental health issues and substance abuse.

Family Functioning that may Include Abuse or Neglect

Family structure is an important determinant of a child's emotional/mental well-being.[27] Studies suggests that children in a single-family household (whether that be from divorce or lack of a present mother/father figure) are at increased risk for mental illness. The majority of this health disparity found between two-parent households and single-parent households is due to the lower income of single-mothers.[28] This could be due to a myriad of factors, such as lack of insurance and access to mental health services that lower income families face.

Of the 75,216 children under 18 years-old living in McHenry County households in 2014, 19% live in a single-parent household. Most of the 14,292 children living in a single-parent household reside with a parent (either biological, step-parent or adopted), however, at least 12% are living with a grandparent, other relative, or a foster family.[29]

[32] Illinois Youth Survey, McHenry County 2016
[33] Id.
[34] Id.
[27] Moilanen, I., & Rantakallio, P. (1988). The single parent family and the child's mental health. *Social Science & Medicine*, *27*(2), 181-186.
[28] Id.
[29] Illinois Youth Survey, McHenry County 2016, at Page 2

There is growing evidence to support the association between poverty and poor mental health outcomes such as psychosis, mood disorders, and alcohol/substance abuse.[30] The data suggest that low incomes serve as social determinants of mental health due to a complex interplay of factors involved in the lives of low income individuals. The vulnerability to mental illness that these individuals face can be explained by multiple factors indicative of low socio-economic status (SES), such as lower educational and social achievement levels, and higher rates of unemployment. These complex factors often lead to chronic stress and without the resources to employ proper coping mechanisms, poor mental health outcomes result. This health inequity is true across the lifespan, as "Children in the poorest households are three times more likely to have a mental illness than children in the best-off households".[31]

Many low-income families face severe hunger and food insecurity. This has deleterious effects on both a child's physical and mental health, and data show it is associated with homelessness, traumatic life events, chronic stress, and internalizing behavior problems.[32] Further, hungry children are more likely to experience anxiety and depressive symptoms. This anxiety can be rooted in the uncertainty of where one's next meal will come from, the physiological or emotional changes that result from food deprivation, or the distress experienced by the parents of the food-insecure household. Hunger is thus important to consider when assessing a child's overall health and healthcare needs.

In McHenry County, 27% of 2013 students were eligible for free or reduced lunches.[33] For a family of three, an income per year of $37,777 or less qualifies the children for free or reduced priced lunches at school.[34] Further, in 2014, 9% of children in McHenry County live in poverty.[35]

As of December 31, 2015, 22,344 of the county's youth were enrolled in Medicaid in McHenry County. Children in McHenry County comprised more than 52% of all

[30] Murali, V., & Oyebode, F. (2004). Poverty, social inequality and mental health. *Advances in psychiatric treatment*, *10*(3), 216-224.
[31] (Murali & Oyebode, 2004)
[32] Weinreb, L., Wehler, C., Perloff, J., Scott, R., Hosmer, D., Sagor, L., & Gundersen, C. (2002). Hunger: its impact on children's health and mental health. *Pediatrics*, *110*(4), e41-e41.
[33] Illinois State Board of Education
[34] Illinois School Breakfast and Lunch Program. Retrieved from https://www.benefits.gov/benefits/benefit-details/1963.
[35] U.S. Census Bureau, decennial Census and 2012 Small Area Income and Poverty Estimates

Medicaid enrollees for the County. McHenry County's child to adult Medicaid proportion is greater than the state of Illinois's 39%.[36]

In addition, the YASI indicated that 127 (64.4%) of the juveniles had a medium to severe family risk.[37]

Conclusion

To summarize above, 358 children were hospitalized which comprised 555 total cases; almost one third, or 110, of those children had readmissions.

At a minimum, 275 children have diagnoses of psychoses. Approximately 14,500 children have a diagnosis of ADHD, approximately 6,000 with a diagnosis of panic or anxiety disorder, approximately 1,800 children have a diagnosis of an eating disorder, approximately 1,800 children have a bipolar disorder, approximately 1,200 children have obsessive compulsive disorder, and less than 580 children have schizophrenia.

Further, 580 to 4,640 students are at risk of violence to themselves or others; 17,980 to 20,300 students are at risk of suffering from depression or anxiety; 197 juveniles are currently in delinquency programs, and 14,292 to 22,344 youth are at risk of poor mental health due to their family functioning or poverty.

Between 275 and 1,800 children have diagnoses that require the highest intervention. Whereas, 6,000 to 14,500 children have diagnoses that require low to mid-level interventions. However, the number of the cases requiring the highest level of intervention could be reduced if those children received early intervention preventing the likelihood of the disorder to rise to a crisis level.

IV. System Capacity to Meet Current Need

No Child Psychiatrist and Long Wait Times

There is no inpatient child/adolescent psychiatric hospital located within McHenry County,[38] thus 98% of admissions occurred outside of the Woodstock were all 18 years old. Just over half of all child and adolescent admissions occurred at one of two facilities, in Streamwood and Hoffman Estates.[39] At least six respondents in the McHenry County Focus Groups indicated that the lack of inpatient adolescent psychiatric services was a problem.[40] Lack of psychiatric services generally was cited as an issue in the focus groups at least fourteen times, with one person saying her wait was at least six months long.[41]

[36] Illinois HFS Medical Programs Enrollment Snapshot from 12/31/2015
[37] YASI Full Assessment Risk Factors 01/01/2016 – 12/31/2016
[38] 2017 McHenry County Healthy Community Survey Report 12-5-2016 at Page 128
[39] McHenry County Mental Health Board 2017 Strategic Plan for System Improvement at Page 35
[40] 2017 McHenry County Healthy Community Survey Report 12-5-2016
[41] Id., at Page 149

A survey conducted by the Community Behavioral Healthcare Association of Illinois (CBHA) in June 2016 revealed that more than three quarters of the organization's 65 member agencies have had to both lay off staff and cut back on the services they offer. The state budget impasse has eliminated funding for psychiatric care grant, forcing providers (86% of CBHA members) to either reduce or eliminate psychiatric. Thus, it is not surprising that the 76% of the CBHA member agencies have wait lists ranging between two and four months for people in need of a psychiatrist, and the remaining 24% have wait times from four months to more than six months.

A continuing shortage of both adult and child psychiatrists was noted, with the number of retiring professionals exceeding the number of recent graduates seeking to fill these roles. Difficulties in filling psychiatric nurse and other clinical positions are of concern. Challenges and opportunities are also posed by a lack of Spanish-speaking mental health workers as well as epilepsy and brain injury specialists. This is particularly true for those who accept Medicaid or serve those with no insurance. With continuing workforce trends, more providers with headquarters elsewhere are providing care in McHenry County.[42]

Centegra previously provided inpatient psychiatric services for youth, but stopped around 2004 or 2006. The program stopped because the doctor retired. Centegra attempted to keep a partial unit hospital going, but that ultimately proved too difficult with no doctor support. For the few years post 2006, the number of youth patients were not enough to sustain an outpatient program.[43] Consequently, Centegra is considering contracting with psychiatrists to provide tele-psychiatry.

Substance Abuse Outpatient

Access to mental health and substance abuse services were noted as a challenge in the public hearings and the HCS focus groups and survey. Just under 10% of survey respondents said that they or a household member were unable to receive mental health or substance abuse services in the past year. The top reasons provided for this includes long wait times, no regular provider and difficulty finding a provider who accepted Medicaid.[44]

In addition, the Person in Need Forum identified child and adolescent services as the target population most in need of increased services.[45]

The absence of a child and adolescent inpatient mental health unit and dedicated detoxification unit or program within the County was noted as a concern.[46]

According to the Provider Update Capacity Management, psychiatric services had the longest length of wait times and the highest number of clients awaiting services.[47] Over 70 clients are awaiting

[42] McHenry County Mental Health Board 2017 Strategic Plan for System Improvement at Page 46
[43] Interview with key informant
[44] McHenry County Mental Health 2017 Strategic Plan for System Improvement at Page 20
[45] MHB-PIN Feedback Survey 2017 Report, at Page 1
[46] McHenry County Mental Health Board 2017 Strategic Plan for System Improvement at Page 47-48
[47] Wait List Info – Capacity Mgmt Form 7-19-16

services, with at least one organization closing intake for new patients.[48] The average wait time is approximately 90 days.[49]

The shortage of psychiatrists poses challenges not only for population mental health, but for overall health of McHenry County residents. Lapses in medications, instability, and needs for high levels of care are among the results as persons in need of services go untreated or seek care in emergency rooms due to excessive wait times for appointments.[50]

Day-Program Capacity

Currently, there are no Day Programs for children in McHenry County. Day Programs are a crucial piece in the continuum of care for children requiring intensive services because these programs help maintain stability for the children preventing crises.

Day Programs along with inpatient psychiatric care, was listed as the least available of services for children and adolescents in McHenry Country mental health treatment.[51] One respondent commented that "if McHenry County cannot access or provide free standing facilities for day and inpatient treatment programs, then money needs to come for transportation to existing programs like AMITA and Streamwood."[52]

Throughout SPW's research, SPW found many providers, school teachers, and stakeholders lamenting the daily, long commutes that must be taken to ensure consistent day program participation. This travel is often necessary because of the lack of such services closer to the major population centers of McHenry County, i.e. Crystal Lake, McHenry, Lake in the Hills.

The stress of round trips, that often take multiple hours, can be especially taxing if the family is not wholly supportive or engaged in the child's treatment process. It can also place pressures on a family's income (especially when the family is a single-headed home), impact school attendance, and even impair family functioning.

[48] Id.
[49] Id.
[50] McHenry County Mental Health Board 2017 Strategic Plan for System Improvement at Page 47
[51] Smart Policy Works McHenry County Child-Adolescent Behavioral Health Survey Results
[52] Id.

School-Based Programs Capacity

Psychiatric mid to high-level intensity services primarily focus on personality disorders and behavioral disorders. Because the DSM-IV diagnostic criteria exclude children below a certain age for personality disorders, a majority of diagnoses for youth are oriented toward behavioral disorders. Many of these disorders become apparent only after the youth begin school; which again pushes the age curve toward children between 12 and 17 years of age. Consequently, schools also have the most data regarding the needs of their students, barriers to services, and common diagnoses.

Respondents to the survey sent by Smart Policy Works (See Appendix A) indicated that schools are already at capacities to triage mental health needs. "We can support students and help them access their education. But when a counselor has a case load of 400 students and the social worker has a case load of 800 students… please don't expect schools to take on more burdens than we already do." Further, these "counselors are not trained therapists, yet are forced to act as trained therapists with the severe needs and lack of outside resources."[53]

One resounding theme derived from the responses can be summarized by this comment: "The biggest issue is getting parents to follow through and get their child help." Respondents continued, "When we finally get a student connected to what they need, it often falls apart… parents, students do not follow though." "We do not even know when they have stopped outside counseling until we start seeing downhill slides with our students." Further, "kids are more challenging as parents are also battling mental health and addition issues." A respondent indicated that the solution rests with "case managers, calling if they miss an appointment and rescheduling when they don't show up."[54]

After reading the respondents' comments, one understands why they listed 'non-urgent case manager' within the top five least available services in the community (partial hospitalization discussed above, inpatient care, transportation, and child psychiatry were the other four least available services). Over half (59%) of respondents indicated that outpatient counseling in a clinic or school based was where they would invest funds, which is more than what child psychiatry received (55%). Further, respondents estimated that two to three percent (or 1,160 to 1,740) of their students who do not qualify for supportive services would benefit from case management.[55]

Responding to this need, Rosecrance has successfully piloted the creation of a mental-health clinic located onsite at a local school. It is staffed by two therapists who work two days a week. Thirty children who are on Medicaid are served through this program which puts it at full capacity.[56] This

[53] Smart Policy Works McHenry County Child-Adolescent Behavioral Health Survey Results
[54] Id.
[55] Id.
[56] Interview with key informant

speaks to the level of need within one school. "We now have a connection with Rosecrance that eliminates the transportation problem that is such a huge obstacle for many of our students."[57]

The current capacity of school based programs is maxed, leaving well over a thousand children who would benefit from counseling and case managers.

Transportation

Currently, the only transportation options for families to transport their children to child psychiatric services requires an hour or more by car or multiple hours using multiple train and bus transfers.

Many survey respondent, stakeholders, and professionals cited transportation challenges as a key barrier to care for children and adolescents. However, multiple challenges make any proposed one solution highly unlikely. Instead, multiple smaller initiatives and enhancements to existing programs may provide the best opportunity for improvement.

A majority of respondents to the Healthy Community Survey rated publication transportation as fair or poor. Further, public transportation had the lowest ranking of any community feature. Key informants of the Health Community Survey indicated that there are limited options, there must be more bus and train stops that connect health the population to health services, and that development of a broad-based public transit system faced significant challenges.[58]

Any public transportation that one could take to the nearest child psychiatric services would take hours by multiple trains and buses. Consequently, the only viable transportation option is by personal vehicle. Realizing this, the McHenry County Mental Health Board allocates some funding to subsidize transportation efforts for the grantees. However, these funds are not fully used by the community programs.

Other communities that could not afford to subsidize a train system to connect multiple villages comprising 20,000 or less populations instead funded rideshare programs that operated on set routes and by reservation.[59]

For example, the West Virginia Mental Health Consumers' Association piloted a program that employed staff to transport a person with limited means using one of the program's vehicles. The program operated in five service areas, each with a 50-mile radius. Although the program did not charge a co-pay or fee for the services, the program received reimbursements through the state's Community Mental Health Service's Block Grant funded through the Federal Substance Abuse and Mental Health Services Administration. However, these funds were limited to paying for gasoline and repairs. Because the program could not use funds to purchase vehicles, the program instead

[57] Smart Policy Works McHenry County Child-Adolescent Behavioral Health Survey Results
[58] McHenry County Healthy Community Study https://www.co.mchenry.il.us/home/showdocument?id=30455
[59] U.S. Department of Health and Human Services. "Getting There: Helping people with mental illness access transportation" https://store.samhsa.gov/shin/content/SMA04-3948/SMA04-3948.pdf

relied on donated vehicles and used the funds to repair those vehicles. The program provided over 3,000 rides in the first year.[60]

Another similar program created a non-profit organization that provided transportation to low-income individuals. These individuals paid a low-monthly membership fee. The fee funds a prepaid account from which the program deducts mileage and pickup charges. "Riders receive discounts in exchange for booking rides in advance or sharing ridges, but riders also have the flexibility of not having to plan ahead or share rides." This program had no geographic limitation since the members paid a mileage fee. However, the program also did not accept public funding precisely so there would be no geographic limitation.[61]

V. Reports from Provider Organization Interviews and Surveys

Participants in the Healthy Community Survey (HCS) focus groups, the People in Need Forum, and the MCMHB public hearings identified a variety of issues that spoke to the quality of system navigation and coordination efforts. Some of this input was broad and at a high level, while others spoke to the needs of specific populations.

When asked for ideas for improving the existing system of care, public hearing participants noted that the continuum of care is fragmented and not working. Specifically noted were the need to address barriers to navigating insurance coverage and a need to better connect services for persons with dual diagnoses. Participants in the HCS focus group of persons with mental illness, substance abuse or disabilities (and their parents) identified the need for transition services between high school and adulthood.

In the McHenry Child-Adolescent Behavioral Health Survey, participants concluded that the greatest barrier for children and adolescents to accessing behavioral and mental health treatment is a lack of local providers, and the least available service is inpatient psychiatric treatment (See Appendix A). When asked what services participants would invest in if possible, the most highly selected answers were child psychiatry and outpatient counseling. Many participants were concerned that without outpatient psychiatric care, mental health situations could worsen to a point of needing inpatient care, of which there is also so little. Affordable and accessible providers are listed several times as a necessity absent in McHenry County. While the survey results seem to conclude that schools in McHenry County have policies and staff in place to address mental and behavioral health needs, participants disagree that current services adequately meet the needs of the community.[62] In addition, over 69% of the Network Council indicated that they believed that child and adolescent psychiatric services were completely unavailable.[63]

Conversations with key stakeholders yielded the following, the County's need rests less with acute, crisis hospitalizations but more with a need for services that prevent re-hospitalizations.

[60] Id. at Page 28
[61] Id. at Page 30
[62] Smart Policy Works McHenry County Child-Adolescent Behavioral Health Survey Results
[63] Health & Disability Advocates McHenry County Network Council Survey Results

In addition, there are at least three private psychiatrists in McHenry County, but none of them accept Medicaid. One stakeholder speculated that an advanced nurse practitioner could see adolescents but then have a psychiatrist monitor the case remotely providing remote medication management. This person could then co-sign the mediations requiring a co-signor. This may also have the added benefit of causing advanced nurse practitioners to be more willing to try other solutions and less quick to prescribe medications.

The schools are an excellent point of intervention and increasing the psychiatric services for youth may reduce the costs and burden on schools to provide tutoring or home/hospital instruction. Although the school pays some of the costs when for student after-school or day programs, those costs would be less than the school district's paying for alternative schools under the students IEP.

In addition, parents must receive some education and assistance developing coping skills for their selves and for their children. Anecdotally, another key informant said she would see some parents admit their children more for respite than for an actual crisis. Further, the stress of caring for a child with high mental health needs could cause depression or anxiety in the parents. This stress is only exacerbated when considering that the parent must now manage paid time off while driving their child at least an hour to the nearest day program. A day program would reduce some of the need in the county, especially for the chronically re-admitted youth.

As for identifying system resources, the HCS survey found respondents were largely unaware of the County's 2-1-1 health and human services information and referral line. Well over half (60.4%) reported that they had never heard of it, and among those that had, less than 15% had ever called.[64]

VI. Future Considerations

Illinois Budget

The provision and support of mental health services in Illinois comes with its share of challenges. First and foremost is the lack of a state budget which has severely impacted service delivery to any provider who relies on state reimbursement. It should be assumed that when a state budget is approved, it will not include sufficient funding to "make whole" those organizations that have had payments withheld over the past two fiscal years.

It is also worth considering that any budget passed will have to account for the massive increases in debts and obligations the state has taken on over the past three years. The Governor's Office of Management and Budgets projects that Illinois will surpass $20 billion in debt by the end of FY18.

[64] McHenry County Mental Health Board 2017 Strategic Plan for System Improvement at Page 23

The MCMHB must consider that most, if not all, of the providers it funds rely on Medicaid and other state funded programs to support their operations. These providers most assuredly have already had to make difficult decisions regarding the services, staffing, and resources they commit to McHenry County.

MCMHB must be prepared to consider more ways and creative ways to support providers to ensure their continued operation and support of those who need mental health and substance abuse services.

Managed Care

Illinois is undergoing a major transition in its managed care implementation. Beginning in 2018, Illinois will transition its entire Medicaid population into managed care. This proposed implementation will impact all counties and all Medicaid populations.

Illinois plans to select 4 to 7 managed care plans to serve all populations throughout the entire state. It's reasonable to assume that when the selection process is complete, McHenry County and the providers it funds will be expected to contract and coordinate services with plans that are new to McHenry County and possibly new to certain populations.

The state also intends to use this opportunity to introduce the concept of integrated health homes as a model of service provision that all plans must implement. This new arrangement of care coordination and service delivery requires plans to enter into arrangements with community providers whereby those providers can have an increased role in providing care coordination and support services. In some cases, it could be conceivable that a community provider could serve as the lead care coordinator for a member.

Considering the possibility of new health plans coming into McHenry County and the fact that those plans will have to take a much more open approach to care coordination, MCMHB has an opportunity to serve as a liaison between the community of providers in McHenry County and managed care plans as those plans begin reaching out to their members. MCMHB would serve the community well if it shared its experience and best practices with plans so that those plans are well prepared to serve as a partner and provider.

1115 Waiver (Behavioral Health Transformation)

Illinois is expected within the next 6 months to take a prominent step forward in the funding and provision of mental health services. The Behavioral Health Transformation is an attempt by the state to rebalance the behavioral health system, promote integrated behavioral and physical health care delivery, support the development of behavioral health services, invest in support services, and create an environment where providers move to value-based care.

This ambitious attempt to revamp Illinois' flagging mental health system comes with it enhanced funding through an 1115 waiver that will not only provide funding, but will also support payments for services previously not funded in the past.

VII. Recommendations and Conclusion

Analysis of active 708 Boards throughout Illinois show that their funding priorities align with our proposed approach. SPW found that Illinois boards allocate on average 5% of their budgets towards wrap around-type services, 5% towards alleviating transportation burdens, and 15% towards Intensive Outpatient Programs. This stands in marked contrast to the McHenry County MHB which minimally addresses both wrap-around and Intensive Outpatient Programs.

Day Programs

Currently, McHenry County has minimal provision of Day Programs for child and adolescents as compared to other 708 Boards throughout Illinois. Yet Day Programs have been identified as an important support that helps maintain stability as well as strengthens a child's physical and mental health. The consistency of day-to-day contact that such services provide can act as a critical support for children and adolescents, especially when the youth engage in these programs immediately following discharge from an inpatient setting.

Throughout our research, SPW found many providers, school teachers, and stakeholders lamenting the long daily commutes that must be taken to ensure consistent Day Program participation. This travel is often necessary because of the lack of such services closer to the major population centers of McHenry County, i.e. Crystal Lake, McHenry, Lake in the Hills.

The stress of round trips, that often take multiple hours, can be especially taxing if the family is not wholly supportive or engaged in the child's treatment process. It can also place pressures on a family's income (especially when the family is a single-headed home), impact school attendance, and even impair family functioning.

School-Based Programs

Mental Health Board (MHB) and stakeholders have identified school districts as willing partners to help meet the mental health needs of their students. McHenry County is home to multiple school districts serving a tremendous diversity of student. Consequently, the willingness and capability of these districts to help meet student's needs is almost as diverse as the student bodies themselves. One sole approach would not be sufficient or perhaps even useful depending on the district, school, and resources made available. SPW recommends a multi-faceted approach based on the school and its comfort level with an increased commitment to their students' mental health. The one consistent theme with our recommendations is reflected in the general perception from school staff that there is increased pressure on current staff to serve a greater role in supporting students. Staff have indicated that it is difficult, if not impossible based on current responsibilities and funding challenges, to broaden their roles and provide services. All SPW recommendations, therefore, endorse bringing in outside providers and practitioners to provide the recommended services.

There are four interventions that MHB could support through a school-based program. First, a professional could provide office hours during school hours to respond to issues in real time. The consistent presence of such a resource could provide great support to staff and students.

Second, a professional could provide traditional on-site mental health services outside of school hours for families who are low-income and who cannot travel to other providers. Such an approach, especially in those more rural areas of McHenry County could serve as a critical local support that would minimize burdens on families who otherwise might have to travel to see their children receive care. Third, a professional could provide medication management and psychiatric evaluations as needed, either during school hours or outside school hours. Fourth, a counselor could be put in place to provide intensive case management services within a school setting. This counselor would serve to monitor a student's progress, medication adherence, and appointment attendance.

Most school-based programs are collaborations between the school social worker, school nurse, teacher, administrator, and a community organization that specializes in mental health services. A majority of a school-based program's work can be performed by a LSW, LCSW, or an APN. This recommendation leaves room for the Mental Health Board to be creative about the medication management or psychiatric evaluations. Presumably, a qualified mental health professional could conduct the evaluations and a psychiatrist could review and interpret the results remotely. In addition, an APN may be able to prescribe the medication so long as the psychiatrist signs off on the prescription. Or, possibly, a student could meet with a psychiatrist virtually.

Rosecrance has successfully piloted the creation of a mental health clinic located onsite at a local school. It is staffed by two therapists who worked two days a week. Thirty children who are on Medicaid were served through this program which puts it at full capacity. This speaks to the level of need within one school. In addition, survey results from schools throughout the county indicate that hundreds more students would benefit from such a service provided on school grounds.

Transportation

Many survey respondent, stakeholders, and professionals cited transportation challenges as a key barrier to care for child and adolescents. However, multiple challenges make any proposed one solution highly unlikely. Instead, multiple smaller initiatives and enhancements to existing programs may provide the best opportunity for improvement.

SPW recommends that McHenry County continue providing funding to local providers for use to pay transportation providers for the transport of patients to and from treatment. We understand that these funds have not been fully accessed. This is, we believe, a function of the lack of providers willing to transport patients. It is possible that a concerted campaign around the availability of

these funds, e.g. to local cab companies, may incentivize some providers to make more transport available.

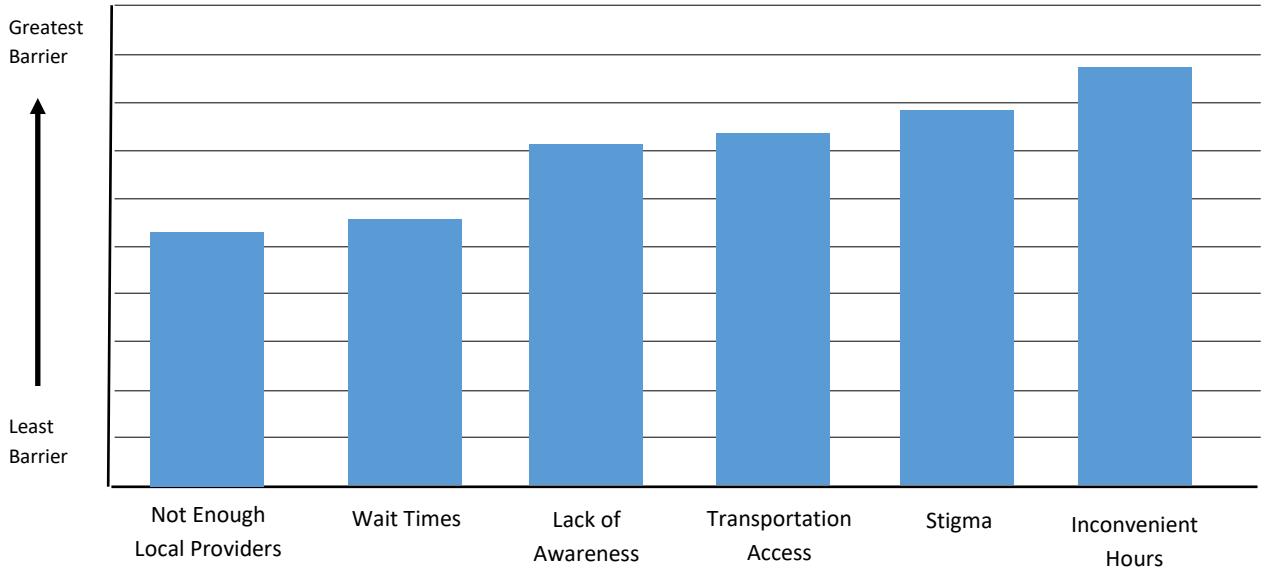
Additionally, we recommend maintaining a budget line item to directly reimburse parents whose children require the high intensity interventions outside the county. A verification from the provider that such travel was incurred by the parent could help ensure that such travel took place.

We also recommend the Board investigate the development of a peer-based transport system where parents and volunteers help bridge the transportation gap. The Mobility Management Program (MMP) is an example of a peer-based transportation program designed to increase participant access to services and activities.

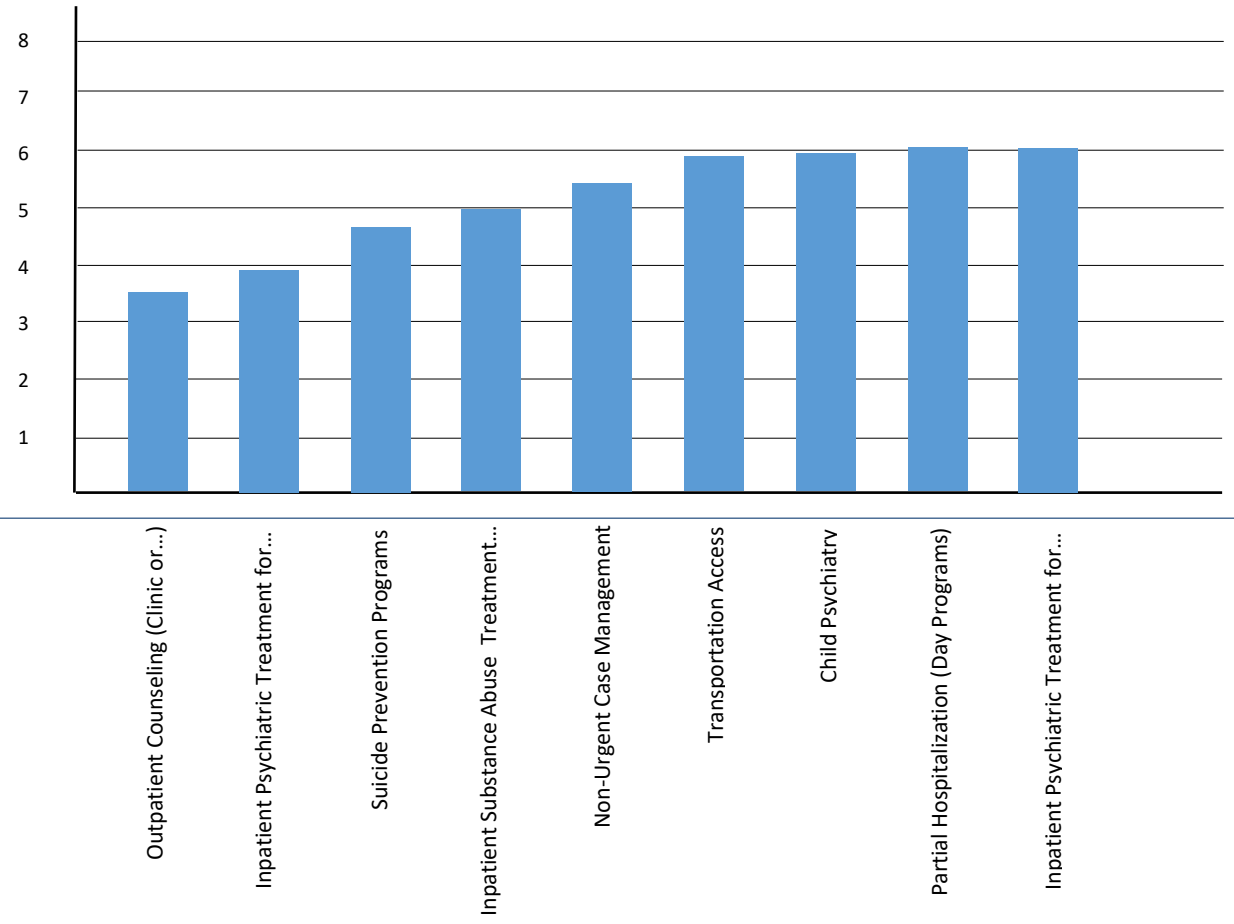
APPENDIX A

Smart Policy Works McHenry County Child-Adolescent Behavioral Health Survey Results

Q1: Rank the following barriers for children and adolescents to accessing behavioral/mental health treatment in McHenry County.

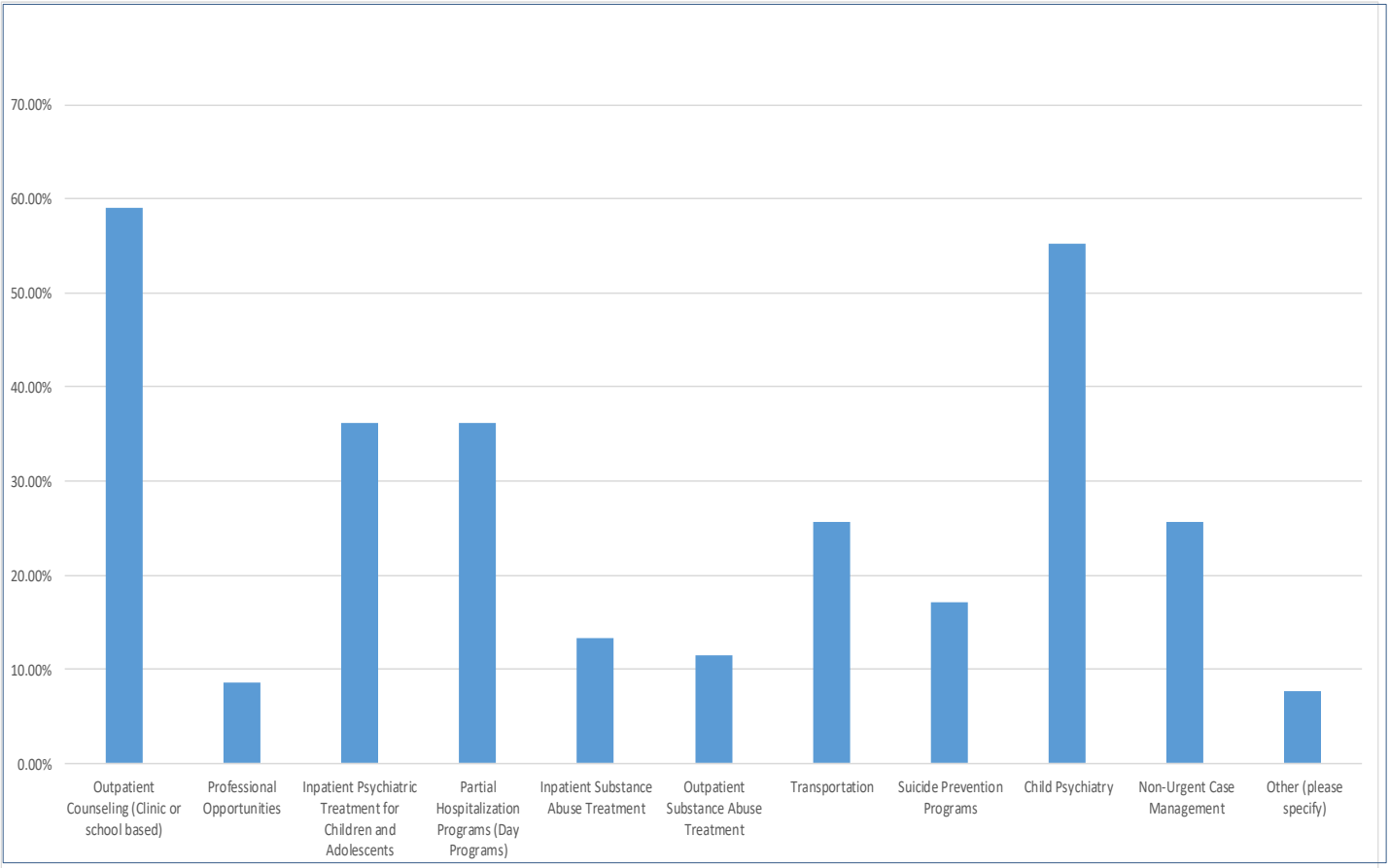


Q2: Rank the availability of these services for children and adolescents in McHenry County from 1 to 10 (1=least available, 10=most available).



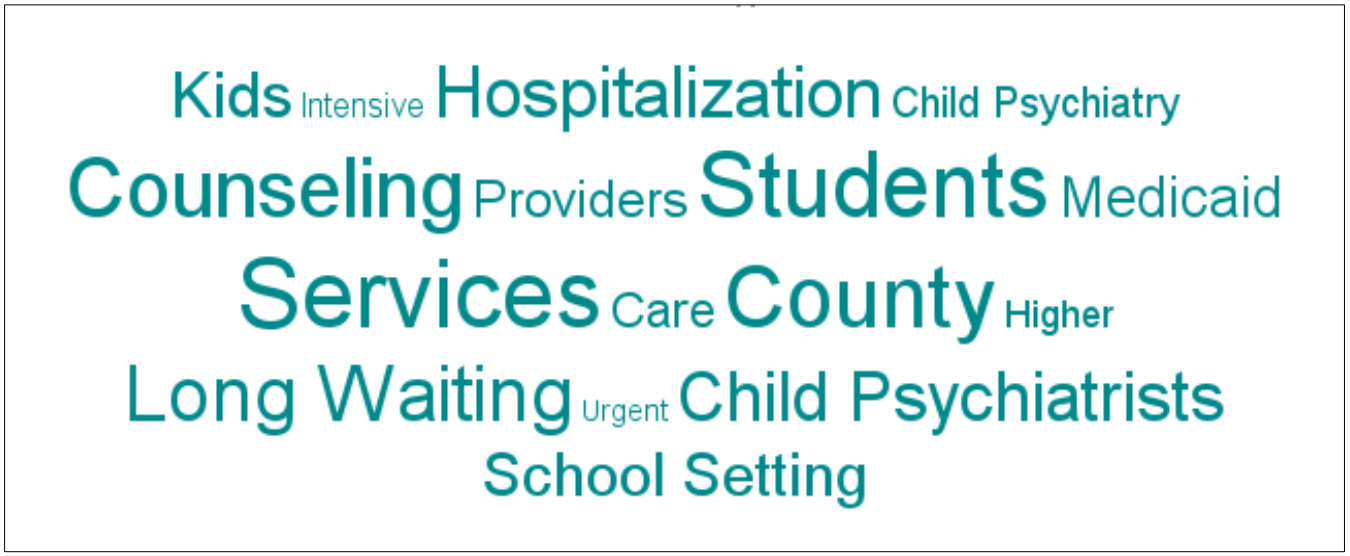
Q3: If you had funds available to improve services for children and adolescents in McHenry County, which of the following would you invest in? Select up to 3.

Answered: 84 Skipped: 20



Q4: Considering your answer to the previous question, explain why you would invest in that service or activity.

Answered: 84 Skipped: 20



Q5: Please indicate whether you agree or disagree with the following statements regarding services for children and adolescents in McHenry County.

Answered: 105 Skipped: 0

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total
Current services adequately meet the needs of the community.	**0.00%** 0	**6.00%** 6	**9.00%** 9	**61.00%** 61	**24.00%** 24	100
The wait times between intake and start of services are adequate.	**2.02%** 2	**7.07%** 7	**27.27%** 27	**45.45%** 45	**18.18%** 18	99
Schools in McHenry County have policies regarding how to address mental and behavioral health needs of students.	**13.00%** 13	**59.00%** 59	**8.00%** 8	**16.00%** 16	**4.00%** 4	100
Staff in schools are adequately prepared to identify and connect children in need of behavioral health services to those services in the school or in the community.	**12.87%** 13	**56.44%** 57	**13.86%** 14	**14.85%** 15	**1.98%** 2	101
Staff in schools have sufficient access to training opportunities to build skills on identifying and addressing the behavioral health needs of students.	**6.93%** 7	**48.51%** 49	**18.81%** 19	**20.79%** 21	**4.95%** 5	101

Q6: Do you have any other comments, questions, or concerns?

Answered: 23 Skipped: 82

- The biggest issue is getting parents to follow through and get their child help. The other issue is getting kids to agree to help. Also, getting crisis help is difficult with long wait times
- It is slowly improving. There are still many gaps in the area reduced wait list, family support , and access to services. The mental health board has done an incredible job shoring up and getting gaps in services lessened. The training opportunities have improved and been beneficial.
- I think the school staff is trained for "tip of the iceberg" social-emotional needs for their students. They do not have the time or training for in-depth personal counseling. While we now have a connection with Rosecrance that eliminates the transportation problem that is such a huge obstacle for many of our students, it only addresses students without insurance or on state insurance. While this is better than we have had in the past, it still leaves out a large section of our student body (those with insurance) who could benefit from these same supports.
- School counselors should be available and prepared for and over flow of students (triage) when social workers are not available or are working with other students
- My concern with the last couple of questions is the implication that schools are mental health facilities. Schools are not equipped to be mental health facilities, nor is that their purpose. We can support students and help them access their education - but when a high school counselor has a case load of 400 students and the social worker has a case load of 800 students....please don't expect schools to take on more burdens than we already do. Outside services need to increase in McHenry County to allow families to access services as a FAMILY.....and not expect schools to act as the surrogate system when it is a family system that is broken.
- Counseling is needed for those with insurance.. the wait time at Rosecrance is 4 weeks or longer and then they have to get to Crystal lake
- Service providers have changed along with availability an in service would be helpful to address current practitioners available.
- I cannot speak for other school districts in McHenry County but District #47 has, I feel, done an excellent job of trying to educate staff in the identification and referral of students with social-emotional/mental health needs through universal screening, incorporation of Erin's Law programs, PD on trauma and behavioral management. There is always room for more though - students are coming to school with increasing needs, it appears, and families are increasingly ill-equipped to meet the needs of their children.
- We need in school case management for those with insurance.
- There is also a concern in the area of available services for the low income or uninsured.
- I can only speak to the high school professionals. I do not feel that all the staff are adequately trained in the middle or elementary levels for mental health.

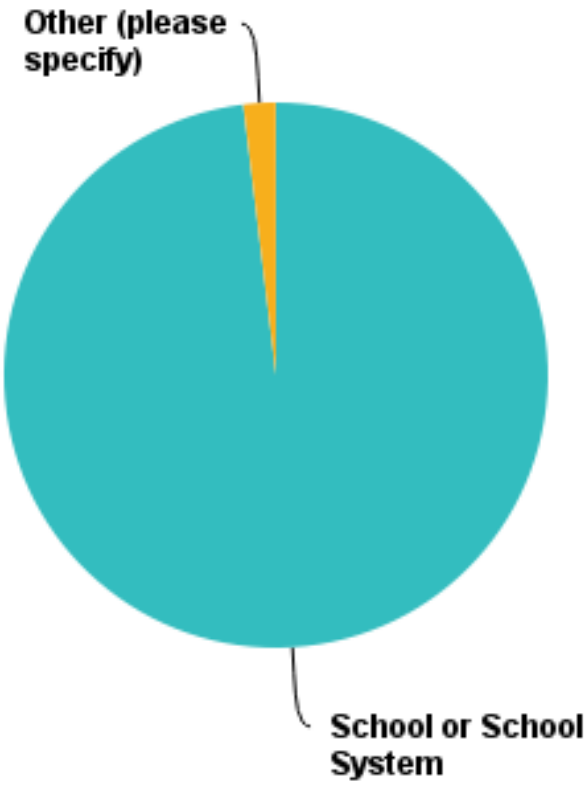
Q6: Do you have any other comments, questions, or concerns? (Cont.)

Answered: 23 Skipped: 82

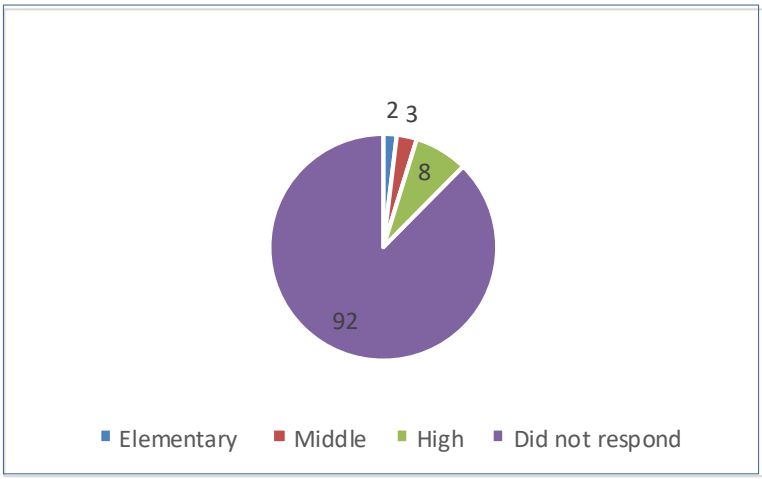
- Your first list of questions would not retain the numbers. I would rate them all ones.
- Working and living near the border of IL and WI, there are limited if any trainings near where I live and work. Most trainings are south or in the Chicago area.
- School staff do have the training, however the student's problems need more than school staff can provide.
- If McHenry County can not access or provide free standing facilities for Day and Inpatient treatment programs money needs to come for Transportation to existing programs like AMITA and Streamwood
- I am not aware of what is available to students. I can refer students but don't know where it goes from there.
- The schools are overwhelmed with all the social emotional needs that we are seeing. Counselors are not trained therapists, yet we are forced to act as trained therapist with the severe needs and lack of outside resources...but also, when we finally get a student connected to what they need, if often falls apart...parents, students do not follow through. I think it would take a special proactive approach to counseling outside where counselors act as case-managers, calling if they miss an appointment and rescheduling when they don't show up...so many just stop going and they really need to keep going to counseling... we constantly call and encourage and try to keep that outside counseling going-but often, we do not even know when they have stopped counseling until we start seeing downhill slides with our students.
- Staff in school cannot be the primary treatment team for students.
- I've been seeing good PD opportunities as well as networking opportunities with private services providers lately. School staff need to take the time to read the emails, go to the PD opportunities, etc. I like Jackie Rhew's lunch lectures. Quick, centrally located, easy to get to, and not so big of a time commitment that I'd feel concerned leaving my building. It's a great idea.
- I can't speak for other schools, we do have a lot of PD. I see the trend as kids are more challenging as parents are also battling mental health and addiction issues- huge increase!!! (Especially with addictions)
- Waiting lists for med eval's and assessments are way too long for people in need. Lacking resources and insurance coverage for quicker access to housing, medical and mental health services.

Q7: Where do you work?

Answered: 104 Skipped: 1

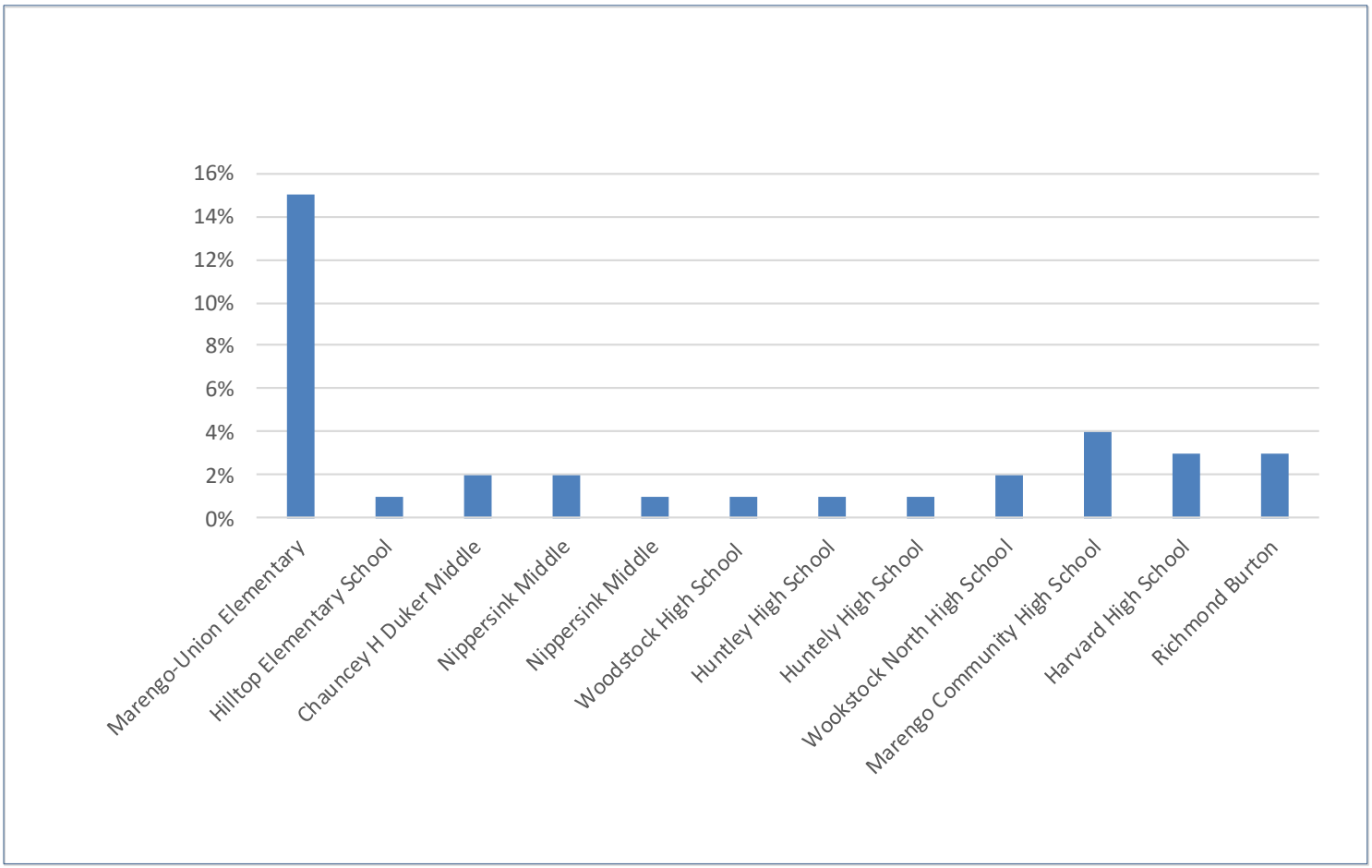


Q8: Participatory Schools



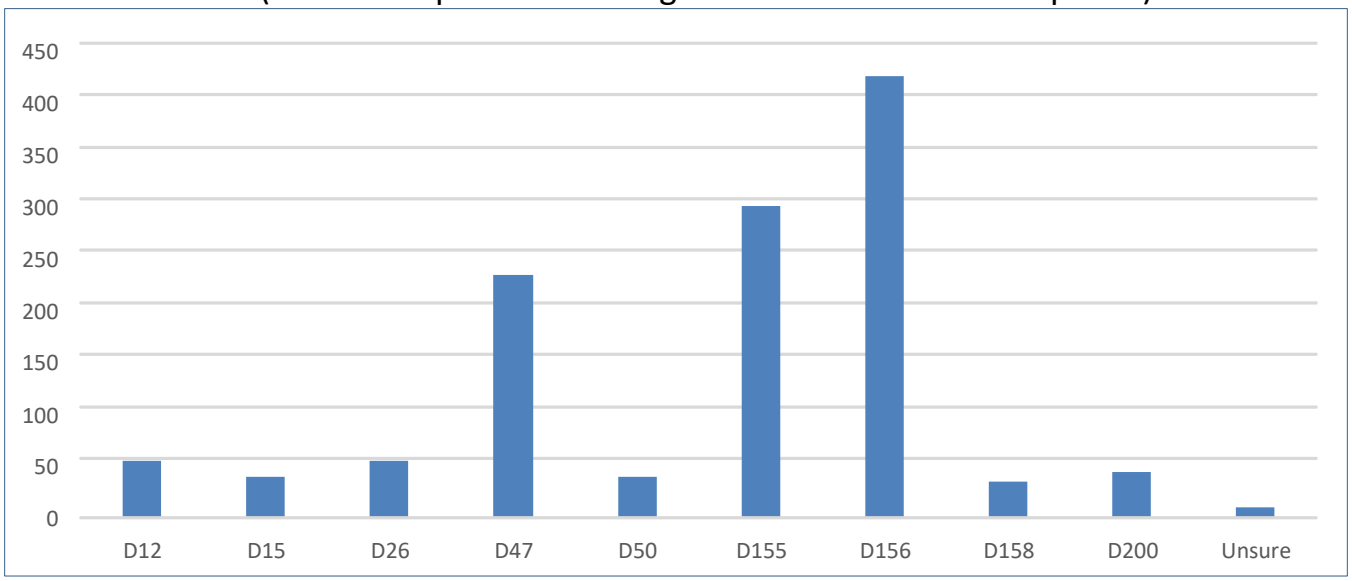
School	Level
Marengo-Union Elementary	Elementary
Hilltop Elementary School	Elementary
Chauncey H Duker Middle	Middle
Nippersink Middle	Middle
Woodstock High School	High
Huntley High School	High
Woodstock North High School	High
Marengo Community High School	High
Harvard High School	High
Richmond Burton	High
Prairie Ridge	High

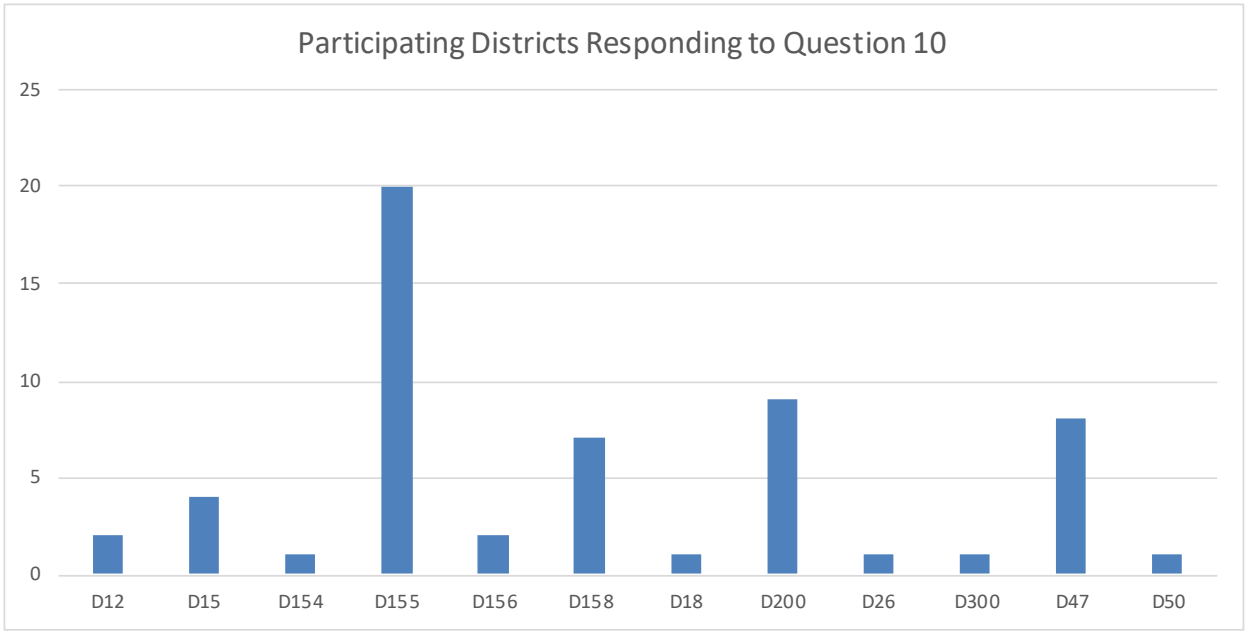
Q9: Please estimate how many of your students would benefit from case management services but do not qualify for SASS.



Q10: How many students in McHenry County are eligible for behavioral health services under IEPs or 504 plans in the school district you represent?

(Number represents average from each district's response)





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