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SCHOOL OF SOCIAL WORK

Children's Mental Health Initiative 2.0 Evaluation: Implementation Year Two Site Visit Report

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Table of Contents

1. Introduction and Background

1.1 Overview of the Children's Mental Health Initiative 2.0

On October 1, 2018, the Illinois Children's Healthcare Foundation (ILCHF) awarded 13-month planning grants to five Illinois communities to develop partnerships and strategies to build children's mental health systems of care (SOC). ILCHF uses the definition of system of care developed by Stroul, Blau, and Friedman (2010): "a spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life."[1] Children and youth with or at risk of mental health disorders and their families need supports and services from many different child- and family-serving agencies. Often, these supports and services are provided in a fragmented fashion. By creating partnerships and integration among agencies and organizations, systems of care are able to coordinate services and supports to meet the ever-changing needs of children and families, with the idea of improving outcomes.[2]

During the planning phase, each of the five communities worked to build the local infrastructure necessary to implement their CMHI 2.0 plan. This included the development of a formal strategic plan, organizational structure, financial model, and plan for sustainability. The strategic plans included an analysis of the community's strengths (assets) and weaknesses (gaps in services), as well as an analysis of the current system of care in the community. Upon successful completion of the planning phase, ILCHF awarded six-year implementation grants to the communities in order to build or enhance an effective and sustainable children's mental health system of care.[3] Although ILCHF expects that these plans will be unique to each community, the implementation plans must be written in ways that are consistent with the Child and Adolescent Service System Principles (CASSP) outlined by Stroul, Blau, and Friedman (2010):[4]

1. Family driven and youth guided, with the strengths and needs of the child and family determining the type and mix of services and supports provided.
2. Community-based, with the locus of services as well as system management resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level.
3. Culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve

[1] Stroul, B.A., Blau, G.M., & Friedman, R.M. (2010). *Updating the System of Care Concept and Philosophy.* Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development.
[2] Illinois Children's Healthcare Foundation. (2019). *Children's Mental Health Initiative 2.0 Targeted Invitation for Applications.* Oak Brook, IL: Author.
[3] ILCHF (2019), ibid.
[4] Stroul, et al. (2010), ibid.

to facilitate access to and utilization of appropriate services and supports and to eliminate disparities in care.

The goals of the CMHI 2.0 are to impact the following outcomes related to effective service systems and child and family well-being:

1. Early identification of children and youth for whom there is concern about possible mental health disorders.
2. Increased capacity in the service system to provide families with evidence-based clinical interventions.
3. Increased parent/caregiver/youth 'peer' provided services and leadership in the local system of care.
4. Effective local use of outcomes measurement data to inform operations and changes in the system, including sharing data between service provider systems.
5. Understanding the costs of service provision.
6. Increased service integration among service providers in the community.
7. Development of a well-prepared mental health workforce.
8. Improvement in life domain functioning for children with and at-risk of serious emotional disturbance; including school participation and academic success variables.
9. Strengthened parenting practices and caregiver-child relationships.
10. Reduction in caregiver related stress for parents/primary caregivers of children with mental health disorders; reduction in parental depression.
11. Reduction in unmet basic needs of families participating in the mental health service system.

1.2 Overview of the CMHI 2.0 Evaluation

The Children and Family Research Center (CFRC) at the University of Illinois at Urbana-Champaign has partnered with ILCHF to design and conduct a comprehensive evaluation of the CMHI 2.0. The evaluation will have several components, some of which are adapted from those utilized in the national evaluation of the Children's Mental Health Initiative (CMHI).[5] The components of the CMHI 2.0 evaluation include:

- An *implementation study* will document the processes that are used to implement systems of care in the five communities. The sustainability of the system of care implementation efforts will be assessed toward the end of the evaluation period.
- A *system of care fidelity assessment* will examine whether the five communities implement services in accordance with the system of care principles outlined by CASSP.
- A *descriptive study of the children and families* served by the systems of care in the five ILCHF-funded communities. In the descriptive study, information will be gathered at

[5] ICF Macro. (2011). *The Comprehensive Community Mental Health Services for Children and Their Families Program Evaluation Findings – Annual Report to Congress.* Washington, DC: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. This evaluation will be referred to within this evaluation plan as "the national evaluation" so as not to confuse it with the ILCHF CMHI 1.0 or CMHI 2.0 evaluations.

intake about the demographic characteristics, living arrangements, child and family risk factors, presenting problems and clinical diagnoses, functional status, and mental health service histories of the children served in the systems of care in the five communities.

- A *descriptive services study* will describe the types of services used by families, their patterns of service use, and their satisfaction with services.
- A *longitudinal outcome study* will assess change over time among the children, youth, and families participating in systems of care services in the five communities. Information on a variety of outcomes will be collected from caregivers at intake and at regular intervals for 24 months following intake. In addition, information on system-level outcomes will be gathered from a variety of stakeholders in the annual stakeholder survey.
- A *cost analysis* will assess the costs associated with system of care services.

1.3 The CMHI 2.0 Implementation Evaluation

The purpose of the implementation evaluation is to describe the activities that are undertaken to implement children's mental health systems of care in each of the five sites over the 13-month planning period and the six-year implementation period. A combination of qualitative and quantitative data collection methods will be used for the implementation evaluation. Qualitative data are collected during site visits in each of the five CMHI 2.0 communities. During these site visits, CFRC conducts focus groups with service providers, parents/caregivers, youth, community planning teams, and other key stakeholder groups. Site visits also include individual interviews with project directors and other staff/stakeholders with essential knowledge about the implementation of systems of care in the five sites and a review of documents such as strategic plans and implementation progress reports. The goal of the site visit data collection is to provide detailed descriptions of the activities and processes that are being employed in each site to implement systems of care, as well as to document successful strategies for and barriers to implementation. In addition to the qualitative data that are collected during the site visits, quantitative data on implementation will be gathered through an annual stakeholder survey that contains questions related to implementation activities and their effectiveness in producing change in the systems of care in the communities.

This report provides information from the second round of site visits conducted in each of the five sites at the end of the second year of implementation. The report provides information to address the following topics and questions:

1. What are participants' understandings of their sites' major goals, objectives, and interventions for changing or improving the children's mental health system of care?

2. What progress has been made in implementing children's mental health systems of care during the first two years of implementation? What activities have been undertaken to implement the interventions that were selected during the planning stage?

3. How did participants describe the implementation infrastructure and processes that guided and supported implementation? Specifically, how did they describe management and leadership, planning and decision-making, and communication within the implementation teams and to the wider community?

4. What were participants' perceptions regarding the role of parents and youth in the implementation process?

5. What were participants' perceptions of the barriers to implementation?

6. What did participants perceive as facilitators of implementation?

2. Methods

2.1 Site Visit Participant Recruitment

The evaluation team contacted the project directors in each of the five sites to obtain a list of community stakeholders and parents who were involved in the system of care implementation in their site. These individuals were sent email invitations to participate in a focus group or interview. The recruitment emails described the purpose of the focus groups and directed those who were interested to an online poll where they could provide their available times for scheduling purposes. The informed consent form was attached so that participants could review the information prior to the meeting and make an informed choice about their participation. Parents and youth[6] were offered a $50 Amazon gift card as an incentive for participation in the focus groups. Table 1 shows the number of community stakeholders, parents, and youth who participated in the focus groups or interviews at each site.

Table 1. Number of Participants Invited and Participated by Site

	Building Compassionate Communities		Community Together		Kane County System of Care (KCSOC)		Kids Connected		Project SUN	
	Invited	Participated	Invited	Participated	Invited	Participated	Invited	Participated	Invited	Participated
Parents	7	1	10	3	13	6	6	0	5	3
Youth	0	0	2	1	0	0	0	0	0	0
Project Staff	2	2	1	1	3	3	7	3	3	3
Community Stakeholders	6	3	26	5	20	9	38	5	27	9
Total	15	6	39	10	36	18	51	8	35	15

2.2 Data Collection Procedures

All data collection procedures were reviewed and approved by the Institutional Review Board at the University of Illinois at Urbana-Champaign. Prior to each site visit, the research team reviewed existing documents related to the system of care in each of the sites, including the initial implementation grant applications and 6-month implementation progress reports required by the funding agency.

Participants for the study were recruited from each site using a purposive method targeting key stakeholders in each system of care. Project Directors from each site provided the research team with a list of individuals to include in the recruitment for the site visits, based on their involvement and ability to report on SOC implementation to date. The team contacted stakeholders on the list via email to offer the opportunity to participate in either a focus group

[6] All youth were over 18 and could therefore provide informed consent.

(professionals and service providers, youth, and parents) or an interview (project staff) to provide their perspectives. Stakeholders then self-selected for participation.

The focus group/interview protocol was developed by the research team to assess a range of topics related to system of care implementation. The questions that were asked are included in Appendix A. The focus groups and interviews took one to two hours to complete. The focus groups and interviews were conducted virtually (on Zoom) by researchers from the Children and Family Research Center during November and December 2021. All interviews and focus groups were recorded and transcribed for analysis. Informed consent was verbally obtained for each focus group and interview prior to starting the recording and participants were provided with a copy of the consent form in advance.

2.3 Data Analysis Procedures

Team members checked each transcript for accuracy, removed identifying information, and uploaded transcripts to qualitative analysis software ATLAS.ti (version 9), grouping the transcripts by site. Team members coded each transcript using a priori codes that were created to correspond to each of the research questions: goal/objective, activity, organizational structure or process (e.g., leadership, communication, teams/workgroups, meetings, decision-making, use of data), parent involvement/leadership, youth involvement/leadership, implementation barrier, and implementation facilitator. Sections of the transcripts could be coded with more than one code; for example, one quote could be coded as both an activity and parent involvement.

The team then generated code reports from ATLAS.ti for each site and for each a priori code. The code reports were analyzed for appropriateness of the coding and for subthemes and patterns that emerged within each category. Once these subthemes were established, we organized the findings around participant quotes and information from existing documents that illustrate the essence of that theme and provide insight into the process of implementing systems of care. After conducting analyses and identifying findings for individual sites, the research team discussed the findings across all five sites to determine similarities, differences, and implications for the research questions.

3. Results – Building Compassionate Communities

The Building Compassionate Communities SOC serves the primarily rural counties of Franklin, Jackson, Perry, and Williamson in Southern Illinois. According to 2020 U.S. Census numbers, Franklin County has a population of 37,804. The largest city in Franklin County is West Frankfort. In 2020, the median household income in the county was $43,671. About 19% of the population live below the poverty level, higher than the state average of 12%. Additionally, 23.3% of children in the county live in poverty.[7] In terms of race and ethnicity, 95.9% of the population is White (non-Hispanic), with about 1% reporting multiracial non-Hispanic, and less than 1% African American. About 1.68% of the population of the county identify as Hispanic of any race.[8]

Jackson County had a population of 52,974 with Carbondale being the most populous city according to the 2020 Census. Carbondale is home to Southern Illinois University. The median income for a household in the county was $39,689. About 25.3% of children and 12% of the overall population were below the poverty line.[9] In terms of race and ethnicity, 74% of the population is White (non-Hispanic), with about 14.9% African American (non-Hispanic), followed by 3.44% Asian, and 2.55% multiracial (non-Hispanic). About 4.43% of the population of the county identify as Hispanic of any race.[10]

Perry County's population was 20,945 according to the 2020 census and its two largest cities are Du Quion and Pinckneyville. The median income for a household was $51,616. About 17.5% of the overall population and 26.6% of children were living below the poverty line.[11] In terms of race and ethnicity, 85.8% of the population is White (non-Hispanic), with about 9.06% African American (non-Hispanic), followed by 1.22% being multiracial (non-Hispanic). About 3.12% of the population of the county identify as Hispanic of any race.[12]

Williamson County had a population of 67,153 at the 2020 census, with the largest city being Marion. The median income for a household in 2020 was $52,076. About 13.9% of the population and 19.1% of children were living below the poverty level.[13] In terms of race and ethnicity, 89.7% of the population is White (non-Hispanic), with about 4.1% African American (non-Hispanic), followed by 2.14% being multiracial (non-Hispanic) and Asian at 1.17%. About 2.64% of the population of the county identify as Hispanic of any race.[14]

The lead agency for the Building Compassionate Communities is Centerstone of Illinois. In Illinois, Centerstone has a 60-year history of providing comprehensive, trauma-informed mental

[7] Census profile for Franklin County: https://data.census.gov/cedsci/profile?g=0500000US17055
[8] Franklin County DataUSA: https://datausa.io/profile/geo/franklin-county-il#demographics
[9] Census profile for Jackson County: https://data.census.gov/cedsci/profile?g=0500000US17077
[10] Jackson County Data USA: https://datausa.io/profile/geo/jackson-county-il#demographics
[11] Census profile for Perry County: https://data.census.gov/cedsci/profile?g=0500000US17145
[12] Perry County DataUSA: https://datausa.io/profile/geo/perry-county-il#demographics
[13] Census profile for Williamson County: https://data.census.gov/cedsci/profile?g=0500000US17199
[14] Williamson County DataUSA: https://datausa.io/profile/geo/williamson-county-il#demographics

health and addiction services, and services for adults with developmental/intellectual disabilities. Combined, Centerstone serves over 15,000 individuals of all ages in Southern Illinois and the St. Louis Metro-East region. According to the implementation grant application, the CMHI 2.0 grant supports several staff positions in part or in full, including a Project Director, Project Manager, a Family Engagement Supervisor, and several Family Resource Developers (FRD). The Family Engagement Supervisor "is envisioned to be an individual who has lived experience with navigating both mental health and community systems, who will support the evaluation component of the project as well as support the Family Resource Developer positions within the project. This individual will provide ongoing support to ensure family engagement with the evaluative process, as well as collaboration with the evaluation team assigned to the project." (p. 10)[15]

As described in the implementation grant application, the initial goals of the Building Compassionate Communities SOC were to strengthen existing collaborative relationships by fortifying current and identified services, learning opportunities, and initiatives that will continue to address community compassion/wellness, prevention/access to services, and coordination of mental health services. Strategies envisioned to bolster community compassion and wellness included professional development opportunities for mental health professionals and other child-serving providers; parental support groups as well as parent training/skills groups; and training and support to area schools that will increase their knowledge of mental health concerns. Activities that were proposed to address needs in prevention and access to services included providing Family Resource Developers (FRDs) at key locations throughout the system of care, including within schools. FRDs can address immediate needs of the family (food, clothing, housing, health concerns) and assist in the referral process for services as needed. In addition, Building Compassionate Communities intended to increase the use of mental health screenings, implement a new client referral system, and develop a client assistance fund. Finally, this project aimed to increase service coordination through the use of High Fidelity Wraparound and Practicewise/MAP.

3.1 System of Care Goals, Objectives, and Interventions

A primary focus of the site visits was to explore participant perceptions of the aims of the SOC and progress toward those goals to date. A number of key themes emerged, largely reflective of the original goals described in the grant to implement the Building Compassionate Communities (BCC), including principles related to systems of care and mental health delivery models:

> *Our goals follow a three-tiered system of organization, on how we want to develop our system of care…our first tier is really about overall community compassion and wellness, and so we have goals within our system of care project to enhance our overall community…. a lot of goals in tier one centered around training and consultation and just making sure that people are well informed in general. Tier two really centers around*

[15] Building Compassionate Communities implementation grant application (2019).

prevention and services for all children and families, and so there are activities within our tier two activities for our system of care grant that center around prevention work.

As the overarching goal of the BCC SOC, creating accessible and effective systems of care rests on a number of other critical aims including enhancing access through service coordination and collaboration, building capacity for evidence-based services, and targeting early intervention.

Service coordination and collaboration. Key to achieving the broad aim of supporting and improving children's mental health is the goal of building a connected system of care that works to eliminate redundancies and more effectively coordinate service provision:

What we're really looking at is this improved system for children who need mental health services, and that means making it more seamless and getting children connected easily to the services that they need. I feel that level of collaboration, whether it is working with the IRIS system for referrals or coordinating with all the schools and other stakeholders in the community is a big part of what we're doing.

Capacity-building. Building the capacity of service providers within the SOC through training, networking, and support for evidence-based practice is another goal of the SOC implementation.

Building on this, on the mental health, but really just looking at how do we build capacity. How do we build capacity of the people that we're serving, the school, family, but thinking much broader, the whole school, community, the whole child, you know however we're building extending that learning to build capacity in our families, and in our larger communities? And even though it has been a difficult time, I do think that the trainings, the professional development that we have been able to provide for many audiences, is helping us get to that increased capacity.

Early intervention and prevention. Another stated goal of the BCC SOC is a focus on early intervention and services for families with young children in the region with mental health needs:

The biggest goal, the overall reaching goal, is to connect different agencies with people in our community, specifically targeting young children, students in the Southern Illinois region, the four-county region that we serve, and trying to connect those students with as many services as possible, to help them improve their mental health.

Participants also discussed the ways that early intervention intersects with other goals and their efforts to make efficient use of resources toward common aims:

I think about COVID and one of our goals is early identification of children who have mental health needs, and we've certainly tried to do that, even by connecting with other

grants that we might have. We have a COVID grant which allows us to see both adults and children who are experiencing issues due to COVID.

Community buy-in and participation. A final goal centered more on the *who* rather than the *what* of the SOC: To cultivate broad community recognition as well as the buy-in and participation of organizational partners. Several participants discussed the importance of school involvement to building an effective community-based children's mental health system. Within that context, participants also talked about rural outreach and participation as a goal for the BCC SOC. As a system serving four counties covering a relatively large geographical area that is primarily rural, adaptation and innovation can be important elements of implementation:

So, thinking about [LOCAL HIGH SCHOOL], brings in kids from as far as 25 miles away. They'll bring kids into their high school, and so while at the summertime that becomes more difficult…during the school year, during the normal work week, we can least engage the students at that site, so that's been nice now…they're looking at a mobile mental health van, something to that effect.

I've always thought…when we talk about cultural competence, that we need to consider that there is a rural cultural competence that needs to be built or recognized.

3.2 Activities and Progress Toward Goals

Service coordination and collaboration. BCC has made a number of efforts toward meeting the service coordination. One area where activities have focused is on community outreach to ensure the community understands what is available to support children and families. One individual described some public awareness elements:

So we did a mental health awareness campaign, and it was just like yard signs, and maybe T-shirts? I don't remember exactly, but they had like a QR code on the signs about ways to access mental health services and what mental health awareness was…

There's been some family events, there's been some radio, larger market marketing, so billboard, radio, the family things, putting together item…promotional items that go out, but then also making sure that the other youth serving organizations, like the Boys and Girls Club, that there's information that goes out that way too.

Other activities have focused on providing services through the schools.

So, one of our goals is to increase non-Medicaid reimbursement services in schools, because we do a lot of work in schools, and so we have been increasing the amount of schools that we collaborate with…provide social emotional learning work with kids who are having a hard time. Kids don't have to be enrolled in formal mental health services to get prevention, intervention and so that is one of our big like tier two activities.

While much has been achieved to date, participants also maintained a focus on continued work in this area:

> *The only things that we haven't gained ground in as far as the project activities would be…we'd envision doing more like mental health screening for kids, in collaboration with either schools or primary care that never really has taken off…with COVID, schools' focus has really been on other things, and so, and a lot of them honestly are doing their own mental health screening for kids.*

BCC also implemented two interventions that were intended to streamline service referrals and the provision of evidence-based services within the communities:

> *Then another big tier three intervention is an online referral system which some other cohorts are using…. IRIS streamlines entry into formal mental health services, makes it easier for schools to make referrals, and then also for us to receive them, track them, get data from them, and things like that.*
>
> *And then I think the last tier three activity or goal that we have is to implement the use of Practicewise and MAP with all of our child- and family-serving clinicians and we've been actively training all of our staff. We've done a train the trainer training so that we can train our own staff, so we're still in the process of embedding that into our child and family serving programs.*

Capacity-building through training and professional development. During the last two years, training and professional development for SOC service providers has been a primary pathway for the capacity-building goal. Specifically, professional development for clinicians to receive certifications and to become competent to deliver high fidelity evidence-based interventions was identified by participants as a central activity and one for which there has been great progress.

> *We have activities in tier three around enhancing evidence-based practices through training, so we offer them not only to our employees, but any mental health practitioners in the community generally for free to enhance the service array for kids.*
>
> *Yeah, the big one is Wraparound training and trying to get everyone trained in that. I think this summer we worked with a child psychologist here in Southern Illinois, and he was able to provide the training. I want to say, at the time, it's not right now, but at the time, 100% of our staff were trained on Wraparound. The reason why it's not right now is because we've had some turnover, and there's been some new people.*
>
> *We've been able to identify trainings that have benefited providers in the community to help with children, whether that be wraparound training, or one training that a number of us just went through was the suicide prevention training, the Yellow Ribbon Suicide Prevention training.*

I think the main ones, have been TF-CBT, EMDR, trauma-based therapy models, we've done some trainings on dialectic behavioral therapy.

Yeah, so obviously COVID's made a huge impact. So, talking about the amount that we planned on spending for travel, that's gone (laughs). We're not traveling, and so we moved those funds to help support the Client Assistance Fund and help support the increase of training. Zoom has been a great tool for us, and so we've utilized that to help provide trainings from the Search Institute…and also trainings that our staff and my colleagues offer… We weren't initially planning on doing so much training. I think this year we offered right around 15 trainings overall throughout the year. I don't believe that was the original plan, so it's been a nice reaction.

The other thing that we haven't done a whole lot with…is group parent training or skills. That's mainly because there are a lot of different pockets of that happening in our communities that maybe we didn't know about when we wrote the implementation plan…So that might be the only other thing that will change; everything else has maintained traction and progress as far as what we set out to do. So, we'll probably stay the same, some of the trainings and things that we might try to roll out service delivery wise or evidence-based practice wise will probably change because of the state's change and how they want to do, child and family serving systems like the integration of the Pathways to Success Program. That cuts out a whole big activity, we have a high fidelity wraparound team forming in our region, we won't need to do that from scratch, because the state is doing that.

In addition to professional development focused on clinical knowledge and skills, participants also discussed having training focused on a particular population or in response to an identified community need. For instance, concerted efforts to build capacity for work with the LGBTQIA+ population was discussed by several participants, one stating:

A lot of the other trainings and things that we've been doing have centered around for tier one and tier two trauma. We've been doing poverty simulation trainings for the community and different things like that, just to be more preventative in nature…We have a family engagement subcommittee that really works on different ways we can engage families in the community, and they work with a lot of different community coalitions and groups and schools to do that. We also have an LGBTQ+ subcommittee, which is looking at really tier one, two and three things to support LGBTQ+ youth, and so a new goal for a year three will be to help schools to form GSAs within their schools – Gay-Straight Alliances.

In addition to building capacity for direct service provision via training and certification for professionals, BCC utilized excess funds by offering small funding opportunities for partners:

I think they call it a grant program…They decided to use it for people to be able to submit for therapy tools that counselors thought were appropriate for…they had a kid that needed point of access for like internet, to be able to do therapy at home; a cell phone to be able to talk to somebody and things like that, instead of using it for that larger different purpose that we couldn't use it for. And it had to be under a certain amount, and there were some rules about it, like under certain amount, only so much per family, those kinds of things, and we did have to all approve it.

I think things like taking that training money and turning it into the small amounts of money for things like, "This child can use this item for therapy, this kid's alone during COVID and needs something to help with energy levels at home because he's making his mom insane."

Early intervention and prevention. Participants felt that good progress had been made on almost all of the SOC goals so far. The only exception mentioned was the goal related to implementing mental health screenings for early intervention within the local school systems. The lack of progress in this area was attributed to the COVID pandemic, a major barrier which is discussed in detail later.

We have not changed many of our project goals and activities because they have honestly, for the most part, even regardless of COVID, we've been able to move forward with all of them and we've been able to achieve the things that we set out to achieve, with all of them in some respect along the way, the only things that we haven't gained ground in as far as the project activities would be…we'd envision doing more like mental health screening for kids, in collaboration with either schools or primary care or whatnot…that never really has taken off for mainly for a couple of reasons too…it's difficult to get people like schools and doctor's office to collaborate on that. But also, with COVID schools' focus has really been on other things, and so, and a lot of them honestly are doing their own mental health screening for kids.

Relationship building and cultivating buy-in. The BCC SOC project director and partners have been working to develop relationships with both individuals and organizations. Existing relationships have facilitated this process. Participants also discussed the importance of proving the purpose and worth of the SOC as a pathway to increasing buy-in as noted above. For instance, partnering with schools to provide mental health screening has been key to both achieving early intervention and increased access, but also for the trust- and relationship-building that lies at the heart of building an SOC:

So, I'm not sure how well we've…how well we've done overall with all the community partners. Some of them we've been able to get people on the team that are in those places, and I think that creates big buy-in, having somebody that has a vision from that organization. I know we had some school that first that were like, "I'm not sure about this," and then getting a, that family resource person in the school. Then I know at least

at one of the schools, after we got one in there, they were like, "How do we get more of these things?" because it was so helpful to the students, and the teachers, etc.

Southern Illinois is a unique beast. You would think that with the population size that everyone knows each other, and to a certain extent that's true, we're all like first or second cousins down here, I get that. But there is a disconnect between communities, and a lot of communities don't know what everyone else is doing. So to get them to come to the table, I think in previous comments I spoke about getting religious leaders, and convincing them of "why?"…So getting them to come to the table and recognizing value has been hard, because that's an agency that doesn't normally participate with mental health. They have a history of not participating in mental health, so reaching across and getting their attention has been a struggle, but we're making headway, so that's been that's been good to see.

3.3 Implementation Supports and Processes

We identified a number of supportive structures and processes underlying the goals and their implementation within the BCC SOC. Leadership was of clear importance here, as well as communication, planning, and decision-making.

Leadership. Site visit participants were asked to describe the leadership for the SOC implementation. There was strong agreement that leadership was shared amongst all of the individuals and organizations that were involved in the planning and implementation committees rather than in one specific person or agency. According to the project director:

I, as the grant coordinator and director, lead the meetings and present agenda topics and things like that, but the ownership of the meeting is really shared…There are representatives from parents, from mental health, from healthcare, from schools, from regional schools, from public health…We have bylaws that we've developed together but it's really like a shared leadership model there isn't like a clear, like chair or anything of that meeting.

We really try to think about this project as a community project it's not a Centerstone project. Centerstone is a pretty big organization, it's in multiple states, and so I think we're seen often as this big conglomerate, and it can act that way…but for this project we try to keep things centered around community, keep things centered around kids and families, make sure when we're leading meetings or conducting meetings that everybody's voice is heard. Every meeting we go around and let people give updates on what's going on in their world; it's equally as important as what's going on in our world and we do have kind of equal participation… I think that people know that we have integrity behind when we say that, and we really mean it and we really do strive to operate in that fashion. And they see that and how we act and how we include others and invite others and work collaboratively with others. Even with other community mental health providers it's more about making sure people have what they need and try

not to make it so much as like who gets to do it, or who gets to build for it, or who gets the money. So, I think all of those things help and then we just try to continue to forge ongoing relationships; we participate in different community coalitions with them. If they asked us to participate in other community events when they asked us to or just to do it to keep up, to let people know that we're still invested in them, just like they want us to and like we want them to be invested in us.

Communication. Communication, both internally within the SOC and externally with the community and potential partners, was discussed by participants, unsurprisingly, as a process central to implementation of overall SOC goals. Internal communication with and between stakeholders, including professionals as well as parents and youth, was discussed.

A lot of the communication does happen in emails or through sharing of emails and things like that, and different listservs…But we do a lot of flyers, we do the annual report, we share updates with the leadership team every month, and they share updates with us on things on their end, and then the subcommittee's feed their updates to the leadership team.

[Communication is] primarily by email. We have a group email that's shared, and prior to meetings there's a group email that goes out. When we needed to get feedback on those authorizations for spending, that's how that went out. Any recommendations from subcommittees come by email.

Participants discussed the ways in which they spread information from the project to the members of the community at large:

We also do press releases through our marketing department, and those press releases do go to the local TV station. I believe they go to the local newspaper as well…and they do put them on Facebook and LinkedIn as well…And then I think last winter we produced a video about our engagement with the local elementary school district and what we were trying to do with them. So myself and one of their Assistant Superintendents were able to get on Zoom, and we had a team kind of make a video for us.

We do utilize social media, Facebook, we will do flyers, it might be hard copies, it might be mailings, any number of things, it just depends on the audience we're trying to reach, and again that's…marketing isn't my area of expertise, which is why we enlist that individual's help

Planning and decision-making. Participants identified planning and decision-making processes that exist within the SOC to implement its stated goals. In line with principles of systems of care, participants talked about the importance of inclusive decision-making in which all voices are heard, or at least given the opportunity.

From the point of applying even for the planning grant we did all of that, as a community, so we invited community stakeholders that included people from health care, mental health, parents. There were people from the SIU school of medicine, there were people from other mental health providers…so from even applying for the planning grant we had a community table where we discussed what the needs were. First of all, discuss where we were lacking, maybe in meeting systems of care philosophy, and then we built the proposed projects and activities from there. Our implementation grant applications still have those same people at the table. And so, during the whole planning year we met monthly I think or bimonthly…and we continued to evolve and change and develop what we wanted our set activities to be for the implementation grant.

We included the community from day one, and they continued to be included until today. We still meet as a leadership team once a month and we review those projects activities, review how they're going, review what else people want to see or how we want to change things… And then we make the decision, because there are people who are pretty embedded in our community and have been here a long time, they know what the needs are, and so we kind of make a collective decision.

Every now and then there's, there's been a few times, where I've spoken about— I feel a little weird because I'm just a parent, but there's been times where I've said, "as a parent…," and they've been very open to saying, "No, that's why you're here!" So I found the group very open and engaging in that format, and that's been great for me as a parent.

Although the implementation teams had good representation from various child- and family-serving groups through the communities, there were a couple of groups that were not present in the planning and decision-making:

We would like more involvement from juvenile justice. We had some involvement from juvenile justice, but then there was a change in leadership there. And I think that person has yet to actually participate in our leadership team, so there could be more involvement there. We did have good involvement from child welfare from DCFS in the beginning, that has also kind of fell off, as I think they've had some leadership changes so that could probably be represented a little bit more…We always are wanting more parents and more youth, we could certainly have more youth involvement in our leadership team that has been a hard sell at least for us, or an area we could probably focus on more as well.

Structurally, planning and decision-making happen using a discussion and consensus model that works across levels (i.e., project director/leadership team/committees/subcommittees). In order to move the SOC implementation forward, subcommittees and workgroups have been formed that focus on specific tasks.

We have evidence-based practice, which is one of the subcommittees. They are looking at what trainings that we can provide that actually fit and have some standing within the scientific community. We have a marketing subcommittee, which talks about how we can get our message out there and involve more people, get them to come to events when we have them. We also have the LGBTQ+ subcommittee, which is just getting started, and so they're looking as to how we can include more of the LGBTQ+ issues within what we're doing, because it can be an underserved community and something we don't want to overlook…The suicide rates in that community have skyrocketed over the past two years, so it's something that that we're concerned about. And then we have, I'm going to mess this name up, it's the families subcommittee. It's where Family Resource Developers do a lot of that work of connecting with the community and trying to figure out what the community needs. So, our Family Resource Developers are a part of that, along with a number of parents and school leaders as well. There's been a truancy one, a truancy subcommittee.

When we review project goals and activities, we always ask them for feedback and see if there's anything that they think we're missing. The development of the LGBTQ+ subcommittee came from an identified need in the leadership team…they will make recommendations and we'll talk about it as a leadership team and then that's either where it will go into a project activity or form a new subcommittee or something like that. We always inform each other things going on in the community, and so, sometimes that might lead to an additional enhancement of a current activity like training or something like that, but basically, they let us know what they're seeing or what they're hearing or what they want, and then we figure out if we want to take action on it, or where it fits within the project goals and activities.

We do have subcommittees that are created, sometimes from identification of need from the leadership team…Really anybody from the community who the people on that subcommittee think would have valuable input or want to be a part of the subcommittee… The Community implementation team is really anybody who wants to participate, hear the yearly updates, join a subcommittee…that's really open to anybody.

The CIT team, the Community Implementation Team are informing members of the community. And these are people that can't necessarily participate in the activities and programs but might be able to help provide something or participate in some way in the future. The leadership team is making the decisions about what we're going to be doing in the short term.

One participant highlighted the fact that the decision-making is done with the overall project strategic plan in mind:

I don't know that's it says "Strategic Plan" on it, but we do look at what are those goals, and what are proposed timelines for implementation or to meet those goals. And we do it (at) all of our meetings, we discuss each one, and where we stand. There are

subgroups that are formed around those outcomes. If there's some work that two or three people can go and do and bring back to the larger group to help keep us moving. We're very strategic in how we are approaching meeting our outcomes.

Using data to support decision-making. Lastly, in terms of site visit participants' perceptions of overall progress toward SOC goals, the ability to use data to assess need and plan responses was offered as one of the key activities undertaken to date:

We use it [data] to share information with our community implementation team and then it could possibly lead to either support for ongoing activities or it could lead to [discontinuation]. Basically it's a report on how the project activities are going and so mainly it's just led to continuation of support for those project activities to show how we're doing towards reaching our overall goals, how many more services, we are doing in schools, how many more relationships with schools we have, and so it's giving an update on how we're doing and then how it will drive further support for those projects and activities.

Yes, and we've been able to work with the SIU School of Medicine to help us break that data down, and we produce a document for our annual report…Piktochart, it's an infographic. So, we were able to produce that and look at the number of people we were able to serve, the impact on the community, and there's some general information from the Health Department that they were able to share about mental health, physical health, impacts in the community that we're seeing overall. It may not be specifically related to us, but there's obviously going to be a correlation because we're interacting with that community where these numbers are coming from. So yeah, we've been… we've been mining as much data as possible.

3.4 Parent Involvement and Leadership

Site visit participants were asked about how parents were involved in the SOC implementation. Their responses indicated that parents primarily provide input on their personal experiences with the mental health system, and that input can inform decision-making. It was unclear what type of leadership roles, if any, that parents involved in the SOC have taken on.

[We] already had a number of parents engaged once I was hired, and many of them have stayed on, some of them have moved on…So parents are able to, they have been able to speak from experience and give us a real sense of how the world works for them, and they've really helped influence the implementation of our family resource developers…One [parent] in particular has a child that's navigating special education. She's been able to provide some very helpful ideas and then direct us towards trainings to help educate our Family Resource Developers about aspects that maybe they weren't familiar with.

We are not treated any differently than anybody else as far as we're there to have input and make decisions, just like anybody else on the team. We serve on subcommittees just like anybody else on the team.

Respondents also talked about efforts to involve parents in SOC implementation. As with building buy-in with community partner organizations, relationships are key:

I would say probably the best recruitment strategy was from our family resource developers. They did reach out to other parents.

It goes back, though, to relationships and connections. I think some people on the leadership team also had some connections or relationship with some of the parents and invited the parents on to be part of it.

A primary challenge to broad and sustained parent involvement is time:

It's a time commitment sometimes. Parents can't see themselves doing one more thing. No matter how I pitch it to them, regardless of if it's BCC or if it's Little League baseball, and tell them how little they have to do, I get a lot of the times, "I just can't do one more thing." And so I've had to spend a lot of time thinking about the message and how I'm selling it. I don't have a solution yet. I'll let you know if I find one.

3.5 Youth Involvement and Leadership

Youth involvement in the implementation of a system of care has been difficult to initiate and really does not exist within the BCC project yet. Site visit participants acknowledged that this is an area that they need to develop better strategies:

None of us have cracked that egg yet. We don't know how to do it. We're trying, but, you know, we do meet during the day. I think our current leadership team meetings are 10 a.m. on the first Thursday of every month. That's not really conducive for a high schooler—they have class. So perhaps looking at changing the meetings and that sort of thing. Um, but student involvement is non-existent at this point. It's something we would like to see, but it just hasn't happened yet.

There was hope reflected in the possibilities discussed for building on youth leadership that is present elsewhere in the community:

Centerstone has the community youth services, and they have a youth action council. And we get, we do have some feedback from that group as far as youth. And then our grant coordinator is part of our county healthy community coalition and the positive youth development. So, we were able to get, I want to say feedback from youth, but as far as youth on the leadership team I would say that is one area we could improve.

3.6 Barriers and Facilitators of Implementation

Workforce shortage and turnover. Across the state and nation, there is a shortage of mental health providers. This challenge was entrenched even before the COVID pandemic exacerbated it to crisis levels. This was acknowledged by SOC partners and they discussed the impact for workload and the capacity of agencies and professionals:

> *I do think that the workforce problems that we're experiencing in mental health have been a huge barrier to service coordination and service delivery for sure. We don't have enough staff to do the work that needs to be done and we can't retain them because other entities either don't have as many barriers as we do in mental health as far as billing and budget and things like that, and they can pay people more. And we, the way we fund programs is really tied to what the state pays us and it's just not enough to keep people, so those are probably the biggest barriers to getting things done, and then certainly right now.*
>
> *There's a lot of turnover. My supervisor who helped write the grant is leaving…So that's been a challenge, but it's also helped us engage with people that we didn't know beforehand, and there's more people out there to tell our story, so that's been, that's been a good thing.*
>
> *I would add too that as we're talking about the needs, so now our school districts realize they have a larger need for maybe social workers, and we just don't have them. So it comes down to that if I'm a larger district and I can pay more, you know, we just kind of steal from one person to another when we don't have enough social workers in our area to fill the needs. And then I think it also then impacts also other mental health providers too as people are changing roles are changing positions so that has been…all of our districts still don't have all of the social workers that they would like to have in their districts…*
>
> *That that can certainly impact having staff that feel overburdened because maybe they're doing the work of two or three people because at the at this moment you can't fill positions. You know it's just too difficult.*

COVID. Without question, COVID and the resulting restrictions during these crucial SOC implementation years has been a barrier and a challenge. Foremost have been concerns for the health and safety of all stakeholders and the process of grappling with when and how to begin a return to pre-pandemic conditions. While Zoom has allowed as much consistency in communication and meeting schedules as was possible, much is lost when people are unable to gather together in person.

> *Not being able to meet regularly. COVID. I feel like that was the biggest one. That one threw a like threw a loop in things…We've had something, like having the…some of the people that are so actively involved being overwhelmed with their jobs, not being able to*

be able to meet. Those are, that's pretty big…having the school shut down for a period of time, that was big. I think those are the largest things.

One participant specifically discussed the impact of COVID for collection and use of important data that would inform service provision and SOC implementation:

I would say some of that data got a little, especially for our school districts, got a little skewed during COVID as we were trying to determine what truancy even was anymore. Because we had so many students that were on remote learning, was truancy that they didn't get on a certain time each day or was it really that they didn't complete the assignments that day…so some of our data is just, I feel like some data we're starting over with a new baseline.

There was also recognition that there have been positives emerge from the challenges of the pandemic as well:

I do believe that, even just some of the things that COVID created, with the web-based therapy care, continuing that for some people. For some people that's not a great fit, but for some people that can work, and continuing that even though we don't necessarily have to have it at this point, that makes it more accessible for some. So, there are some pieces that are better that way. The fact that there's some out-of-the-box thinking that has come from Building Compassionate Communities, I think that's very helpful.

Rurality. Some participants noted barriers to implementing a SOC that are unique to rural areas of the state:

I see it as a barrier. I think it's much harder in a rural area, maybe I'm wrong. I see it every day where I work, transportation issues, monetary issues, provider issues, just not, like not having enough providers, wait lists. There are just so many things that come up when you live in an area like we live—it's so spaced out, it makes accessing care so much more difficult.

Professionals, partners, and clients alike may or may not have consistent connectivity in rural areas of Illinois, impacting service delivery and SOC participation alike. This may impact the ability to engage in email-based communication, to receive timely information, and to participate in virtual meetings and discussions. Being in a rural area compounded this, and multiple stressors for parents and youth create further cumulative stress and need:

So the connectivity with infrastructure is a barrier in Southern Illinois. You know, so we have work, we are working to address that, especially with our schools. But some of our schools, even when all of this hit, put up, in some of the rural towns, just an area where students could go. So sometimes it's not even a barrier of affordability, it's a barrier that it's just not even there, it doesn't exist.

Other barriers, um, internet connectivity in this area. I swear if we ever found out who owned [network service provider] we'd have riots in the streets down here. Because having to react and do Zoom all the time, a number of us, if one of us goes out, all of us go out in terms of Internet. So internet connectivity has been a struggle sometimes.

Facilitators. While a number of barriers were discussed by participants, they also talked about facilitators to the implementation process. In addition to finding a silver lining in COVID, the leadership of key individuals, communication, technology, and funder support emerged as important supports and strengths of BCC. Below are some examples of these perceptions:

Yeah, so [project director] she really has a finger on…she's able to balance what our mission is, what our strategic goals are, what's actually available to us, and then help execute a plan, and she's able to bring all those resources together. She knows everybody (laughs) in mental health, and the school districts and that sort of thing. She has a lot of great relationships. So through that she's been able to really kind of pull the resources and really focus our energies toward certain goals or ideas. I, on the other hand, come up with outlandish ideas and say, "we should try this," and she's like, "Okay. How does this fit? How is this going to help us?" One idea that that I came up with was that space is always an issue, and trying to protect confidentiality is always an issue in schools, and Southern Illinois especially, a lot of our schools are from the 1950s, so they're not designed for today. And I found these office pods and you can install in a school. And she never said "no," she never said "no." She said, "Let's wait and think about it." They're about $3,000 a piece, so that's why we're waiting (laughs). So yeah, she's really helped us focus our resources and execute a plan every time, every time, and she's utilized her own skill set to do that.

Just as rurality and related issues with internet access, transportation, and lack of services were highlighted, participants also spoke of the rural context as an important facilitator for SOC implementation. Specifically, they discussed existing networks and relationships as well as a spirit of community mutual aid:

And it just makes sense, especially in a system of care model, that relationships are the foundation. But my previous work as an aside, has been in rural, and that's always been the case that relationships—many hats, many facets of the relationship—but that's what makes it go.

I mean we've always had a really good sense of collaboration and there's tremendous partnerships that happen in Southern Illinois. I mean we know that if we don't work together and leverage our resources that we don't get things done. But that doesn't always mean that when you're around a table that your opinion or your idea or ideas are always valued or felt like they're heard. That has not been the case with this group, it is a diverse group and I appreciate that because I think it just makes us better. But it is nice to be in these meetings and know that my ideas or anyone's ideas will be valued and respected and it's a safe place to share those ideas.

I think one thing that makes coalitions or collaborations work successful in rural areas is the longevity of people around the table. I don't know that that's specific to rural or something, but it is a very rural thing that that most of us, we may not have always been in the roles that we're in right now, but we've known each other for a long time. And I think that helps us be more successful, because we do have these established working relationships and know about each other. And another thing for rural is that we have to know that we…we need to know a lot about you, almost like before you are welcome to town, that kind of…and so we do have those, we have those relationships, and I think that that's important. And so I think we've overcome those barriers.

The ability to connect with other grantees to share ideas and support was discussed as something that has really facilitated efforts to date:

"…reaching out to [other grantee site] …and working with other agencies in the state has also helped us. [They] both have worked on introducing mini grants into their communities. I was able to utilize them to help do that here in our area as well, and also utilize their knowledge about IRIS to help that get started here in Southern Illinois. So that collaboration with other agencies has been pretty special.

And it was also noted by one participant that the benefits of supportive relationships go both ways, helping SOC implementation as well as service provision within schools:

You know, it's through being on this leadership team that I have changed some of the services that are offered in my office to the school districts, and it really came from, from being on here. We've put truancy is a huge issue with us, that we're the ones that deal with it, and so I've added a family resource developer in my office from our grant for truancy from the state of Illinois. That she's really focusing on our truant kindergarten and first graders, so that we can try to find out, "What do those families need, and how can we help them?" That we can kind of stop that cycle before those kids get even older, and then what other resources are out in the community, and some of those resources come by sitting on this leadership team. So, it has really helped me in my office and the services I'm able to provide to our districts and families.

Internally as well, the trust and rapport that exists within the relationships has been a huge facilitator for moving SOC implementation forward:

I think we've been together long enough that we, we have a faith in each other that you're not going to ask for something that's insane—you're going to know what you're asking for. And then we do ask questions sometimes, but for the most part it's, if you're, if this group is getting together and meeting and they have this recommendation, you might ask some questions. But for the most part we have a trust and a faith that we're all working together for the greater good of this area for access to mental health, access to care and, so I yeah, that. I think it's like we really feel like we're all working together.

The shift to virtual meetings and electronic communication during the pandemic has been a matter of necessity, and the ability to conduct business via Zoom for some has been a positive. For instance, for:

> *Yeah, work schedules, children. I think it'd be easier, while we're doing this Zoom thing, and I've been mulling this over, like even if we go back to in-person meetings, maybe having a Zoom option. I don't know if that would work or not, having a like a Zoom camera in the room, so that people could…because If you have like a stay-at-home mom that is willing to come to the meeting but can't really come to a meeting because she's got kids. Maybe having that option open for people who can't actually get there. Maybe would get a little more buy-in from parents who have that firsthand perspective. I'm not really sure. I know it's really hard when you're working full time, and you have kids, and all of those things, and to be involved in something that's time-consuming like this; however, it's important so…*

4. Results – Community Together

Community Together is located in Macon and DeWitt Counties. According to 2020 U.S. Census numbers, Macon County has a population of 103,998. In 2020, the median household income in the county was $53,725. About 15.2% of the population live below the poverty level, and 23% of children in the county are in poverty. About 4.3% of the population does not have access to health care coverage.[16] In terms of race and ethnicity, 76.3% of the population is White (non-Hispanic), with about 14.7% African American (non-Hispanic), followed by 5.39% being multiracial (non-Hispanic). About 2.28% of the population of the county identify as Hispanic of any race.[17] In 2020, DeWitt County had a population of 15,516. The median household income in the county was $57,727. About 10.3% of the overall population fell below the poverty line, better than the overall state percentage. Still, 16.4% of children live in poverty and 3.9% of the overall population of the county are without health care coverage.[18] In terms of race and ethnicity, 94.6% of the population is White (non-Hispanic), 1.96% being multiracial (non-Hispanic) and .534% African American. About 2.74% of the population of the county identify as Hispanic of any race.[19]

Heritage Behavioral Health Center is the lead agency for the Community Together system of care grant from the Illinois Children's Healthcare Foundation. According to information provided in the implementation grant application, the overarching goals of the Community Together project focus on strengthening the mental health system of care in several areas, including: 1) family and youth-centered system planning and evaluation; 2) family and youth-centered, strengths-based services delivery; 3) integration and coordination of services, supports, screening, and data across child-serving agencies, schools and primary care; 4) adoption of evidence-based practices at prevention/early intervention, routine outpatient, and school-based/intensive levels; and 5) development of home and community-based services where children and families live. The six-year implementation plan will include a developmental process through which system enhancements will unfold, with the early years focusing on prevention/early intervention, screening and referral processes, integrated behavioral health/physical health, and establishing baseline family/system outcomes and fidelity levels. Later years will focus on adding evidence-based practices until all are implemented. The Community Together grant supports, in whole or part, several positions at Heritage Behavioral Health Center that provide leadership and support to the SOC implementation: a Project Director, who provides oversight and direction, and a Family Engagement Data Coordinator who has a dual role of serving as a data coordinator for the evaluation as well as a navigator who will assist families who are served in the SOC. The implementation grant also supports several clinical/direct service positions.[20]

[16] Census profile for Macon County: https://data.census.gov/cedsci/profile?g=0500000US17115
[17] Macon County DataUSA: https://datausa.io/profile/geo/macon-county-il#demographics
[18] Census profile for DeWitt County: https://data.census.gov/cedsci/profile?g=0500000US17039
[19] DeWitt County DataUSA: https://datausa.io/profile/geo/de-witt-county-il#demographics
[20] Community Together implementation grant application (2019).

During the site visit, individual interviews were conducted with the project staff from Community Together and one youth (over 18) on the implementation team, and focus groups were completed with community stakeholders and parents on the community partnership team (CPT).

4.1 System of Care Goals, Objectives, and Interventions

A primary focus of the site visits was to explore participant perceptions of the aims of the SOC and progress toward those goals to date. A number of key themes emerged, largely reflective of the original goals described in the grant to implement Community Together:

> *Our goals are to strengthen the overall mental health wellness for youth and families, birth to 21 years old, and to provide timely accessible services for that particular group of folks. We have a couple of focus areas which include supporting the zero to five population and their families, and also supporting LGBTQ youth and their families.*

Increasing access to services and service coordination. One goal that was emphasized by several participants was increasing access to mental health services as well as targeted elimination of barriers to access.

> *I would say that part of the focus would be to put more of an emphasis on mental health as a part of regular health care but making sure it's super accessible. Like how, since we were kids, there were dentists that came and visited schools, so they put that emphasis on your physical health and making sure your teeth are healthy. But there's nobody that was coming to make sure that kids were mentally healthy and not falling through the cracks as they aged and there was nobody to help the parents figure out what those supports are.*

Participants also identified reducing stigma about mental health in the community as a primary element of this overall goal. As one respondent stated, “it's kind of become a trite statement and by…I don't know if we'll ever eliminate it, hopefully we will, but definitely reduce the stigma of accessing mental health.” Others echoed that sentiment as key to the overall mission:

> *Linking to the appropriate service, making sure that they get it in a timely manner that it's done professionally and confidentially, of course. And then, also destigmatizing mental health services and what that looks like. Also, just being able to have that awareness and education, helping others understand. I know we do a lot of that already with all of the trainings we do, and with the trainings that are available to the community. Just kind of bringing us all together as a community to where we just support and help each other, but we work off of each other's services so we're not duplicating them.*

Related is the goal of service coordination and implementation of a system-wide referral and client tracking system.

We talked a lot about IRIS and having the coordination of the referrals and getting organizations in our communities, and then the other surrounding covered communities, that they would be they would be using this, so that there weren't gaps and services or balls dropped etc., so I know that was a big one.

Another participant stated that the SOC aim is to "highlight mental health in our communities and address mental health challenges in our communities, especially at an earlier age. By working through existing collaboration partnerships organizations." Collaboration as a pathway for increasing awareness and access is an important thread connecting the findings about goals and processes needed to reach those goals.

Mental health service capacity-building. Another goal mentioned was building the capacity of service providers within the SOC through training, networking, and support for evidence-based practice is critical to implementation, in particular when efforts to increase access are successful.

Increasing capacity and developing skill sets and providers and teachers who are getting [professional development], for attending these programs and for any community members who are participating. Just a better understanding of issues such as mental health, such as racial…diversity and equity, such as LGBTQ awareness issues.

The goal of building an SOC with evidence-based practices was also clearly articulated across participants. One stated:

We noted in our planning that we wanted to have several folks trained in different types of treatments, evidence-based treatments. One of the areas that we focused on, we have…we started off with I think one person we identified in our entire community…who actually had a certification in evidence-based treatment. We knew that that was a need and something we wanted to work towards, and so, since implementation, we have four folks who have been certified in dialectical behavioral therapy. We've had one certified in cognitive behavioral therapy, trauma-focused.

Early intervention and prevention. Another stated goal of the Community Together SOC is the focus on early intervention and services for families with young children:

I would say that the overall all goal of Community Together was to have a greater impact on children at a younger age, and so, how do we…how do we reduce trauma, address trauma that's already occurred in our pre-K through grade school ages…I don't want to say focus less, but maybe take the emphasis off of how to react to behaviors that are exhibited at the teen years middle school years when now we're trying to fix that which could have potentially been prevented at an earlier age or addressed in an earlier age…

One of the plans was to embed a clinician in as many schools as possible, so there is access that young kids need and that's been going pretty well…despite like you said COVID and the staffing shortages…that was one of the things we talked about today was how to get around those barriers that we're having because there's not a great deal of masters levels professionals knocking down the doors of Decatur trying to fill these roles.

One of the other ones is, which is similar to the clinicians in the school, but it's the early intervention specialist…it's like a clinician in the schools but it's for daycares…to identify those situations that could potentially need more help earlier, so instead of waiting until they're in kindergarten or first grade, to a crisis situation it'll start at like the preschool level or even younger for some kids.

Another participant perceived that early intervention emerged as a goal once the implementation process was underway as collaboration and use of data quickly brought it into focus:

But the early behavioral health therapist wasn't something that was in writing in our initial proposal, but it was something that the daycare providers and the Head Start providers were saying, "We absolutely need this. We could use five of them right now." And so, we had some deeper discussion about, "What could that look like? And if we did this, how could we make this sustainable?" And then, we were able to have some of these discussions, because, actually, both the United Way and the county mental health board are also part of our team. That is just a way that we could collaborate together and have that discussion, and then move forward towards implementation.

Community buy-in, participation, recognition. A final goal centered more on the *who* rather than the *what* of the SOC: To cultivate broad community recognition as well as the buy-in and participation of organizational partners. Several participants discussed the importance of school involvement to building an effective community-based children's mental health system. One individual stated:

A part of that is really trying to get the buy-in right, really trying to get others in the community to understand the importance of this and come on board with it. That's…where we started with is really trying to outreach and network and communicate and trying to get them to…understand how great this can be for our community, how we desperately need it, and I feel like that is part of that strategy.

4.2 Activities and Progress Toward Goals

Access to services and service coordination. One part of increasing access to services is increasing community awareness of them, and Community Together has made a number of efforts toward meeting this goal. These activities have been aimed at better understanding the community and ensuring the community understands what is available to support children and families. One individual described some public awareness elements:

We did a lot with the advertising. We had the yard signs. We had signs on the buses and…billboards.

One activity that has aided timely access to services is the implementation of IRIS, the Integrated Referral and Intake System. Several participants described how it has benefited the families served by the SOC:

One of the big things that we have done is implementing IRIS…where we can have those timely accessible services. And so, we've seen quite a few referrals completed through there, and so that's been very exciting…We have more than 50 partners that are part of our group, and I think…actually, we might be even closer to 60…We're continuously adding to that group of folks, providers include medical providers, social service providers, mental health providers. Really being able to meet, again, all the different kinds of needs for our different families.

I feel like, especially with IRIS there's a better ease at getting referrals to different agencies and just knowing what is available. As a professional you always hear about programs like this used to be here, and this used to be here, and IRIS gives it all at your fingertips, and we can refer and there's just a lot of ease of getting families and children to services.

The number of partners who are participating in IRIS is growing. They are using a system, so we know those warm handoffs are occurring. It has been less than a year since implementation and again some agencies have adopted it and have really used it to great effectiveness for home referral and home referral and parenting assistance.

I think IRIS has been the biggest, honestly, implementation piece that we can actually visually see the work that we're doing in our communities, in terms of the services that are being provided and how quickly we're turning around those services and those responses to those referrals.

Participants alluded more than once to sustainability questions, but felt that, regardless, some benefits such as IRIS could transcend the life of an SOC:

But yeah, just as I would tell you that, if nothing else, comes out of the Community Together programs six years from now, IRIS will be firmly entrenched and the individuals in our community who are experiencing crisis and challenges will have navigators who are better equipped to do those warm handoffs and connect need with resources like we've never seen before.

Capacity-building through training and professional development. During the last two years, training and professional development for SOC service providers has been a primary pathway for the capacity-building goal. Specifically, professional development for clinicians to receive

certifications and to become competent to deliver high fidelity evidence-based interventions was identified by participants as a central activity and one for which there has been great progress. In addition, many of the trainings that are being provided are for evidence-based practices, which is another one of the SOC goals:

> *[The] wraparound approach is evidence-based and the trainings that are…that we're receiving, they are all evidence-based. And, and the curriculum has been produced by accredited institutions and so that is happening. IRIS is evidence-based and so…that the things that we're putting in place are evidence-based…and we keep looking for new opportunities new evidence-based training opportunities, new evidence-based platforms to better implement our work.*
>
> *Wraparound certification…we will have that completed by November, so there will be six of us, I believe, that will have that certification. So, we're really, like, we're ramping up those certifications, so, that's pretty exciting.*
>
> *I already see, there, that we've had five certifications in the time, compared to the one person we knew with the certification. And we've had lots of different trainings as it relates to mental health first aid, which is also evidence-based. And so, our plan is to continue some of those certifications. We are going to have several folks trained, I think by February of 2022, in a combination of dialectical behavioral therapy, along with EFT and parent management training…And we are offering…the DBT and the CBT trainings, not just to Heritage folks but also to others. And so, we're getting a diverse group of folks who will get a certification…We've reached out to them and said, "What are your interests? Which one would you be interested in?" And we will cover those expenses, so that they can move forward with their certifications.*

In addition to professional development focused on clinical knowledge and skills, participants also discussed having training focused on a particular population or in response to an identified community need.

> *We've done a lot of training around LGBTQ and providing additional supports and information, done a lot of trainings in regard to that, not just to mental health professionals but to families, as well, and to organizations in terms of considering what their environment looks like, are there ways they can strength[en] their allyship as they're serving a diverse group of folks. We've also done some work as it relates to anti-racism and just having some conversations reflecting the diversity of the entire population.*
>
> *And then, tracking folks who've obtained certificates for the anti-racism and the LGBTQ allyship training, and then the Safe Zone trainings that we've done within the districts. So again, people may not remember Community Together, but they will remember that we had to go through a Safe Zones training, with the district, which was a mandatory project where we trained about 600 folks on safe zones.*

Early intervention and prevention. Participants mentioned two activities related to early intervention and screening, including implementing mental health screenings in schools and hiring an early behavioral therapist position that would be located in the daycares:

> *We've worked pretty closely with school leadership and had meetings with principals and administration on what can we do to get a baseline of where students are at. And looking at different kind of mental health screenings, which ones would we prefer. Again, it's not up to me to choose them, but I'm providing information for them to look at it and say, "You know, here is something that we're interested in"…we've met and talked about the potential of implementing screening.*

> *We hired an early behavioral therapist position, so again, focusing on that birth to five population, making it possible for us to do some work with the littles, but also then being able to connect with the family, provide them with linkage and supports. That particular person has resigned, and so, now we're working on just right now managing the case load and then working on building that capacity and having another person in that position.*

Relationship building and cultivating buy-in. The SOC Project Director and partners have been working to develop relationships with both individuals and organizations. Existing relationships have facilitated this process. Participants also discussed the importance of proving the purpose and worth of the SOC as a pathway to increasing buy-in. For instance, partnering with schools to provide mental health screening has been key to both achieving early intervention and increased access, but also for the trust- and relationship-building that lies at the heart of building an SOC:

> *Another thing is our involvement in the schools has been pretty significant. That was slow to start, but now we are seeing an increased need. I had two phone calls, today, from administrators, "Can you please be in the schools now?" And we're, again, working and figuring out how do we meet this need that is definitely present; they're calling me, they're asking for help right now. And again, it's a bit of a challenge, and just kind of navigating how do we do this with our limited number of staff. It's very exciting to get these phone calls…we've had numerous phone calls both with early education and with elementary and high school levels, saying, "Could you please help us? Would you be able to provide a clinician? We're very interested in getting additional support." That would not have been a thing a couple of years ago, I don't imagine.*

> *I remember when it started…and some people knew each other but not everybody, and now it seems like everybody is aware of what everybody else does and many of the people in the group have been working really closely together, so that's really nice to see. I think it takes time for those relationships to develop to a point where you can really kind of facilitate that kind of work.*

Building relationships and collaborative networks has been a primary activity of SOC implementation to date, both for the grant period and beyond:

> *I think the best part of using the structures that are in place is that they're going to be there once the grant is no longer in place…And part of what they do is they often check in to see, like, what new updates there are, or what things we're currently working on and how they can support the different kind of initiatives that we are working towards. But we're also then able to hear what's happening…and what kind of initiatives that are popping up. And then we figure out how we can best complement each other, and not to necessarily duplicate what everybody else is doing, but how can we kind of complement and then be able to then enhance the work overall, and support everyone overall.*

4.3 Implementation Supports and Processes

The ability of a community to implement SOC or any other large initiative depends in part on the supportive structures and processes such as project leadership, communication, planning, and decision-making. Site visit participants were asked about each of these implementation supports and processes.

Leadership. Primary among the key processes and supports was leadership. As the only project staff funded by the ILCHF grant, the majority of the leadership for the Community Together SOC initiative is provided by the Project Director. In fact, she was the only person mentioned when participants were asked about leadership. The Project Director has responsibility for tasks such as recruiting and supporting new members of the Community Planning Team, including parents and youth, setting the agendas and leading the meetings, meeting with partners in other agencies, and working with the evaluation team. Participants praised the characteristics and strengths of the Project Director, including her knowledge of the community and providers; organizational skills; the ability to provide support to individuals as well as organizations; and relationship-building and use of self, or one's ability to be authentic and to engage and inspire others. For instance, one stated:

> *I mean she's super positive and keeps everybody in the loop…and she's really determined. I think that's what you want, in someone who's implementing a project like this and she's very organized…she's met with me numerous times separately to get my feedback and any of my ideas that I have about what the organizations have shared and how they can collaborate better. So yeah, she's been really a driving force throughout this project, and I think she does a great job with it.*

> *You know I'm an old girl, and I've been on 1,000,001 committees and this has been the most productive group. I know we keep saying how amazing [Community Together Project Director] is but what she's done is just extraordinary. How she's brought all of the different agencies together and kept them together and build something really solid that's already benefiting the community…it's just been really amazing to watch.*

Another important element of leadership identified by site visit participants relates to a leader's ability to change how they lead as partnerships and buy-in grows in a SOC. For example, the role of the Project Director as well as the community co-champion have been instrumental in laying the foundation and moving implementation forward. However, as the SOC achieves aims such as broad-based participation and shared governance, the role of such central drivers will appropriately change. The Project Director, an employee with the lead agency on the grant, has provided the type of leadership needed to undertake a project like this and to bring partners to the table.

> *And now it seems like the train is moving on its own. She doesn't have to power everything herself. There are things happening that she's helped to set in motion over the last couple of years, but now it's kind of about a life of its own and it doesn't rely on her for everything.*

Communication. Participants discussed the ways in which information is disseminated within the SOC implementation teams. Most of the project-related information comes from the Project Director, and site visit participants felt that her emails were clear and direct. They also appreciated that she was willing to meet one-on-one and share information individually with those if they needed to (for example, if they missed a meeting).

> *I think email, overall, has been pretty effective. I think depending on the nature of the email, if there is a response that needs to be had, we note that in the subject heading, so people are able to notice that a bit more than just another email in their inbox.*

> *There would be the executive team communications, and they would be labeled so I know exactly what was for me…We would have in-person meetings regularly so that was another way to get that communication. Like I said she did always make herself available if you couldn't make it to a meeting, rather than just saying we're sending minutes out. She would offer to chat with you on the phone or meet with you in person, whatever works for you…I was always really thankful that she took extra time out of her schedule to make sure that communication was there. Other than that, I think that, because she had so many of the key players at the table that communication then helps disseminate it out to the rest of the community, as far as what's going on. They did put information out from their organization, on behalf of the project.*

There were many different ways that the SOC project disseminated information about events to the larger community:

> *I've had partners from different colleges, universities, say, "We have this event going on. Can you share it with all your contacts?" Then I also pass along the same thing to my contacts, "Would you please go ahead and – " like, mail trains, basically. And so, that, I think, has been effective, people are attending various events and various trainings, and most of the invitations are through word of mouth. Some of it's through Facebook, where we do highlight different events that are happening…We have lots of different*

partners who utilize social media in that way, so I'm able to share that on our Facebook page, and then also then ask all of our partners, "Would you share this event on your page?" And they all do, which is, again, a nice form of collaboration…Even the Chamber of Commerce, they share our events, the local newspaper will share our events.

Planning and decision-making. Participants identified planning and decision-making processes that exist within the SOC to implement its stated goals. Structurally, planning and decision-making happen using a discussion and consensus model that works across levels (i.e., Project Director/leadership team/committees/subcommittees). Participants described those groups and processes:

We have a lot of community meetings that were in existence prior to our grant, and so, a lot of the needs or the wishes of the "dream big" moments happen in those meetings. We meet and people will share some of those ideas…Initially, in our proposal, we mentioned very specific certifications, including wraparound, with some of the big-picture things that we wanted to do. But the early behavioral health therapist wasn't something that was in writing in our initial proposal, but it was something that the daycare providers and the Head Start providers were saying, "We absolutely need this. We could use five of them right now." And so, we had some deeper discussion about, "What could that look like? And if we did this, how could we make this sustainable?"

We have the executive team, and when I was attending the meetings we had a really solid group that pretty much was there every time…Her team would run things past that group and get opinions before she would bring it to the full group which I thought was great because then it wasn't just Heritage…but they were getting the input of the group…They'd send things out in advance, so you have the opportunity to review and actually form opinions and thoughts and questions you'd bring it to that executive team meeting and we would discuss.

Two examples of the process for decision-making and group input were given during the site visit:

Even in the writing process for the grant they were very receptive and seeking that feedback and actually using it. I think that's really important because, we serve the whole community…You can't just get a grant and tell the community, "this is what we're going to do, this is what you're going to do to be a partner for our system." You've really got to get the buy-in, and I feel like they really have been effective at that, but also purposeful and genuine with it, it wasn't like a "let's check the boxes and go through this process." It really seemed like they did want to do it right and really get input from those that we're going to be working in the project.

One big one that really sticks out a lot is that IRIS project and when they proposed that. You could tell they had already done a lot of homework, as far as looking at options…. They were able to bring it to us in more of a concise package of "here's what we're thinking because here's all the benefits to it, what are your thoughts as an executive

team, like would your agency be willing to do this? What are the possible challenges that you see? Do you think this will fit our community, because obviously communities are different and not everything works everywhere." So, I can really remember that being something that they really were looking for local feedback and input…it wasn't just like a "we're shoving this down the throats of our community." It was very much, "what do you all think about it here's why we think it's good here other places that have used it successfully and effectively in their communities," and "will this work here?" So I really felt like we actually had a voice.

From the program director's perspective, careful consideration is given to how to engage partners in different ways during the team meetings:

I try to take it in bitesize pieces…I use Mentimeter, quite often to get them to engage. Utilizing scales and word clouds, so they can do it anonymously without unmuting or having to put it in the chat next to their name. And so, they're able to give their perspective on different pieces.

4.4 Parent Involvement and Leadership

All of the site visit participants were asked to describe the ways in which parents and youth have been involved in the Community Together SOC implementation process. According to several participants, it was difficult to get parents engaged in the process during the early stages of the initiative:

But parents have been a struggle as well, and the parental and youth involvement has been a struggle, from the beginning. And we have to have a balance of youth and agency leadership and there are a lot of agencies we'd love to have them a part of the greater body, but we can't because we can't get parents to participate. I know we've tried incentivizing it through gift cards. And I don't know how much of that is pandemic and how much of that is not pandemic…. But parental involvement is hard and getting parents to participate in these kinds of community efforts is very difficult…Having parents who are…who are directly affected by the issues that we're discussing be a part of the decision-making process, and we haven't cracked that nut yet, but we're still trying.

It was hard to engage all the youth and parents, but I think the pandemic has really like limited our resources in the sense of going out to them and try to reach them in their own space—that's made it even more difficult.

We have parent involvement at all of our team meetings. At the beginning, our numbers were not at the percentage that we wished that they could've been. Again, though, life happens, with some folks, and they were unable to kind of participate in the way that they intended on doing so.

Since they struggled with parent involvement at the beginning of the initiative but have since then been able to get parents involved in the meetings, follow-up questions were asked about how they accomplished this. Participants indicated that it was largely due to the efforts of the Project Director, who reached out to many different organizations to find people who might be interested and then took time to meet with them individually:

> *So, for parents, we initially started off with recruiting, pretty heavily, with folks that we served, and reaching out and offering this as an opportunity for them. And we've found, particularly for the individuals that we served, that it's much more complicated, because particularly the demographics that we serve are going through a lot of things, in addition to dealing with youth with mental health challenges or substance use challenges. And so, we started recruiting by word of mouth, and we had a couple of caregivers who had friends who had children with lived experience, and so, that's sort of how that kind of came to be is friends of friends of friends. And once in a while, we had another partner who said, "I have the perfect person who might be a good fit," and so that was another opportunity, too. We plan to, potentially, recruit some folks, specifically, from the school district, but again, with COVID, that presented some challenges, as the typical parent meetings weren't meeting because of COVID. And so, our plan is to continue to kind of outreach whenever possible. We also had some opportunities to do a lot of Facebook Live presentations, and some just ongoing presentations that happened in the evening, as it related to LGBTQ and race.*

Once an initial group of parents were involved in the implementation teams, a variety of strategies have been used to keep them involved and active in the process:

> *Prior to COVID, we offered transportation and a stipend and a meal, and now we are meeting virtually, we offer—well, it's a gift card, not a stipend—so a $30.00 gift card to participate in an hour meeting. And then, if they participate in any kind of events, then they would also get gift cards based on the amount of time that they participate in any of those meetings. Generally, I meet with them or connect with them to just check in on how they're doing. Initially, before they even come on, I kind of explain sort of what the team dynamics are, what the culture of the team looks like, our mission, our vision, sort of why we're doing this project to begin with, and the importance of their voice and how that matters and why that matters for our team.*

Since parent involvement is difficult to achieve and maintain, site visit participants were asked if they had other ideas about strategies to get more parents (and youth) involved. Several people had ideas to share:

> *We've identified some folks who are able to participate and give their input, and we're actually, within the team itself, we're going to have a separate parent council. And this is something I've talked to some of the parents about, and I'm very excited about—just this idea of they do come and they participate in the meetings, but they also would like to have just a separate space to talk about the things outside of everybody else being in the*

room. And so, we're gonna be able to do that. We did have, pre-COVID, an opportunity for them to all get together, and it was around the holidays, and they had childcare provided, it was just a perfect setting to have all the things. And they were able to have dinner and just be with each other, and folks shared that that was, like, one of the most meaningful things that they could've had. And they are excited about eventually we will get to that place again where we feel like that's a comfort level where we can all do that. And so, in the interim, I think just being able to have a separate sort of parent council—I'm not sure that will be the final name for that—but just a parent leadership group team, just an extra component. It won't necessarily…it may include additional parents with children with lived experience, or it might just be the current folks on our team. It's whatever they decide is the best fit for them, but I'm going to let them take the reins on that. I shared it with some of the parents, not all the parents know this yet, and this is something we're going to talk about at our leadership meeting in a couple weeks.

The parents that participated in the site visit had additional thoughts about what might increase parent involvement:

I felt like we had a really good thing going when we had like our mental health fair. Like yes, we had a fair and so now that I feel like maybe we're able to do more like with COVID, we're able to start doing more face-to-face and in groups that's very important to a parent. I'm gonna speak for myself…I apologize everyone…for myself as a parent it's important for me to feel like I can sit down, that what I'm about to say and what I'm about to hear or participate in is relevant enough for it not be just a quick thing. I want to be able to have a place where I can sit, I mean, I have certain things that I like to do as a parent and I feel that now, maybe we can start getting back to having those in-person groups…I really feel like that that will bring in parents and also our youth. Because we started doing that and it was looking good and I was so excited. We loved that one that we had, it was freaking amazing. We had it, somebody to watch our kids, didn't have to deal with them, we had a meal provided for us, and we were just able to visit with other parents. That's so huge to me and I feel like we need to get back to that.

How do you get more involvement? I think, advertising it and…nobody, like the general public or people who don't work in education or something like that aren't going to be super interested in, yes, become a part of this focus group. Yes, let's sit down and have an "executive meeting." Like this word seems scary and not real. And also to think about like who the hell has time to join another committee or be a part of a thing? But if started out with something like a parent support group or get together night kind of thing because, like we played like this game—it was like something like exploding kittens or something, it was weird I don't know—but it was fun and it's something that you don't get to do very often and it was important to be able to do those kinds of things. So start it off as like a leisurely relax like "hey there's somebody to watch your kids" and make their plate, and then that that was the end of it until the event was over, and THEN you start having those important conversations. You start implementing it, little by little.

And then doing that enough, I think that's the best way to get quote unquote "regular community involvement" versus somebody who is like a part of the system of care.

I agree, I mean so many times I'll be thinking ahead of time or I don't have the energy or I'm just too stressed right now I can't do this. But then I realized over time…that it matters that I'm there, they seem to really care that I show up… So what are the indications of that, I just seemed like somebody else at the table even though I'm not running an agency. For a long time, when I first started going to the meetings I thought I was there because I worked at [agency] but [Community Together Project Director] introduced me as a parent and then so I started introducing myself as a parent and it was just so fun. Like I'm just here as a parent. Wow that's amazing. Like here I'm at this table just as a parent. And so that makes you feel really valued, and I know it sounds silly but a lot of the meeting she'll send you a gift card from Amazon, and it's just "thanks for participating." Or a handwritten note, "thank you for participating it really matters that you're there" and it's wow. I mean I didn't do it for the gift card, but that sends a really strong message that they want me there. And so that means a lot, and so I have shown up and I've been tired and just or stressed out or didn't really want to expand but thought I really should go. So I think it's really showing parents that you value them. The other thing is that over time, it became really valuable to me because I got to see all the different services.

Although the parents and youth that were involved in the Community Together SOC implementation clearly felt valued and appreciated for their participation in meetings and enjoyed the time that they got to spend with other parents, it is less clear that parents and youth took on leadership responsibilities within the SOC implementation efforts.

I will say that I don't feel that parents have as much input as we are trying to say they do. And communication is definitely not a strong point. There is not a lot go follow through. I have volunteered for several things and heard nothing back more than a few times.

I mean not, from my perspective. Okay it's more of a feedback, I mean that's not really a leadership role but it's more of like a comment here and there, I guess, I don't know if that makes sense.

4.5 Youth Involvement and Leadership

Youth involvement was more limited than parent involvement. The youth who were involved in the Community Together SOC implementation did not have lived experience receiving mental health services, but instead were involved in health careers and became involved through a program at their university.

And so, through that, we actually recruited a youth who was excited to hear more about Community Together…And so, that was a really just unique opportunity. I would've never

known this person prior to having this training that we invited folks online to be a part of…We also utilized students…that are interested in mental health and can connect on that level, and so we've been able to recruit some youth there.

I was paired up with [Community Together Project Director] because she was the leader of this Community Together implementation, and so I was initially paired with her and just to provide a youth perspective, since I'm from here and kind of have a little bit of idea of like what you, like youth life is like. And she wanted me to just jump on board and get into the meetings and kind of give my perspective on maybe new projects that they implement or if there's any problems or things that I think are going well in the community, that I just kind of provide some feedback to her or give new ideas of what they could do. So, I sit on those meetings and I've been doing that, since COVID. So that's been my role in terms of the structure from my, from my side, it seems like I just meet with [Community Together Project Director] and she seems to be the leader of the whole thing. She talks through the meetings; she's the one that speaking majority of the time.

Since youth involvement is something that many SOC implementation efforts struggle to achieve, site visit participants were asked if they had any ideas about how to increase youth involvement:

Right now, none of our meetings are conducive to a youth who's in school. We used to have lunch meetings—they should be at school at that time, they should not be able to come to lunch. Our meeting today was at three o'clock; I know that my kids don't get home until 3:40. And then, like getting home and then like right away you have to jump on a zoom call with a bunch of adults…Now that [in-person events are happening] it'll be easier to do things in-person and it might be a little bit easier to entice them. I know that I was recruited through an email or a flyer or something of that sort. Sixteen-year-olds, 21-year-olds don't read emails or flyers; they're just like "cool story bro I'm going to throw this away." I think that it would be more beneficial to have something at the end of a mental health first aid training. For team mental health first aid, "by the way, there's this group that you could be a part of, get your voice heard and they'll be pizza every meeting," that kind of thing so like they might come for the pizza. So, the first time you'd have like 20 kids show up, but then after like seeing what it is like whenever you might have like five it'll stick around. That kind of thing.

I was in an adult learning class and every night if there was food—because there'd be a couple times that we order pizza—and I've never seen so many like older teenage boys. Like "no, you do not want to help me carry my books to my car. You really just want pizza." So like you put a flyer, you see saying "hey there's going to be a meeting with like free cookies" the likelihood that you'll get, like I said, you'll get like 100 of them, to begin with. But that might be what you need to make five or six of them stay and figure it out from there.

I think hitting it more at the school level would be great or like if there was some way that it would be like a benefit. And it's kind of hard because the most underserved youth, in my opinion, may not have the time… Or like, I don't know how to how to word it, but you know how some kids are really motivated to get involved and want to have a group position to put on their resume for college…maybe you're like stuff like that, but it's hard, because some of the most underserved already have a lot of them on their plate, and like not always are able to reliably get on a meeting on Zoom or that type of thing. So…but I think that hitting it from the school level if there was some way to.

4.6 Barriers and Facilitators of Implementation

Workforce shortage and turnover. Across the state and nation, there is a shortage of mental health providers. This challenge was entrenched even before the COVID pandemic exacerbated it to crisis levels. This was acknowledged by SOC partners and they discussed the impact for workload and the capacity of agencies and professionals:

We don't have or historically haven't had an abundance of mental health services readily available. In addition to stigma, of course, I think that the workforce issue in health care in general, was an issue before COVID and now has been exacerbated. We've lost a lot of people and not just here but in health care in general to burn out, to trauma, to abuse and I don't know how long it's going to take to recover from that or how healthcare will recover from that.

We have had turnover in those positions throughout COVID…stuff like that has affected our ability to have a consistent person in a position that then has to learn how to use these programs and use them effectively. And if you lose someone in that way, then that also kind of stunts your growth in your organization.

COVID. Without question, COVID and the resulting restrictions during these crucial SOC implementation years has been a barrier and a challenge. Foremost have been concerns for the health and safety of all stakeholders and the process of grappling with when and how to begin a return to pre-pandemic conditions. While Zoom has allowed as much consistency in communication and meeting schedules as was possible, much is lost when people are unable to gather together in person.

COVID has not only changed how people meet within the SOC, but for some has drastically altered the roles and capacity of providers. As individuals and organizations that provide mental health and health services, some stakeholders simply had to redirect their resources away from Community Together and many existing community programs.

So I think a big one that has of course affected everything that we do, especially when it comes to the continuation of care, not just in our building but with some of our partners is, is everything that has happened with COVID…Our staff were no longer just expected to do their jobs or a focus on the proactive things like implementing IRIS or coming up

with new ideas on how we could implement these parts of the systems of care. But they were also contact tracing or going out to infection control visits.

The logistics of managing the pandemic have meant that resources that used to be able to be out in the community have been diverted solely to pandemic response. The health department, same situation, I mean everyone at the…at the health department has an additional duty now of contact tracing…. The leadership those individuals who should be able to help with the visioning with the implementation are being consumed with the mechanics and the logistics of COVID response as well. We really haven't talked much about the impact from a complete staff perspective, but even those…even those individuals who are working now have two and three hats, thanks to the pandemic.

I think COVID, obviously, presented other challenges in that our leadership team consists of a lot of folks who needed to make some pretty significant changes with their organizations, at the onset of COVID, in terms of figuring out how to manage staff and operations, and how to keep everybody as healthy as they can, all of those kinds of components. And so, we temporarily put a pause, recognizing that all of us needed to kind of navigate this new way of living, and giving everybody just a moment to focus on what they needed to focus on, and then revisit where our goals are and how we can figure out all this new stuff together, collectively, after we've managed our own sort of pieces first. We didn't want to put the burden on folks and say, "We need to do this right now in this moment," recognizing, right, we had this thing happen that's never happened in our lifetimes before. So, we wanted to make sure we gave people grace and time to reflect on what they needed to do professionally, and also personally gather their thoughts before we recollected and discussed revisiting our mission vision and outcomes."

In addition to impacting the ability of people and agencies to prioritize SOC implementation and planning, COVID also greatly impacted the ability to work together collaboratively:

Again, with COVID, these have been tricky in terms of connecting in a way that we would have without COVID. So, like, having a townhall would've been a great idea, you know, pre-COVID. But doing that now with a lot of people in one space, not really a great sort of place for that to happen.

COVID has impacted how we do the work, because accessibility simply was not the same, particularly at the beginning of COVID, where we weren't able to just meet face-to-face with folks. And some folks simply weren't comfortable with even or didn't have access to the technology that they needed, to really connect with providers.

…but we still have challenges with connectivity and not everybody has connectivity, so there's physical barriers like transportation, there are virtual barriers like internet connectivity.

…access or the meetings used to be in person and now with COVID they're online a lot of times, that is a huge barrier to participation, especially if you're dealing with like underserved communities like youth and parents that may not have the resources to get online reliably. That would be a barrier to the orientation of this project, I would say.

Transportation. A critical community-level barrier that may be more unique to a rural community is the lack of transportation for both parents and youth:

Definitely, in our community our biggest barrier is transportation for our patients and clients in this… families in general, we do have public transportation…it's reliable but it's hard to maneuver and buses don't go to every spot all the time…

Facilitators. While a number of barriers were discussed by participants, they also talked about facilitators to the implementation process. The shift to virtual meetings and electronic communication during the pandemic has been a matter of necessity, and the ability to conduct business via Zoom for some has been a positive. For instance, for:

This is almost all gone virtual and so good on us for being able to do that. And, and I, I for one hope that we never go back to pre-pandemic normal because Zoom has made my life, a lot easier.

I think with COVID, the benefit—if there is a benefit—would be the opportunity for virtual meetings. So, we have folks in two different counties, and so the ability to meet all at once without having to travel actually improved our attendance a bit at meetings. Over time, I think people are getting more exhausted with video meetings, and we're kind of navigating what may work best for the future. But I do think, in the beginning, that was something that was really helpful for us, is that we could connect in a way that was just easier for everybody, generally, because we didn't have to do the traveling piece for some folks.

In addition to finding a silver lining in COVID, the leadership of key individuals and funder support emerged as important supports and strengths of Community Together:

I think for us, having the co-champion in place for our IRIS launch was really tremendous. Because this particular person knew a lot of folks in the community, they were able to really promote and also utilize their connections in a way to really say, "Hey, we have a relationship. We can support each other more in the work that we do, and interconnect our pieces more by doing this work together." And so that was a tremendous help in terms of really getting that started. Because I often knew folks, but then this other person knew folks that I didn't know, and so we were able to complement each other…and really get the word out about the pre-work of IRIS, and then start moving forward with that.

[The funder] have been really, actually, really amazing. They are very flexible, they're very responsive. If we need to adjust or changes, we've been able to do that very easily. If I've had a question or a concern, I get a really quick response, and that is very helpful. I also appreciate that there's a lot of positive reinforcement or feedback, not only in our calls together, but that [FUNDER REPRESENTATIVE] reaches out to my supervisor to say, "She's doing a really great job." I appreciate that my boss gets to know that our funder thinks I'm doing a good job. That feels really good when I feel validated in the work that I'm doing.

5. Results – Kane County System of Care

Kane County is an ethnically and economically diverse county 40 miles west of Chicago, with a population of more than half a million people. It has the second largest city by population in Illinois (Aurora, 193,431) as well as sparsely populated rural areas. The median household income in the county was $83,374. About 8.5% of the overall population fell below the poverty line, lower than the overall state percentage. Also, 12.4% of children were under the poverty line. About 8.2% of the population do not have access to health care coverage.[21] In terms of race and ethnicity, 56.1% are White (non-Hispanic), 5.26 are African American (non-Hispanic), and 4.04% Asian. About 32.4% of all races reported identifying as Hispanic.[22] Different estimates suggest that the number of undocumented immigrants in Kane County exceeds 30,000.[23]

The Kane County Health Department is the lead agency for the Kane County System of Care (KCSOC) grant from the Illinois Children's Health Foundation. The Health Department described its role as a "convener and coordinator of activities" of a unified system of care,[24] and their grant supports in whole or in part several positions that provide leadership to the system of care: a project director, a project manager, and a systems navigator. Central to the system of care are three non-profit mental health agencies that provide the majority of the children's mental health services for the county. Other partners in the system care represent the domains of education, juvenile justice, substance abuse treatment, health care, and family support. A review of the KCSOC implementation grant application that was submitted to the ILCHF indicated that the SOC project would improve health outcomes for youth and families by focusing on three goals: 1) identifying children with, or at risk for, mental health issues earlier, 2) linking children and families to mental health services and supports that are accessible and meet their unique needs, and 3) increasing the use of High Fidelity Wraparound (HFW) to provide supportive services for the entire family.[25]

During the site visit, individual interviews were conducted with the principal project staff from the Health Department and focus groups were completed with professionals on the community implementation team (CIT), parents on the CIT, members of the Workgroup on Inclusion, Diversity and Equity (WIDE), and members of a new Parent Council.

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[21] Census profile for Kane County: https://data.census.gov/cedsci/profile?g=0500000US17089

[22] Kane County, DataUSA: https://datausa.io/profile/geo/kane-county-il#demographics

[23] Tsao, F. (2014). *Illinois' Undocumented Immigrant Population: A Summary of Recent Research by Rob Paral and Associates.* Illinois Coalition for Immigrant and Refugee Rights. https://robparal.com/wp-content/uploads/Illinois-Undocumented-Immigrant-Population.pdf ; Migration Policy Institute (n.d.) *Profile of the Unauthorized Population: Kane County, IL.* https://www.migrationpolicy.org/data/unauthorized-immigrant-population/county/17089

[24] Kane County Health Department (June 7, 2018). *Building a unified system of care in Kane County.* Presentation to the Illinois Children's Health Care Foundation.

[25] Kane County System of Care Implementation Grant Application (2019).

5.1 System of Care Goals, Objectives, and Interventions

Participants were asked to describe the strategic goals of the KCSOC project. The goals included enhancing service availability and access; increasing client voice; a focus on diversity and inclusion; and the ability to provide High Fidelity Wraparound services to those families that need them.

One goal that was identified was increasing the inclusiveness of the system of care and bringing more resources to more children and parents in need.

> *The first goal is identifying kids who are in need of different mental health services and families who are in need of different mental health services and supports and then getting them linked. The second goal is then getting them linked with the right resources in the community to make sure that…all of their needs are met, so that they are able to function as an individual and as a family and just have positive outcomes overall.*

> *[The strategic goal is] trying to meet the needs for the community, is really what it is. They're looking at what the resources are that are out there, and they're looking at where those gaps are, and how do we fill those gaps to reach that.*

> *But one of the needs that was identified by that team at that time was that there's not a lot of services for parents[…] And then prior funding used to be more flexible […] as everything got leaner, they're really only doing billable hours stuff. And then parents identified that it's a very isolating process […] to have children receiving, for instance, therapy services while the child's old enough to be in there independently and the parent feels really kind of isolated and is not getting a lot of support. So that's one area that we're trying to create services around. So that came out of the implementation team meeting and the strategic plan.*

> *The overall goal is to create a system that connects each part, each touchpoint that a family, in particular, a family or a youth in crisis. So, whether it's the school, whether there's a community organization involved, for example, the community crisis center, the school, the organization, just every different touchpoint. To build a system that creates greater communication across these different touchpoints, to bring the best outcome to that family, and give them the best possible support.*

Increasing access for children in need was discussed hand-in-hand with the idea of increasing family and youth's voice in the system of care:

> *One, really looking at how we can build more formal youth voice into the mental health system. Two, building capacity and increasing family voice, to make sure that we have people engaged, as well.*

The goals are to create more opportunity and access for youth and their families to be served within their natural home environments, to create greater capacity for mental health services, for all ages of our youth. And to fill the gaps of levels of care, and to further engage family and youth voice in the process.

To have a seamless array of care for the people in our communities, and that easier access when we want to refer to each other, so that people don't get lost when they're trying to navigate the system…we are definitely entrusted in making sure that there's parent engagement and youth have their own voice in the process, and that we listen to them, as providers.

One participant added that diversity-inclusivity had emerged as a goal out of meetings of the Community Implementation Team:

What came out of it is something that's really important, is a diversity-inclusive committee…that's a group of individuals from the community, from the Kane County area, representing different organizations, nonprofit, the healthcare, the hospital. So, a little bit of different organizations coming together…that's really important that has come out, out of the planning committee, because their input, especially the children that are underserved. And that is something that we really get a good feedback from these organizations of how, what are their needs in mental health, by the parents that they serve.

The ability to provide wraparound services was also mentioned by a participant, a goal from the very beginning of the project:

The last goal is just to increase the use of wraparound services, but also wraparound with fidelity…there's a very strict recipe for it. But really just getting providers in the community and different sectors to embrace the wraparound approach…just looking at a family holistically, working together as a team to support a family, getting them connected with resources that maybe you don't necessarily provide…letting children and families kind of create their own path and develop their own goals, rather than, "Well here's what we think you should do."

5.2 Activities and Progress Toward Goals

The KCSOC has pursued a variety of activities designed to promote children's mental health and make progress toward its goals.

Implementation of a new service referral system. One important intervention that participants credited with a large role in the SOC is the Integrated Referral and Intake System (IRIS) software for managing referrals in the SOC. The University of Kansas Center for Public Partnerships and Research developed IRIS to facilitate the making and tracking of referrals among community agencies.[26] As one participant put it, "the goal of IRIS is…to improve our referral system within Kane County, but also increase communication amongst service providers and...care coordination." IRIS enables an agency to make a referral to another agency electronically without the need for telephone calls. The referring agency can track whether the recipient agency responded to the referral and contacted the family. Users collect data about referrals, compute statistics, and produce an intuitive graphic that shows lines of referral between agencies and maps how the inter-agency system of referral is working. The primary goal is to connect families to services more quickly and effectively. One participant described some of IRIS' functions:

> *I can click on an organization… I can hover over them and really see who they're making referrals to, who's making referrals to them. And this data shows us not only where potential gaps or opportunities are…down on the lower portion of the screen, those bubbles that means they're not making referrals to [a mental health agency], and vice-versa. That gives us the opportunity to have conversations, to look at how our referrals are occurring, and really dig into are we missing opportunities or are there genuinely gaps in these different areas.*

Central to the effect of IRIS was a multidisciplinary group meeting regularly to review IRIS data and discuss the implications for improving services. Participants reported not only that IRIS had increased referrals but had also facilitated communication and collaboration of a wide range of stakeholders in the system of care. The SOC began to plan IRIS in 2020 and began to implement the system in 2021. The agencies participating in IRIS has increased over time and includes organizations such as dentists' offices not usually associated with children's mental health care. As of January 2022, there had been approximately 800 referrals through IRIS. One participant credited IRIS with facilitating discussion of diversity and inclusion, which led to beginning the Workgroup on Inclusion, Diversity, and Equity (WIDE). Several participants described the scope and effect of IRIS implementation.

> *IRIS has been implemented and they're looking at utilizing it even further, but I think that has been really great for engaging partners outside of the mental health system, and to being bigger partners within partners with the mental health system…they had to…fill*

[26] The University of Kansas Center for Public Partnerships and Research (2022). *We help you build healthy communi*ties. https://connectwithiris.org/

out an MOU and be involved in the process, and attend meetings to learn about it, and be at a table with—because, it doesn't matter what part of the collateral systems you work in, everybody needs to access mental health resources, more today, maybe, than even two years ago…they're also feeling like their voice is heard and that they don't know what happens after they send a referral. And so now, IRIS gives that feedback loop for them, that I think that people always felt like they never really had

My intake worker loves it, because it closes that feedback loop, it's like a warm handoff. Before IRIS, we all worked together very seamlessly. However, there could be times when you referred and you weren't 100 percent sure that the family showed up, and it was a lot of phone calls. they have a visual, the IRIS flower, and it shows you…we had somebody refer to us, and we weren't the right place. And so, the feedback loop was immediate, that the referring agency knew that we couldn't take that client, but then we figured out where they should refer. So, for us, it's a very nice visual and concrete way to do referrals, so, we like the IRIS system at our agency.

Our waitlists are huge, and our staff are under a lot of stress right now. if you have a tool that can help you not make five phone calls, that's going to free you up and enhance the satisfaction, a secondary reward to some of these goals that we're looking at, which is that, if it helps your staff feel better about the work they do, then they're going to stay engaged. It's really hard to keep people in community mental health, these days. So, any job satisfaction that comes out of a system that makes their life easier doesn't just help the community, which is the primary goal, but the secondary goal that's being accomplished, with IRIS in particular, is that component of making my intake workers' life a little easier so she can go on to the next family.

One product of the IRIS group meetings was the identification of unmet service needs and beginning action to address those needs:

One example was during the first quarterly meeting people were like, "There's no LGBTQ services listed," we had no one. So that was a problem for people, because there's a lot of LBGTQ youth in our community. So, we used that information that was collected and kind of then we really focused outreach efforts on working with LGBTQ organizations getting them hooked-up in IRIS or if an organization provides services specifically for LGBTQ youth like putting that on their profile, clicking the service area so that people are able to find them.

Providing flexible funding to meet families' unique needs. The SOC has implemented a process of providing flexible funding for individual family needs using funds from the CMHI grant. At regular meetings, provider agencies can solicit the group for funds to help meet a variety of individual family needs. One participant described the process:

The requests can come from someone that is…plugged into the community, that works for one of these agencies…they submit…a formal request…for example…one of them was

…the family was asking for $200.00 for…a better bed for the kid. The child…they were having trouble resting and they didn't really have comfortable space or…it was meeting a need just as simple as that. So, the representative came, and they just gave a brief few-minute presentation, and then we all talked about it and expressed our thoughts… then we all did a formal voting. It's…been rewarding to see that process be implemented, because these are real needs that are being met in our community.

Supporting grants to other provider agencies. Through a Request for Proposals (RFP) process, the KCSOC has used some of its funding to support projects by provider agencies to enhance children's mental health. It has also provided small grants to schools for enhancing school social workers' offices. Two participants from provider organizations described their experience with the RFP process:

There was an RFP, through the system of care, and we received some funding to have…we have a program called Family Connections, and we do it in partnership with school districts. It's a program where we work with parents on parenting skills and parenting support and lifting them up and giving them a safety net. And then, at the same time, we work with the kids, and then at the end, we bring them together…it's a very nice way for the parents to have support from each other and from us as professionals and the kids are there—it's a really great program, and through the system of care, we were able to expand it.

They put those RFPs out to all of us…the nice thing is that…you could personalize it…we did it specifically around staff services, and we hired an engagement specialist to tackle the youth that are being reassessed, reassessed, reassessed.

Development of a workgroup on diversity and equity. The Workgroup on Inclusion, Diversity and Equity (WIDE) meets monthly with the goal of improving cultural equity throughout the community. It provides relevant educational experiences, for example, a presentation by a local college professor on the history of the term Latinx. WIDE also does networking to help find resources for specific families or agency needs. One WIDE participant explained:

Because it's an expansion of networking, a lot of questions get asked to the group from various member organizations. And we get an email or we get an update about, "Hey, does anybody know about this?" or "This activity's coming up and can you promote this?" So, we get a lot of timely communications. And so, we get requests for participants in certain things, they're looking for a childhood provider for this, and does anybody in the group know anything like that. So, it's a very helpful networking system.

High Fidelity Wraparound. As noted above, one goal of the KCSOC has been to implement high fidelity wraparound services. There have been challenges to implementing it. Given the current reimbursement model, it is financially difficult to implement wraparound services, though service providers are making efforts to implement it to the extent they can. Participants explained:

Wraparound…that's been a little slower going in the community just because of different financial restrictions, it's just not sustainable for organizations….So they're doing what they can, but they don't have the specific wrap teams where one person is the care coordinator. But they are still working with different providers and bringing together to work together to meet the needs of the families.

The Illinois Department of Human Services is planning to provide training in high fidelity wraparound and provide reimbursement to make it central to its Strategic Plan for Children's Mental Health. But implementation of this work on wraparound was delayed by COVID, and at the time of these interviews, the SOC was still waiting for the state's action to implement high quality wraparound fully. The workforce challenges also make it more difficult to implement high fidelity wraparound. Participants commented on the current gap regarding wraparound and their anticipation of the opportunity to do wraparound in the future:

We used to do it all the time when there was funding available before system of care, and then, DCFS and the Illinois State Board of Education were the ones that provided those funds. And they stopped that funding, and then, sadly, the wraparound world kind of disappeared….So, we have not done it at our agency, in the last couple of years, because it requires proper training, and if you're going to wrap a family, it's very nice to have funding when you find out what they need…the actual high-fidelity wrap, I'm glad it's coming back. It's just a matter of coordinating it, since it did get stopped in its tracks by COVID.

And the guidance that we've received from the Foundation, which is really sound, is how can we best position ourselves, our community partners, so that if the state starts to be more supportive of wraparound services, that we have people who are trained. And there's always kind of a chicken-and-egg thing, in my mind, because you're waiting, on one hand, for the state to roll out training, and on the other hand, you don't want to sit and wait…in terms of some serendipity, the person who coordinates our juvenile justice counsel for Kane County, that's a strong partner, she's on our implementation team, she also now is helping to roll out some of the wraparound training for the state. So, we are looking to really maximize on her knowledge of the system and what's going on, so that we can provide a lot more wraparound services. But I do think there's still a tremendous amount of tension for all of these things, because these are all improvements, and our organizations are in survival mode and trying to get people in.

Coordinating with other behavioral health initiatives. An additional activity that was mentioned was "aligning" the system of care with the state's new Pathways to Success Initiative. Pathways to Success provides an "evidence-informed model of intensive care coordination and additional home and community-based services" to Illinois children on Medicaid "who have complex behavioral health needs and require intensive services and

support."[27] One of the mental health agencies in the KCSOC applied to be the Care Coordination and Support Organization (CCSO) in the Pathways to Success program for its service area, which include Dekalb as well as Kane County. The CCSO will provide care coordination and support services and mobile crisis response services for children enrolled in the program. Other agencies will provide intensive home-based services, family peer support, therapeutic mentoring, and respite services. One participant anticipated that developing Pathways to Success in Kane County might require some effort, since some of these tasks might pose challenges in the reimbursements they can provide and the staff they can attract at a time of declining workforce. At the time of our interviews and focus groups, agencies within the KCSOC were working on their plan for the Pathways to Success program, and one of our participants felt that Pathways to Success would require focused attention:

> *I think it just has an impact, logistically, on how we organize ourselves. And again, being a decentralized system in Kane County, that increases the importance of us working together intentionally.*

5.3 Implementation Supports and Processes

The ability of a community to implement SOC or any other large initiative depends in part on the supportive structures and processes such as project leadership, communication, planning, and decision-making. Site visit participants were asked about each of these implementation supports and processes.

Leadership. The KCSOC has developed an array of teams to implement the SOC and work to improve care. Central to the SOC is the leadership team from the Health Department, consisting of the Project Director, the Project Manager, and the Systems Navigator. This team provides most of the day-to-day leadership of the KCSOC. Participants described the importance of this team for coordinating the work of the organizations participating in the system of care:

> *[KCSOC Project Manager] will decide on some structure to help us prioritize which things out of those 25, probably doable fantastic ideas that we're going to actually dedicate our time to…she structured the conversation, so that we went through each part of the strategic plan*

> *Our health department team, I think, is really great at engaging community stakeholders and voice. I see that as one of the really big strikes on the team.*

Members of the Community Implementation Team deeply appreciated the leadership from the Health Department staff:

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[27] Illinois Department of Healthcare and Family Services (September 7, 2021). *Pathways to Success: Frequently Asked Questions.* https://www2.illinois.gov/hfs/SiteCollectionDocuments/PathwaysToSuccessTownHallQA08202021.pdf

[KCSOC Project Manager] cares so deeply and she figures out how to make stuff work. Now, I don't see her day-to-day life on how she makes it work, but I see the outcomes of it…when something is raised in the group, it doesn't get pushed off. You know, they always say if you want something to die, assign it to a taskforce [laughs]. This is the opposite of that…[KCSOC Project Manager] and [KCSOC System Navigator] are just, they just are so—they're so dedicated.

[KCSOC Project Manager] is a great ambassador…for the system of care. Just talking about the need for family voice and choice to be at the table, talking about the importance of working together, collaborating, and then providing solutions around that.

Both [KCSOC Project Manager and Systems Navigator] are very good at communication…that's such a key strong point for them, and [KCSOC Project Director], as well…it's that personal relationship, that one-to-one conversation, that builds that trust…that one-to-one conversation…to make sure we're on top of things.

They're both [KCSOC Project Manager and Systems Navigator] very authentic and very dedicated to this work, and really do try to listen to everybody's input, and do a great job of…when someone says something, they really think about it and how to implement it in the work that everyone's doing.

[KCSOC Systems Navigator and Project Manager] work tirelessly, against many, many, many barriers, to push this work through. And it's above and beyond what their job description or anyone should really have to work through, it's just the level of dedication from the whole group, the whole implementation team.

The Community Implementation Team has met monthly throughout the course of the project. A number of participants praised the collaboration that existed in the project; one participant described a "collaborative mindset" that has characterized children's service professionals in the county for a number of years. The Leadership Team described getting input from the CIT as an integral part of the leadership process. Often the KCSOC Project Manager used surveys or the Jamboard on Zoom to solicit the input of the CIT. One participant talked about the leadership that came from the CIT:

All of the group that do the meetings on a regular basis…and talks about the main strategic goals…community leader partners, the parent partners…they're all voices for the same message…a critical component is that…the same message…is being driven out…to say…that you need to support families in a holistic sense. That we are looking at more than just pieces of them but all of them, and that if we don't work together, then ultimately, we've failed them in any one part of it, right? So, I think all of those partners are our leadership in that process.

Communication. Much of the communication in the project is handled by the Project Manager and the System Navigator (for parents participating in the SOC development). The project manager was praised for using emails effectively to communicate with the partners:

> *[KCSOC Project Manager] gets information out to different groups in different places, all of the time, and then works to engage them back into the system of care. She'll let them know about the WIDE group or let them know about other meetings that are available that they could possibly attend.*
>
> *There's a lot of really timely communications—I think we just get [emails] once a week…we get requests for participants in certain things, people…looking for a childhood provider… it's a very helpful networking system.*
>
> *[KCSOC Project Manager] is coordinator of [emails]…you can get things from multiple places, from [the Health Department], from [other mental health] provider, because everything is kind of intertwined. When we're talking about the community needs assessment under behavioral health, there's a connection with it. So, there's a real intention not to duplicate both initiatives or services, and to share best practices. That's how I get it, by emails.*
>
> *I'm finding [emails] always timely, I'm finding that it's always concise, it's never a waste of my time. I feel very, even though sometimes there's stuff that I get that's, like, "Wow, that doesn't pertain to me," it's still part of the group that I belong to. I don't see things that are foreign to me, that I wouldn't understand why I'm getting it. There's an intentionality of how we get our information, which is helpful, to me.*

The KCSOC System Navigator was also praised for using multiple methods to communicate with parents, as this quote from a parent illustrates:

> *When it comes to communication, [*KCSOC System Navigator] *doesn't only do just the emails…she takes that extra step and send text, so she can make sure I receive it on time…and to the parent council, also, she's in constant communication and she send text. Because she understands that not all the parents…have the time to be checking the emails.*

Committees and Decision-Making. While some professionals' participation in the CIT has waned over time and DCFS has been difficult to engage, other organizations have been added and the overall membership has been larger. School professionals have found it difficult to participate in the CIT meetings, given all the demands the COVID pandemic has presented for the schools, though they have been meeting monthly in a separate meeting convened by the KCSOC System Navigator (described elsewhere in this chapter). Participants talked positively about the group process in the CIT meetings as one participant described themselves as "a really cohesive group for a long time" and how it helped them with their work with families:

When I go to the meetings, I'm impressed with how many people show up, and how many people really speak their mind on things. I feel like everyone is very engaged in it. I really love hearing from the parents that are on the team, they bring a perspective to it not just for the system of care, but they say things that I will quite frequently bring to my agency and to my clinicians, just about their perspective on things. So, I really like the engagement of the participants in this process.

That's one meeting I truly enjoy attending. Yes, we meet from 6:00 to 7:00 or 7:30, but at the end of the day, we come out with some good ideas, a lot of communications, "You can help me this—", "I have an issue with one particular participant—" …it's a nice cohort...not just all of us that are professional, but that input from that parent really gives us a better idea of what other support, what other resources that we can provide.

As we discuss elsewhere in this chapter, the KCSOC has developed additional multidisciplinary groups to pursue the goals of the SOC. These include the Workshop for Inclusion, Diversity, and Equity (WIDE); a monthly group led by the Systems Navigator to plan the Youth Voices Forum, which has also served to support school social workers; and an ad hoc group to plan Suicide Awareness Month. Also included are a group that meets regularly to provide flexible funding in individual cases, a group that oversees and review findings from the IRIS referral software, and a Parent Council.

5.4 Parent Involvement and Leadership

The KCSOC has made a considerable effort to increase parent engagement, voice, and leadership in the SOC. The primary focus of the System Navigator's work is to promote and support parent engagement and voice. In the SOC planning year, the Leadership Team conducted a community survey to identify needs and interest in children's mental health community and reached out to several parents who completed the survey to recruit them for the Community Implementation Team. The Community Implementation Team still includes three out of five parents from the beginning of the project, and parent voice has been a consistent element of the CIT throughout its tenure. The System Navigator onboarded parents to the CIT and supports parents' involvement in the SOC, both outside of meetings and during them, as one participant described:

We would have a structured part of the conversation say, "okay parents just tell us your reaction to this" and trying to make sure that they talked instead of having the professionals talk. Or I will slow down the conversation and say, "parents do you know what we're talking about?" or "are you interested in us explaining?", because parents aren't paying attention to the new funding from the state.

One professional described the value of hearing the parents' perspective:

Hearing those parents' perspective of, "I feel like I was completely dropped by my therapist," …Or, "I feel like I was not heard, at all. They totally listened to my kid and

they didn't listen to me," those different perspectives I think that they bring to the table. And it takes such vulnerability to own that in a group of people and say that, where, potentially as providers, you could potentially be, "No, it's not like that," right? But people aren't like that in the group, they're very open to hearing the feedback, it takes that vulnerability to bring that perspective to the table is key.

Parent Cafés. One of the parents on the Community Implementation Team provided the leadership to start a series of Parent Cafés. They provide an opportunity for parents to drop in to meet other parents and gain information and support. Professionals facilitated the first Parent Café, but now over 20 parents connected to the SOC have been trained to host the Parent Cafés, and parents are now hosting them without professional involvement. One series of Parent Cafés training has been for Black families and another series for Latinx families, held in Spanish. The Parent Cafés have been held over Zoom, but the goal is to offer them in person.

Parent Council. The Kane County Health Department wrote a Request for Proposals to fund the development of a Parent Council, which led to a contract with Community Organizing and Family Issues (COFI),[28] a well-established non-profit that has organized parents to advocate for improved communities and service delivery throughout Illinois. In partnership with the SOC, COFI promoted the Parent Council through networking, social media and flyers. Provider agencies in the SOC helped build the Parent Council by recruiting parents among its clients, and news of the Parent Council also spread by word of mouth. The Parent Council began meeting in 2021 and continues to meet regularly. It has drawn its membership from the Latinx community in Kane County and holds its meetings in Spanish. The Council included both parents who were engaged in mental health services and parents who were not but still cared about the need for children's mental health services. COFI provided leadership training to the Parent Council to help them develop skills in community outreach. Participants described the training:

COFI has their own model of training that they call self, family, and team…they start working on what's one personal goal you want to work on, a family goal, and then a community goal….it does seem like you lose some parents in that process because it's quite intensive training. But then the ones who stay have got some more skills and tend to be quite committed.

The parents when they work on themselves, they definitely make a lot of changes, personal changes like they start thinking about themselves and were like, "I'm going to learn English, I'm going to start driving, I'm going to learn more about computer skills." And then when we move to family goals, they start thinking about how to support their children and I don't know, eating healthier, looking for mentoring opportunities, *and all different after-school programs. When they're working on as a team, they also learn different skills on how to work together, how to do things that have in common all of them. And one of the things that they decided to do was technically learning more about mental health issues. And they were wondering about how I can recognize symptoms of*

[28] Community Organizing and Family Issues (2022). *The COFI Way builds parent power.* https://cofionline.org/COFI/

depression in my children or how I recognized that my stress level is higher than it's supposed to be. So, they also wanted to have a lot of family activities.

By 2022, the Parent Council had completed a survey of community need conducted through interviews with hundreds of parents. The survey was not just data collection; Parent Council members engaged parents in conversations designed not only to gather information but to engage parents, respond to their concerns, and connect them to the larger parent effort. The Council anticipated reaching out to school administrators to advocate for enhancements to school referrals to mental health services. Working to fight bullying, increase use of restorative justice methods, and improving nutrition in the community are additional goals of the Parent Council. The Parent Council is also working with a provider agency to add to the agency's board.

Another parent participant talked about the empowering effect of the Parent Council and COFI's involvement.

I just need to raise my voice, advocate, I have the power, I know how to do it. We actually just have a group of parents graduated this week and one of the moms, she was like, "I feel like I'm a leader and I have been a leader for 35 years." But now with the COFI model, I feel like I needed these tools to become a leader with respect, a leader with not…with knowing how to escalate the systems. Like "who do I need to start my conversations with" and then "who do I need to go with what's next?"

5.5 Youth Involvement and Leadership

The KCSOC has created an annual event to engage youth in the community on the topic of mental health and increase their awareness.[29] Virtual youth forums have been held in 2020, 2021, and 2022. Student speakers shared their personal experiences in a virtual gathering of students, teachers, administrators, mental health professionals, community members and media professionals. Eleven different high schools in Kane County participated in the 2021 event.[30] After the events, the SOC produces a report sharing students' perceptions of their recommendations for improving the response to youth mental health problems. According to the 2021 report, youth requested more spaces for them to talk about mental health, greater access to supportive adults with knowledge of mental health, and more access to reliable mental health information.[31]

[29] Kane County Chronicle (February 20, 2022). *Kane County System of Care presents annual Youth Voices Forum on Mental Health* https://www.shawlocal.com/kane-county-chronicle/news/2022/02/20/kane-county-system-of-care-presents-annual-youth-voices-forum-on-mental-health/

[30] Kane County System of Care (2021). *2021 Youth Voices Forum on Mental Health Full Report. https://www.kanehealth.com/Documents/Children/Mental%20Health/YVF%202021%20Report%20Final_ENG.pdf*

[31] Kane County System of Care (2021), ibid.

5.6 Barriers and Facilitators of Implementation

Similar to the other CMHI 2.0 sites, the KCSOC has encountered substantial obstacles that have slowed the implementation of the project.

The COVID Pandemic. The COVID pandemic descended on the country early in the first implementation year of the project and has posed a challenge ever since. It has affected agencies' ability to provide mental health services, schools' ability to respond to children's needs, and the ability of the stakeholders in the system of care to meet and collaborate. The Kane County Health Department resembled first responders in their response to the pandemic, and the SOC staff from the Health Department pitched in, stealing hours from their work on children's mental health services. Participants described the problem:

> *But us in particular were very impacted by that because we were at the health department, and it was just such a level of crisis that they…that we ended up doing a lot of COVID work and I'm one of the only Spanish speakers, so I have done a lot of COVID work. And you also couldn't exist without responding to COVID. Because, for me working with parents and families and a lot of immigrant parents and families and we're really being decimated by the pandemic, so I also felt like as a human service professional I had to respond to what was happening.*
>
> *All the [Parent] Council families have had COVID. Everyone has had someone die. It's been very traumatic.*
>
> *It's just caused so much crisis on everybody that everybody was just so overwhelmed. Everything is so backlogged. It's always hard to work with the schools but, the administrators are so overwhelmed that that's been more challenging than I think it might have been a normal time. Obviously trying to do everything virtually adapting to that. Now the shift has been made that people are like "Oh wow! mental health is a next pandemic." In many ways…but then it's such a crisis that the providers are so overwhelmed too that it's hard to ask people to do anything different or to do anything extra….the schools are really overwhelmed. People are just really burnt out right now. You just definitely just see the grind just wearing on people.*
>
> *When COVID happened, we had to stop everything that we were doing, analyze it, get those safety procedures in place, make sure our staff was safe, make sure our clients were safe, our buildings were equipped, so that none of the services were interrupted. And then every time you thought that things were improving, it didn't.*
>
> *One staff member, she had two people in her immediate family that died, and then two in her extended family that died within six months. So, the staff were experiencing their own grief, and they were actually experiencing a parallel process to what their clients were experiencing. And it might be the first time in my life I've ever had to manage that as somebody over, usually, we're not experiencing the same trauma as our clients*

are...that were hard to navigate and negotiate, that are not our usual typical stressors that we manage. And plus, there were people who their significant others were being laid off of work. So, then they were, "Oh, I need to pick up more hours. Is my job safe?" And there was a lot of those kinds of things that we were negotiating with our staff, who then were negotiating that with the clients that they serve. So, it was just like a hot mess.

Workforce Shortage. There is a national workforce shortage of mental health professionals that is afflicting children's mental health services across the country.[32] Increasingly mental health professionals have opportunities to gain substantially greater income through various forms of private practice or by working for organizations that have more resources to pay mental health professionals. Mental health provider agencies in Kane County are all short staffed. This increases waiting lists and puts a premium on billable hours, which are limited for many SOC related interventions and reduces the time that professionals have to participate in the development of the SOC. One participant described the problem in detail:

We can't find enough therapists to meet the needs of the community. And everything is intersecting all at once: the pandemic, people's mental health crisis, those basic needs that people have. And if you have that vortex happening, I've never seen a waitlist this high in 25 years. And so, if you have all that happening at the same time—that you put ads out and you get three resumes—I remember the days when I would have a stack of resumes, and I would have the cream of the crop to pick from. And now I'm getting resumes where they don't even have a master's degree in the field—so there's a crisis happening that we're all dealing with, where more and more people are going to need mental health…it's all happening at a time when, yeah, I'm desperate for qualified mental health professionals to come work for me. People all over the world, now, are reassessing, "Do I want to do this? Do I want to give that much?" It's very stressful, it's often low pay. We've been dealing with this for years, but I think it's just been heightened.

Facilitators of Implementation. We asked participants to identify any factors that facilitated the development of the KCSOC. The most frequent theme in their responses involved relationships: the history of interagency collaboration in the county, the continued agency participation in the CIT even during the pandemic, and the array of different human service collaboratives that have developed in the county in addition to the SOC, and the family-like atmosphere among those involved in the SOC. The quotes below illustrate this theme:

The way we set our process up, where it is a partnership with these different collaboratives that exist.

Having the right people at the table.

[32] Caron (September 14, 2021). *'Nobody Has Openings': Mental Health Providers Struggle to Meet Demand.* New York Times. https://www.nytimes.com/2021/02/17/well/mind/therapy-appointments-shortages-pandemic.html

Different organizations are interested in different things where we have a champion on the implementation team or even a champion from their organization. Like they may be like, "Oh I have someone in my organization who would be awesome to help with this." So, then we facilitate the process, but we're engaging people along the way to help us with this.

I would say our nature in Kane County. You know, I've only been at the health department for, like, two-and-a-half years, but just, our nature of collaboration, and how everyone kind of already had that collaborative mindset. And so, when we build these relationships, when we all see that we're on the same page, it really helps to kind of do these things and have people actually commit to it and do it.

Participants also mentioned a wide range of other specific actions or resources. These included the IRIS system, the availability of Zoom during the pandemic, telehealth laws allowing reimbursement for remote services, the new Pathways to Success state funding, and the contribution of the Health Department both in responding to the COVID pandemic and in providing small grants from the foundation funding to support small behavioral health service initiatives.

6. Results – Kids Connected

The non-profit organization, the Primo Center, is the lead agency for the Kids Connected project. For forty years, the Primo Center has been providing services for families on the West and South sides of Chicago who are homeless and at risk of being homeless.[33] The Primo Center most frequently serves the Austin, Englewood, West Garfield Park, North Lawndale, and Hermosa neighborhoods, though the Kids Connected project was designed to serve the entire city of Chicago. The Primo Center operates a homeless shelter, offers trauma-informed mental health and case management services, provides home visiting, and coordinates with health service providers. The need for improved children's mental health services in Chicago is substantial. The Chicago Coalition for the Homeless reports that an estimated 58,273 people experienced homelessness in 2019. The majority of parents and children in homeless families have experienced trauma, yet their ability to access and make use of mental health services is limited.

The Primo Center partnered with two experienced and active agencies serving homeless families (Heartland Alliance and Catholic Charities) to develop the Kids Connected system of care initiative. The purpose of Kids Connected is to create a system of care to fully serve homeless children in Chicago with social-emotional challenges and their families. Kids Connected will provide integrated care that fully addresses all aspects of their care—physical and behavioral care, education support, housing—resulting in improved health outcomes, education stability and the end of their homelessness. The primary intervention articulated in its implementation application is a high-fidelity wraparound program. The Primo Center and its partners refer to the service provided through this program as care coordination.

The strategic plan accompanying the implementation application specifies implementing the high-fidelity wraparound model as one objective, and also lists these additional objectives: conducting a landscape analysis on domains that impact health outcomes for homeless children and families; completing secondary research on best practices of a fully integrated system of care; gathering information from people with lived experience; and surveying payers to gauge support of implementation of the Kids Connected system of care model. Kids Connected project staff funded by the CMHI grant include the Primo Center Chief Executive Officer, Chief Development Officer, and Chief Officer of Quality and Impact, and a Project Director. The grant also funded two full time care coordinator positions; one at each of the partner agencies.[34]

The Primo Center and its two partner agencies developed a plan in which they would collaborate to identify and provide care coordination services using a high-fidelity wraparound model with homeless children throughout Chicago. A broader Community Implementation Team with representation from multiple agencies was also created to support the development of the system of care for this population.

[33] The Primo Center (2018), *CMHI2.0 Grant Proposal*.
[34] The Primo Center (2019). *Implementation Grant Application.*

During the site visit, individual interviews were conducted with the principal project staff from the Primo Center (CEO, Chief Officer of Quality and Impact, and Project Director; the Chief Development Officer is no longer with Primo Center), and focus groups were conducted with three staff from the partner agencies and two members of the Community Implementation Team. No parents or youth were able to participate in interviews or focus groups, so we are unable to include their perspectives in this analysis.

6.1 System of Care Goals, Objectives, and Interventions

There was a consensus among participants that the goal of Kids Connected was to improve the mental health and quality of life for children and families served by the program through coordination of efforts among multiple agencies and service professionals involved with families who are homeless. The goal is essentially the success of the high-fidelity wraparound service at the center of the Primo Center's project. This was clear in several participant responses:

> *Our strategic goal is to create and implement a high-fidelity wraparound approach for children experiencing homelessness and their families…we're doing it through care coordination, which is the wraparound facilitation, we're doing it through enhanced services, and then, we have system partners to help guide us through the system needs for homeless kids.…What we were most excited about, through this project, and still are excited through this project and funding, is that it puts homeless kids front and center, that in our system have so often been neglected for so many years.*
>
> *We know we have a lot of families dealing with the homeless system. They're dealing with the school system, the mental health system, child welfare, health care...the experiences of the services are really fragmented. Systems are not really set up to serve vulnerable families or families experiencing instability, and so one of the strategic goals is to reduce that, to find ways to help these systems work more cohesively….And then I think the kind of more micro focus, how do we actually connect families and children to the resources that they need.*
>
> *…to get Kids Connected to the high-fidelity wraparound services. And we worked primarily with all children that were homeless. So, to get them linked to care and provide them and their families the resources they needed to recover…linking them to mental health services to address trauma, linking them to food and whatever else they needed to address the social determinants of health and so all of those medical, psychological, and social factors needed to increase their…or support them in their recovery. It also involved linking the parents to care too if that was needed.*
>
> *…decreasing gaps in and improving mental health statuses amongst this group and also increasing educational outcomes and by doing so stabilizing housing so that folks can get the services that they need in a wraparound way. So, serving the whole entire family*

and making it definitely a family-centered approach where the families have a lot of say in how and what services that are being provided to them.

My understanding of the…overall goal of this project is to develop a system of care for families that are experiencing homelessness, that have a youth…that has mental health needs.... I think the way that we first identified how we're going to build that system of care is to get all of the players in all of the systems that affect either homeless families or affect youth with mental health needs, together in the same room.

6.2 Activities and Progress Toward Goals

According to the implementation grant application, the primary goal of Kids Connected was to provide High Fidelity Wraparound (HFW) services to families who are homeless and have a child with mental health challenges. A Core Implementation Team was formed to administer these services, the Project Director was trained in HFW, and Kids Connected began to provide care coordination services to children and their families in the second half of 2019. The Core Implementation Team consisted of the Kids Connected Project Director, clinical managers from Catholic Charities and Heartland Alliance, and care coordinator staff from the three partner agencies. The Kids Connected Project Director trained the other staff in HFW, and the team met on a weekly basis to discuss cases and methods. Weekly meetings shifted to monthly meetings, and Primo Center's Chief Officer for Quality & Impact and Director of Communications began to attend the meetings, as well.

The onset of the COVID pandemic made implementation of HFW untenable for Primo Center, Catholic Charities, or Heartland Alliance to provide. The care coordination team at Primo Center developed a hybrid model of wraparound service in which care coordinators convene family team meetings combining in-person and online participation. Staff of the Primo Center described providing Kids Connected care coordination services despite the COVID pandemic:

We didn't stop services, so that was something that we were proud of. The high-fidelity piece, we had to let that just go a little bit, while we focus[ed] on just making sure we didn't stop those crucial services such as the community support, the case management, the psychiatric, and the therapy that the child was receiving….Our CEO made it clear that there should not be a hold on clinical services being provided, as a majority of the kids that are in the program are in our homeless shelters. So, during the time of COVID, we all could not be in the building, but we kept those essential workers working, due to what the family wanted. If the family wanted it in the gymnasium with a glass shield, or they want to do it on a Zoom telehealth, the agency was able to work with the city to get a grant to get them computers. And so, we were able to utilize telehealth, still providing services, with those families, through laptops that we had set up in one of our multipurpose rooms. We had our psychiatrist, he never stopped. He did telehealth….I'm proud of the progress we were able to continue to make by maintaining service enrichment for the families in need.

While the Primo Center was able to provide care coordination services during the pandemic, Catholic Charities and Heartland Alliance provided these services to a much smaller number of children and families—far fewer than they had initially expected to serve.

During the autumn of 2021 there were a series of meetings among Primo Center, Catholic Charities, and Heartland Alliance, in which it was decided that all Kids Connected care coordination will be provided only by the Primo Center, and responsibility for managing the Community Implementation Team will shift from the Primo Center to Catholic Charities.

6.3 Implementation Supports and Processes

The ability of a community to implement SOC or any other large initiative depends in part on supportive structures and processes such as project leadership, communication, planning, and decision-making. Site visit participants were asked about each of these implementation supports and processes.

Leadership. Primo Center staff provided much of the leadership for the implementation of Kids Connected and participated in both the Core Leadership Team and the Core Implementation Team. The Core Leadership Team includes top-level managers from Primo Center, Catholic Charities, and Heartland Alliance and consists of at least the Primo Center CEO, the retired CEO of Catholic Charities (who left when she retired, but recently returned), and the CEO of Heartland Alliance. The Primo Center CEO reports there was also a caregiver on the Core Leadership Team who will be replaced. The Core Implementation team was led by the Kids Connected Project Director, who is also staff of the Primo Center. The Primo Center's Chief Development Officer managed the Community Implementation Team, but retired from the Primo Center in 2020.

In late 2021, Primo Center, Catholic Charities, and Heartland Alliance agreed to have the Catholic Charities Associate VP and Clinical Manager assume responsibility for managing the Community Implementation Team, including identifying gaps in membership, facilitating meetings, and engaging the team in a process of reflecting on the strategic plan and forming workgroups and other strategies to implement it. The Primo Center CEO reports that the Chief Officer of Quality and Impact is her #2 person to whom she delegates responsibility for Kids Connected as necessary. The Chief Officer of Quality and Impact was hired in April 2020 and explains it has been her role to identify Kids Connected progress and barriers and support the provision of care coordination by the three agencies on the Core Implementation Team.

One participant's description of Kids Connected highlights the leadership roles of the Primo Center CEO and Chief Development Officer:

> *Yeah, I would say Primo for sure. I would say both [Primo Center CEO], of course, and then, [Primo Center Chief Development Officer], who's no longer with Primo, sadly….So, [Primo Center CEO], I think, is, systemwide, the face of this project, like, everyone knows that [Primo Center CEO] is in charge of this project. And [Primo Center CEO] does a great*

job of reminding people that this is a collaboration, and Catholic Charities and Heartland are very involved, as well, but she is absolutely the face of this project. And then, as far as the management of the strategic plan and the meetings and things like that, that was always [Primo Center Chief Development Officer]. So, again, Primo, but Primo Chief Development Officer was the face of all of that work, and that is the piece that is now going to be transitioning to [Catholic Charities Associate VP and Clinical Manager].

Communication. Site visit participants reported that initially, Kids Connected efforts to communicate with Community Implementation Team members included Doodle polls to set meetings, emails containing reminders and cancellations, meeting minutes, and SOC updates. In addition, Kids Connected staff sent fliers to Community Implementation Team members to facilitate referrals to Kids Connected for care coordination. However, participants also described gaps in their knowledge that could be traced to a lack of communication. Participants who were members of the Community Implementation Team were not aware of how SOC decisions were made or of what changes or progress had been made. They were vague on how the SOC was structured and the contents of the strategic plan. One participant on the Community Implementation Team who worked for a shelter explained that there was no mechanism to inform her of whether any of the people in her programs were receiving Kids Connected Care coordination. The Primo Center CEO, when asked about processes used to keep Community Implementation Team members engaged, explained, "Honestly, that's been a huge weakness of ours."

Initially, communication among members of the Core Implementation Team was supported by regular meetings. There was, however, an impactful misunderstanding between Primo Center and the two contracting agencies on the Core Implementation Team that were intended to provide care coordination along with the Primo Center. For more than a year, participants from Catholic Charities and Heartland Alliance had an understanding that the Primo Center would be making referrals of children, youth, and families to these agencies for care coordination. The Primo Center's understanding was that these two agencies would identify and intake cases through their own contacts and outreach. Site visit participants suggested that the decrease in meetings and lack of direct communication made it difficult to correct this misunderstanding:

Our understanding was that we were getting clients referred to us by Primo…clients …that had child welfare experience because that is our area of expertise, or had medical concerns…Heartland's area of expertise…We were not getting referrals from them…Either clients did not present with having child welfare involvement…or Primo just served those clients because they had the capacity to and that was easier…At some point, it was communicated to us that it was our responsibility to find our own clients…All of a sudden you're given these high expectations that we're really struggling to meet…I did not have a ton of experience with this specific population, and we're trying to do outreach very differently because of COVID.

There…was…a breakdown in communication…. It proved to be an ongoing struggle…. We anticipated our teams being able to build…strong relationships…. Without the capacity to get together for monthly meetings, it really was a barrier.

I think for people to learn to lead remotely is really difficult too. And so, I think there was sometimes when Primo thought, well, this is understood between organizations, and we were like, no we didn't. That's not what we gathered…

A member of the Core Implementation Team described that the channels for this Team's communication with Kids Connected leadership were not clear:

There was a bit of a top-down approach…where…there needed to be more of a loop of communication.… Sometimes if we were trying to report…we had a hard time knowing who or what channels or the information that was needed, and there was never…a meeting to address that. *The communication, although it was a gallant effort to try to stay consistent, I think that it did fall short.*

The communication issues extended to data sharing. Although Catholic Charities and Heartland Alliance appeared able to share data with one another, there was difficulty with the sharing of data between Primo Center and these two agencies. Both Primo and the two agencies report not receiving data from one another.

The Primo Center CEO believes the planned data dashboard will enhance system of care communication:

We see this dashboard as the graphical representation of how the systems are working together.… And through common shared elements and the data sharing agreement, for the kids that are enrolled in the program, we seamlessly can have this communication across our system partners. So, we don't have to go develop a report, send it out to everybody…people can, in real-time, see, at a bird's-eye view, what is happening with the children. And…where they're at in the process, where the goal areas are, who they've been linked to.

Implementation Teams and Decision-Making. At the time of the site visits, **t**he Community Implementation Team had only met twice during the two-year implementation period. Participants reported that the meetings had less attendance than in the planning period and focused less on the Kids Connected SOC and more on the challenges constituent organizations were facing in providing services to their clients during a pandemic:

We've had at least one community implementation meeting, if not two, that was held virtually.… But it wasn't so much, at that point, about, "Let's look at the strategic plan, and let's think about how we're going to build a system of care," because that was just not anywhere where anyone's minds were or what we could focus on in that moment. We were trying to focus on, "How do we get to

tomorrow? Because our services look completely different than they've ever looked before." And so, we really spent the time that we were meeting together …talking about what is going on with everyone's agency…how are services being provided, what sort of…supports can we offer one another, and what can we learn from one another. Because we all need to get through this pandemic somehow, and if we can try to help one another get through it, we'll probably all be better off as a result.... We probably hit the pause button on everything else that we needed to do, because people just couldn't spend their time and efforts on focusing on doing something when we were trying to figure out how to survive, essentially.

At the time of the site visit, there were plans to revive the Community Implementation Team. It was anticipated that the team would begin to meet twice a month to make up for time lost to the pandemic and turnover of staff.

Late in 2021, the Core Leadership Team, with the addition of Associate VP and Clinical Manager of Catholic Charities, convened to "review the strategic plan and discuss whether...it still makes sense."

Primo Center CEO…tasked us [the Catholic Charities Associate VP and Clinical Manager] with "Review it again…think about the top three priorities…we should focus on."…I'm understanding we are going to have another core team meeting that will...come to a conclusion…on our [top 3] priorities. And then, we will, at the next meeting…roll that out to the rest of the group and get their feedback, hear whether they think we should be doing anything else…that we didn't include originally.

Workgroups to tackle children's mental health workforce issues and use of data were formed prior to COVID but did not meet during the pandemic. The Primo Center CEO explains that Community Implementation Team members did not want to break into workgroups but preferred to work as a team on each of the 11 strategic goal areas. One of the participants who will manage the Community Implementation Team discussed plans to get workgroups back on track:

We didn't actually, at least with my workgroup…never actually did anything, because…we got caught up in the pandemic. But the plan is…we're going to make progress on the strategic plan…. We'll review the strategic plan, we'll develop our new priorities, what's achievable within the next 12 months…and develop workgroups that will be led by either members of the core team or…any member of the Community Implementation Team, that will…help get us to where we need to go with the strategic plan.

The Primo Center CEO reports using the stakeholder survey administered by CFRC as a source of data for decision-making. Primo Center staff have provided to the Community

Implementation Team numbers of children/youth served, types of services/supports provided, and team composition. This data collection and reporting has not been systematic, but the Primo Center CEO reports that the planned data dashboard will enable a more systematic collection and sharing of information.

6.4 Parent Involvement and Leadership

All of the site visit participants were asked to describe the ways in which parents have been involved in the Kids Connected SOC implementation process. Unfortunately, no parents were available to participate in the site visits, and the analyses therefore do not include parents' perspectives on their own involvement in the SOC, which is a vital component of the evaluation. According to other site visit participants, seven parents who had been involved in the planning period, including one on the leadership team, participated in the Kids Connected implementation team prior to the pandemic, but since the pandemic began, parent involvement at the systems level has been negligible:

> *We have had parent advocates that were a part of the core team, and…a part of the systems team. Because of everything they were going through with COVID, we are having a transition. Our one leadership team member had to step down. We had somebody else identified, but there was a COVID issue, so that certainly is in process. But we do have…parents who are very invested and very motivated.… Where there's been…fallout of their participation [it] has been…linked to their need of taking care of…basic needs around COVID*.

Parents were recruited by the Kids Connected Project Director and from among parents hired by Primo Center to work at the shelter. The Project Director would meet several times with caregivers to "build trust" and explain the project and why their participation at the systems level was wanted:

> *It was my job to get families involved and help them…understand…what we were trying to do…. I had meetings with parents and talked about this whole project.… A lot of families [said] "Wow, I wish I could have had that when I was going through what I was," and so that made them say, "Yeah, I want to be a part of it. If I can be an asset to another family, I'm willing to do that*."

Kids Connected staff have supported the parents' participation at the systems level by providing compensation ($25 for each team meeting), transportation, childcare, and taking care to schedule meetings that do not conflict with caregiver obligations.

> *We had to create our meetings according to the families' time…trying to make sure that we're not infringing on their own personal time with their family, their kids, and things like that.*

Additionally, the Kids Connected Project Director would hold meetings with parents, with food, to discuss and prepare, providing a "nonjudgmental platform [where] people actually listen to what their needs are not…telling them what they need."
Parent participation fell off during the pandemic and at the time of the site visit there were plans to "reboot" parent participation at the systems level:

> *I've heard [Primo Center CEO] talk about how we want to…get parents re-involved, and I think that specifically speaks to the community meetings that we've only had a few of during COVID. That's such a rich part of those meetings.*

The parent who was on the Core Leadership Team is no longer available. The Primo Center CEO is in the process of identifying a parent for that role. One participant described a plan to provide additional supports to enhance the effectiveness of parents' participation on the Community Implementation Team:

> *I'm not sure…the parents always understand what their role is. And I don't know if it's just that they're given the information and…by the time they're sitting in the room…they've…lost track of what their role is and what they should be contributing to. I feel…sometimes the conversation has gone a little sideways. I think the information that they've shared has been super valuable and very rich, but I'm not sure that it's always in response to what the discussion is at that point.*

6.5 Youth Involvement and Leadership

The Primo Center CEO described youth involvement and leadership as an "identified need." The Project Director identified relationship-building and explaining the purpose of Kids Connected to them as important elements of recruiting youth. He also identified the need to provide safe transportation "across…gang lines and things like that" as an important component of enabling their participation in systems team meetings.

6.6 Barriers and Facilitators of Implementation

The COVID Pandemic. The Primo Center CEO noted that responding to COVID was particularly complex for homeless shelters that employ and serve people who are the most marginalized, most at risk, and least connected to or trusting of health care systems and services:

> *COVID really, really knocked us out…. We were dealing with all the social injustices…in the communities that we're all trying to serve. We had hugely affected and traumatized workforce and clients that we were trying to serve.... We're working in communities of traditionally underserved, uncared for, neglected communities that have tremendous distrust of vaccines*.

Participants described how the COVID pandemic affected the Core Implementation Team and its delivery of care coordination services, as well as the Community Implementation Team.

Members of the Core Implementation Team shared how the pandemic interfered with training and retaining care coordinators:

> *We were hoping to have people on-site and cross-train and all that. We weren't able to do it.*
>
> *We hired someone for this position, and we had to onboard this person, do everything remotely with this person.… I think that our care coordinator…would have been stronger if we were able to be on-site with her. I think she would have had a stronger presence… [for the] outreach and engagement that she needed to do. I think we just would have been able to support her better if we were able to link her to a team, if she was able to shadow. And we couldn't do that, we were trying to do it all over the phone and through Zoom. And so that impacted it too. I think it's really hard for someone to come on and integrate into an organization, especially with the project where we're working so closely with external partners and not have a team on-site, a leader on-site to…help her navigate all of those systems*.
>
> *We hired a care coordinator that worked, was getting his feet wet and was promising for a couple of months. And then everyone went home.… He could never really make working virtually and engaging with clients work for him.… He identified that, thankfully, before we identified that, but I think we would've probably identified that at some point.… He resigned.*

They also described that the pandemic made it difficult to recruit and sustain contact with clients:

> *We were planning to outreach in schools and kids weren't in schools*.
>
> *Being able to access people was…challenging…we were planning to go to different shelters, we were planning to meet across service providers, and we weren't able to. The shelters had really strict protocols. We had really strict protocols about number of people on-site and how long you could actually meet with somebody.*
>
> *With our Kids Connected clients…we probably only started servicing them [before the onset of COVID protocols].… Homeless families…are so transient.… We were calling our clients…their phone numbers may have changed.… We [couldn't] go out in the community and physically locate them.*
>
> *Everybody was working remotely. And so to actually do the coordination piece was extraordinarily difficult with families [given] their access to internet or being able to do anything remotely. The digital divide became really present*.

Finally, the Primo Center Project Director reported that providing wraparound services remotely, as was required by COVID protocols, did not conform to the high-fidelity wraparound model, resulting in the use of the hybrid model discussed above. Even with this hybrid model, there were limitations due to COVID. The pandemic made it difficult to include teachers in meetings, given the enormous demands placed on them to provide online learning during the pandemic, and it also became impossible to include informal support person involvement, which is characteristic of HFW services.

Participants from all three agencies on the Core Implementation Team agreed that their ability to collaborate with one another was also negatively impacted by the different ways in which their agencies were affected by and approached the pandemic:

> *Each of our agencies responded very differently to COVID.… Primo was…still in person at their shelters, a lot of the time. Heartland, I think, is still home 100 percent of the time. The people that were working within this project are not in-person very much. Catholic Charities was in the middle. So then, just as a collaboration, we're all trying to navigate… our own agencies and our own expectations and our own restrictions.… It didn't appear, from my perspective, that any of the three of those agencies'…guidelines overlapped and were the same.… I think that…added…an additional layer*.

A member of the Core Implementation Team shared that coping with pandemic stressors contributed to a disconnect between the Core Implementation Team, the Community Implementation Team, and the overall Kids Connected strategic plan:

> *I think again just from where I sat, I mean we were very focused on sharing referrals, getting referrals, and following up. So, my eyes were really focused on the ground and the services that were being provided. So, in terms of the overall kind of strategic plan for Kids Connected, I do know that initially we had many meetings or a couple meetings about that and then COVID hit. And like it really—we weren't able to collaborate in ways that we were hoping to throughout the duration of when we were involved in the project. So, I have to say during it, we were very focused on less of…the large picture and more of on the services that we were able to develop and connect people to*.

Participants also reported that the pandemic reduced their capacity to participate in the Community Implementation Team, as they shifted to adapt service delivery to COVID safety protocols.

> *I think there's been kind of this siphoning off of…capacity. There's all these other things the agencies are having to deal with. So last year, remote learning. Our homeless service system had no coordinated response to the need for remote learning. All these shelter programs or homeless programs…had to figure out on their own how to deal with decompression of shelters or trying to create safe and healthy environments within*

shelters. There are all these other things that…put…longer-term projects on the back burner.

They described that Community Implementation Team meetings, held virtually, became infrequent and with fewer attendees, compared to the pre-implementation planning period, with the onset of the pandemic—just three months into the implementation period. Additionally, as previously described, meeting content focused on how individual organizations on the Community Implementation Team were dealing with the pandemic and not on implementing the Kids Connected strategic plan:

> *We had some good synergy…and then COVID hit and that totally screwed everything up for everyone.*

Workforce Issues. Participants also identified workforce issues as impeding their ability to implement the project. As mentioned above, the Chief Development Officer of the Primo Center, who had had responsibility for facilitating the Community Implementation Team, retired in 2020. The CEO of Catholic Charities, who had developed the Kids Connected project with the Primo Center and Heartland Alliance, also retired. All three agencies that planned to provide care coordination experienced turnover in their staff. Catholic Charities, for example, had 30 vacancies out of 74 positions and had, due to the resignation of a care coordinator and difficulty with replacement, a three- to four-month period in which it did not have a care coordinator to staff Kids Connected. Catholic Charities also experienced a complete turnover of its legal staff, and the new legal staff did not support the data sharing agreements that had been developed for the project by the previous staff.

The Primo Center CEO discussed the inhibiting effect of workforce shortages on Primo Center's implementation of wraparound services.

> *And now I feel like, as the months are going on, as more people are leaving their positions and creating the workforce issues, our openings organizationally, which do support the kids in the program, so our case managers, therapists, whatnot, our openings are staying open longer than they were, like, a year ago. Like, a year ago, we literally had…two or three options, or more, for every open position. And now I have a clinical director position open that's probably going to sit open for a little while, I have two therapist positions open, I have two case manager positions open. They're probably all going to be open for a little while, and they—oh, we're okay with care coordination, that's fully staffed. But that kind of receiving team of people that can be doing the case management and therapy and whatnot. And in terms of the enhanced added workforce, of bringing in part-time clinicians and community support workers and whatnot, we're really struggling.*

Other participants also described how workforce issues negatively affected services for families:

In homeless services and social services in general…it was a problem before the pandemic, and especially [for] shelters and residential programs. [They] just could not hire enough staff or had really severe coverage issues. I know of programs that had to serve fewer young people or families because they just couldn't provide coverage, and that was before COVID. And then COVID hit, and… there's been all these additional barriers to hiring people, especially people who are not comfortable working in person. And then also, there's been this influx of federal money into homeless services. So, there's been a huge demand for agencies to staff up. And so both of these things happening together is just nobody can hire. Everyone's kind of in crisis now around just having enough staff to kind of get the basic things done.

Turnover in the staff who had represented their organizations on the Community Implementation Team diminished the capacity of this team:

We had some team players that were pretty significant system players, that either retired or…there was a change in leadership. We lost a really great strategic person at DCFS.

Facilitators. Site visit participants identified two facilitators of implementation: the relationship between the lead agency and the funding agency and the high level of motivation of Community Implementation Team members. The Primo Center CEO cited as a facilitator an unusually open and supportive relationship with the funding agency as key to going forward with implementation of the system of care despite setbacks:

Having a really strong relationship with the [Illinois Children's Healthcare Foundation].… We had a few times that I had to reach out to the ILCHF Program Officer and say, "Look, things aren't going well, and this is what's happening."…Having that kind of authentic and real-time relationship with the foundation…was a huge support for us.

Participants communicated that shared concerns about fragmentation of the multiple services often needed by homeless families and the absence of focus on children's mental health brought organizations into the Kids Connected planning process. Participants expressed that these shared concerns and desire to address them are likely to sustain the involvement of Community Implementation Team members in a revitalized team and process.

A very authentic eagerness to come together and develop and participate in wraparound services for kids,… Willing and wanting to improve…services for kids.

The buy-in was…frustration around…the coordination of services.… We were excited to see something, anything to try to combat the problems…we were facing as service

providers.… We're going to be talking about why these things aren't working and how we can improve.

There's a lot of interest…in being a part of this.

I…reflect on…the meetings we…had during COVID.… That was always a point of meetings, to be mindful of our strategic plan and working towards all these goals. Even though that might not be the focus of this…meeting, or even the next one, because…we have so much other stuff to talk about and resources to share, we still know that that is such an important piece of things, and I think…that's never been lost. It just has taken up until the last few months to be able to come together…and create this plan of how we're going to go forward with reviewing the strategic plan…picking those top three goals… and then moving forward.

7. Results – Project SUN

Project SUN (a Strong and Unified Network) is located in Kankakee County, Illinois. Kankakee County is located 50 miles south of Chicago in Eastern Illinois. According to the 2020 census, the population is 107,502. The median household income in the county was $59,370. About 13% of the overall population fell below the poverty line and 17.8% of children live in poverty. About 5.4% of the population do not have access to health care coverage. About 8.2% of the population do not have access to health care coverage.[35] In terms of race and ethnicity, 72% are White (non-Hispanic), 15.1% African American (non-Hispanic), and 1.39% multiracial (non-Hispanic). About with 10.4% of all races reported identifying as Hispanic.[36]

The lead agency for the Project SUN grant is the Community Foundation of Kankakee River Valley (CFKRV). This organization is not a direct service provider in Kankakee, but instead is a "vehicle for charitable giving that builds overtime, substantial endowment funds for the community."[37] The CMHI 2.0 grant supports several staff positions in part or in full, including the agency executive director, a Project Director, and a Parent Liaison/Office Administrator. Central to the Project SUN system of care project is a partnership with the Helen Wheeler Center for Community Mental Health, which provides a substantial portion of the child and adolescent mental health services in Kankakee County. A review of the Project SUN implementation grant application shows that there were four primary focus areas for the CMHI 2.0 grant: 1) building the infrastructure for family and youth engagement, 2) providing prevention and early intervention across developmental stages, 3) implementing wraparound care planning, and 4) expanding access to a broad array of services and supports.[38] Over 50 different objectives and activities were outlined in the initial Project SUN implementation plan.

During the site visit, individual interviews were conducted with the principal project staff from Project SUN (the Project Director, Parent Liaison, and Executive Director of CFKRV), and focus groups were completed with community stakeholders and parents involved in the community implementation team.

7.1 System of Care Goals, Objectives, and Interventions

When asked to identify Project SUN goals and objectives, participants identified several, including improving the access of children and youth and families to existing services, engaging families and youth, addressing racial inequities and increasing the cultural competence of child mental health services, improving inter-organizational collaboration, increasing identification and early intervention of mental and behavioral health needs, and increasing mental and behavioral health services. Although implementing wraparound care planning was one of

[35] Census profile, Kankakee County: https://data.census.gov/cedsci/profile?g=0500000US17091
[36] Kankakee County DataUSA: https://datausa.io/profile/geo/kankakee-county-il#demographics
[37] https://www.cfkrv.org/
[38] Project SUN Implementation Grant Application (2019).

Project SUN's four major goals in its original implementation plan, site visit participants shared that this goal was temporarily suspended or put on hold.

Increasing access to services. Several participants articulated goals related to increasing the access of caregivers to services for their children. These goals focused on increasing knowledge of community resources for children, youth, and families and training navigators to help parents access services for their children, including mental health services and a wide range of complimentary services and supports:

> *One of our number one goals is to have multiple points of access to the system of care…to enable others who we consider primary contacts, school personnel, doctor's office personnel, clergy, people in the faith community, natural helpers—to help families know where to go to get information.*
>
> *A critical piece of our strategy, to make sure there's easy access, to know what mental health resources are available in the community, and where people can go to start their journey.*
>
> *One of the things they wanted to setup was a website so that all of this information would be there for people.*
>
> *Improving outreach…so that more of the community knows about the available services.*

Increasing parent and youth engagement. Many participants cited engaging caregivers and youth as a goal. In explaining the goal, they tended to focus on family/parent engagement in navigating, advocating, and shaping services for their child and playing a significant role in system planning and implementation:

> *Another critical goal is parent and youth engagement…[for] caregivers, to make sure they realize they are in the driver's seat…that they're…the navigators of their child's journey along the road for mental health services.*
>
> *There is the strong goal…to empower…[parents] to pursue what is going to be the best plan for their child.*
>
> *To build a family-driven and youth-guided community where parents and children's voices are heard in their care plans.*
>
> *I think the goal is to empower people to advocate for themselves…not themselves, but … family-to-family…I look at it as families heling other families and…coming together to make sense of…the system of care.*
>
> *It's the SUN, strong unified network, between the families and the professionals*

Racial Equity. Participants identifying racial equity as a goal described how this goal was newly developed during the implementation period as people in Kankakee County reacted to the murder of George Floyd:

> *In light of everything that has been going on, we wanted to bring people together to discuss our differences and heal the community.*
>
> *The [effect] of racism on mental health, that came more to surface when the death of George Floyd happened and a lot of our kids…are seeing this…. Kids are fighting over it.*
>
> *Justice, equity, diversity, inclusion, to make sure…that minorities that have been underserved in the past are brought to the table in professional capacities…[and] are getting access to the services that they need.*

Cultural competence was a closely related goal:

> *Being culturally competent, having a bilingual person in our organization, having a high need [among]…Spanish-speaking families.*
>
> *I think the goal is that we end up with providers that are representative of our community.*
>
> *So that we can eventually see our mental health providers reflect those who are in our community so people can go to providers that look like them or relate with them in…their history.*

Increasing early identification and mental health services. One participant identified increasing early identification and intervention as a goal. This was one of the four major goals of the original implementation plan:

> *We have such a shortage of mental health providers in Kankakee County…. The more we can do to prevent problems and…treat them as early as possible…with the limited resources…we have, the better we are.*

Two participants identified increasing the availability of mental and behavioral health services in the county as an SOC goal:

> *Recruiting more mental healthcare workers, behavioral healthcare workers.*
>
> *One of our goals is to pass the referenda to establish a 708 mental health board that will be able to levy a tax to help provide more services.*

7.2 Activities and Progress Toward Goals

When reviewing the progress of Project SUN toward the goals and objectives set forth in their initial implementation plan, there has been a modest amount of progress toward some goals and little progress made on other goals. In addition, new goals and activities have been added since the initial implementation plan was conceived.

Increasing access to needed services. Participants described several activities in which Project SUN staff and workgroups have engaged in efforts to increase the access of children, youth, and their families to existing services. One has been the development of an online searchable data base, known as KAN-I HELP, of local resources for children, youth, and families that covers a wide spectrum of needs and was described as including information on over 850 local resources. Project SUN has provided navigator trainings throughout the community on how to navigate, and how to help caregivers navigate, using this website. Staff administered monthly classes to non-profit agencies, the county health department, schools, churches, and individuals wanting to help.

> *For example, we have an online database called KAN-I HELP, it stands for Kankakee-Iroquois Information Network. And KAN-I HELP is something that we…we did a monthly class, for much of this past year…and we're now looking at putting that online as modules, so people could take it on their own—to empower them to best use that information system. So, we've targeted agency people, but anybody, really, can…become familiar with this. If you are the neighbor on the block that everybody comes to, to say, "Hey, what should I do?" you should know how to use KAN-I HELP. And KAN-I HELP covers a wide spectrum of human resource—human needs, human service needs.*
>
> *I think while [Project SUN Community Navigator] was there, when she was training agencies, I know she trained all of our case managers on…KAN-I HELP…. And that gave our clinicians and case managers access to, when they're doing discharging and things like that, going on the website to connect them to resources in our community. So that was something that was helpful. And she did it for anybody in the community who wanted that.*
>
> *So that is actually one of the things that has really grown and has stayed strong. We provide trainings for that monthly, except for more recently, we've been doing that kind of every two months or quarterly to just, as we get more trained…But with that, the community navigator training, I feel like it really empowers people because when they complete it and learn not only about Project SUN, they learn about our KAN-I HELP database that houses over 850 local resources that includes dentists and what insurance they take. So, if a family's on Medicaid, it's really beneficial for them to know that right off the bat versus having to call multiple times and this family just keep getting turned away. So, yeah, so they learn about Project SUN, our website with our online database, and then they learn about referrals to Project SUN, how a family can get referred to us, why Project SUN would reach back out to that organization. How to do self-referrals…is a family just coming in with their own questions. So, it really equips everybody with multiple things during this training…. So that is definitely something that has come a*

long way, and we are very proud of that training, and like I said, we keep track of who is involved as far as their title and position and the range of people in our community that are really willing to just go through this training.

In addition, Project SUN staff has itself provided direct support to caregivers seeking to connect with services for their children and families. The Project SUN staff attends community and school events to let caregivers know of their availability to help with navigating services and distributes information on local resources for children, youth, and families.

Increasing parent and youth engagement. Participants also shared that Project SUN staff and work groups have implemented several strategies to engage and support caregivers and youth. They report administering several Parent Cafés to provide opportunities for caregivers to speak with experts, share experiences on topics of concern to them, and select topics for future cafés. Participants report that participation in the Parent Cafés dropped with COVID.

The original parent cafés that we used to have in the large meeting room at the library…we would have a content expert speak, and then we would have a parent representative who would give testimony about, "This is what my day is like. This is what it looks like for me. These are the kinds of things that I'm experiencing, and the barriers, and the exhaustion of the situation that I'm in." And I know that we also had some parents speak, in the Zoom parent cafés, with a content expert.

Parent cafés are another kind of casualty of COVID right now. But those were running really well, with opportunities for the parents to serve and decide what should be discussed in the topic, things like that.

Site visit participants reported that a caregiver on the Community Planning and Executive Teams suggested crafting classes for caregivers to provide informal opportunities for mutual support and was hired part time to administer them. Additionally, the Parent Liaison reported providing an informal support chat group for caregivers. Participants reported that staff are working to establish a local chapter of the National Alliance on Mental Illness (NAMI) to provide supports to caregivers and youth. They report staff engaging youth in planning and implementing an annual mental health awareness event for teens:

I can also speak about teen mental health and wellness events that we've had in May, every year, to bring the youth and the agencies together to offer them tips and tools on better mental health and wellness. So, we had one, this past May, and it was called End the Stigma, Open-Mindedness. We had a lot of great people there at the farmer's market in downtown Kankakee.

Racial Equity. Following the murder of George Floyd in June 2020, Project SUN organized and funded additional activities related to racial equity. Participants reported that the Project SUN cultural competence workgroup administered a survey on racial inequities that will be used for planning and is partnering with a local university to analyze survey results. The Project

contracted with a provider to facilitate “My Piece of the Puzzle” community conversations to increase awareness and communication about racial inequities and provide training to “healing ambassadors” to continue facilitating small group discussions.

> *The only piece that has recently come up in light of what’s going on in our world has been the racial equity piece that we’ve been working on. And I don’t think that was originally part of the strategic plan. But it’s become a program that’s, it seems to be working. So, and it’s getting Project SUN’s name out there. They’ve had a few meetings already. This program is just now getting off the ground with having convenings around it.*
>
> *We wanted to bring people together to discuss our differences and heal the community around racial equity. And so, they’re doing a program called My Piece in the Puzzle. And they’ve hired a consultant to come in and facilitate this. This is a multi-month thing happening which we hope will continue to move forward for years to come, as long as we need it. But anyway, it’s helping that healing for our Black and Brown communities. And for the White community to understand what they’re going through, what the Black and Brown community is going through. And kind of opening up our eyes to everything that’s happened around us.*
>
> *And then, when all of this is said and done, they’re hoping that some of the people that come out of this training will be called healing ambassadors, where they will be able to go out and kind of conduct these small group roundtable discussions and bring people together. But then also, there’s a component where they’re working with the leaders of the community and basically training as well and just being those ambassadors to help the healing process.*

Increasing the use of evidence-based mental health services. Participants reported several initiatives to increase use of evidence-based practices. Project SUN staff reported collaborating with the Kankakee School District to provide training for administering Theraplay, an evidence-based therapy that promotes child-parent bonding through play. It was explained that while the school district trains school staff, Project Sun is preparing to train six facilitators to lead community-based parent-child programs.

> *Theraplay is a…is a therapy that promotes child-adult bonding through play. And so, one of their strategies is something called sunshine circles, and had initially, is traditionally been done preschool, early elementary, but they have been building it to now go through high school. And so, we're part of a big project that's trying to implement that in our school system, and Project SUN is trying to…the intention is for Project SUN to then have facilitators who will offer that skill building to parents, how to interact with your child in a playful way while building mental health skills.*
>
> *So we're trying to implement it at the community treatment level, the school, day-to-day universal kind of application, as well as to have Theraplay-trained facilitators lead*

parent-child programs. And I believe there are six people being trained to be coaches to make this happen. So, we have a very, very elaborate collaborative structure that we're building. Hopefully we will begin to offer the parent-child piece in the spring. But the emphasis has been getting the school personnel trained this past year, which has been interrupted of course with COVID. But they did, they were able to train I think about 40 people in November, they had the two-days of training in person.

Participants report that Project SUN also funded training in Moral Reconation Therapy (MRT) for staff of the juvenile probation department, the Kanakee School District, and a non-profit group home for youth. MRT is an evidence-based cognitive behavioral intervention for youth to increase life purpose, moral decision-making, and medication adherence, and decrease risk-taking behaviors, substance abuse, and recidivism. Participants report an additional collaboration to build trauma-informed practice among school staff.

High Fidelity Wraparound. Originally planning to administer trainings on High Fidelity Wraparound, this training was funded for one staff member of the community mental health center, but it was explained, other area providers failed to step forward for the training. Participants shared that developments in state policy and a lack of enthusiasm on the part of mental health providers had so far prevented implementation of wraparound:

We thought, in the very beginning, that Project SUN would be doing the case management, case coordination for the wraparound services.… That whole thinking has been impacted by…class action lawsuits and…changes with the HFS [the Department of Health and Family Services]

We kind of moved away from the high fidelity wraparound.… A lot of the agencies in our area are understaffed…they weren't as excited about it as we were.

We still have the goal of wraparound, but it looks different…and we're still…moving towards…refining that.

7.3 Implementation Supports and Processes

Leadership. The leadership of Project SUN was described by participants as consisting of the Project Director, the executive team, and workgroup chairpersons. Participants praised the leadership:

Our leadership has kept us disciplined…motivated…focused on the needs of our community.… When we were cut off from the world…the work has continued. And they've…been very good about giving us feedback.

The Project Director reported that leadership has been more "centralized" than ideal.

The Project Director has supervised a full-time Parent Liaison, a part-time Communication Liaison, a part-time peer mentor, and student interns. Participants report that the project staff manages and provides internal communication for SOC participants by supporting virtual and in-person meetings, engaging in extensive emailing, and attending all project meetings and activities:

> *For the most part, most of the work that's being done, Project SUN [staff] is involved in it, so they're keeping the communication going back and forth, as well.*

Project staff are reported to regularly circulate meeting notes and survey results to all SOC participants via email. Participants report that the Project Director creates agendas for most SOC meetings (executive team, community planning team, and workgroups), sends agendas out before meetings, and asks for ideas for other agenda items. A parent participant calls this a "total open-door policy. If you would like to get something on the agenda, she's an email…or a phone call away.… She's very open."

Participants report that the Project Director recruits SOC participants to do the work of the SOC. She describes identifying participants who may be able to perform necessary tasks as part of their jobs. She also invites people to staff workgroups at community planning team meetings. Participants describe that the Project Director selects people with relevant expertise to chair workgroups. She and her staff also work closely with and provide substantial support to chairs of the work groups. A participant described project staff as being respectful of others' areas of expertise.

> *That's one thing I do value about the Project SUN Director and Parent Liaison.… They know when they may lead, but it's also they know when to follow.*

Leadership for Project SUN is also provided by the executive team. The executive team is described to be co-led by the executive director of the Community Foundation of Kankakee River Valley, the lead agency for the grant, and the executive director of the county's community mental health center. It consists of decision-makers from a range of local agencies/organizations, including schools, juvenile justice and social service agencies, the county health department, mental health providers, hospitals, the United Way, and caregivers of children and youth with mental health needs. Although members of the executive team have specific, staggered, renewable terms, there are no terms for the co-leaders. The executive team is described by participants to meet regularly once a month to review progress against the strategic plan, provide consultation to staff, and participate in SOC decision-making.

> *I serve on the executive committee. I came on…last year.… We're very focused on continually assessing the strategic plan implementation, reviewing where we're at, where we need to go, what our future considerations need to be. Do we have family and youth engagement? Have we done enough work on early prevention, education, the system of care navigation services?.... Do we need to revise…the strategy?.... We're focused on the budget and how to best allocate the budget to the resources that will*

have the greatest impact on our community.… Voting, making…or listening to…recommendations that have come up to us through committee work

Communication. One participant reported that one-to-one communication with Project SUN staff regarding the confluence of her agency 's and Project SUN's goals and activities keep them involved:

The staff persons are…active and engaging.… They look at your community as well as the place you represent…as part of how…we might be able to get involved…I…count on them to contact me at least four times a month…with something…to keep us involved. So…we just look at Project SUN as part…of what we do.

Community planning team (CPT) members reported several other types of communication keep them involved in the CPT: how staff shares agendas prior to meetings and sends out meeting notes, relationships with Project SUN staff, the sharing of information on upcoming events, training and grant opportunities, adjusting meeting times to participant schedules, and treating participants as team members. "You really do feel like a part of the team," stated one member.

One of the things that Project SUN does very well…is communication…. They've been excellent in…giving us information…not only our agendas, our meetings, our meeting notes, but about trainings, training opportunities, grant opportunities…and that is one way to keep people involved.

Every meeting they close with the list of all the activities that are coming up.… Everybody's…engaged with asking questions.… We know when the next meeting is.… They even ask…what the best time is…to make sure…people are good with the time.

Asked about managing differences within the CPT, staff explained there is an effort to facilitate communication among those whose opinions differ. Speaking of an instance in which providers and caregivers expressed conflicting priorities while reviewing the strategic plan, staff explained, "We allow people their space to effectively communicate with one another and…say…what's important."
Project staff engages in a great deal of external communication, trying to hit "different people in different ways." The Project Director reports engaging in one-to-one meetings with leaders of child and family serving agencies and tries to gain their buy-in by identifying overlap in mission and vision and ways in which engaging in the SOC may facilitate the agency's work, as opposed to simply "adding another piece."

Project staff created and maintained an SOC website, tries to reach youth with active Facebook and Instagram pages, and produces a monthly newsletter, an annual report, cards, and brochures that they distribute widely. Some of the literature is produced in Spanish. Project staff is present, distributes literature, and engages in outreach and conversation about Project SUN goals and activities at many community events (e.g., the county breakfast attended by local politicians and leadership, Hispanic celebrations, United Way events, parties, festivals). As

part of external communication efforts, staff joins other related local coalitions (e.g., a committee preparing for the evaluation of a local court, the Kankakee County Mental Health Council, the Kankakee County Hispanic Partnership, and the Child and Adolescent Local Area Network). Staff is working on billboards and welcome packets to communicate SOC goals, activities, and resources throughout the county:

> *Externally we do community presentations for other organizations. We use our website.… We have Facebook and Instagram pages.… We try to routinely have something out there.… We have been working on…a public launch with billboards and some newspaper advertisements.*
>
> *Provider 1: There have been booths at every community event…I showed you the little bookmark flier that we're sharing with all our clients.*
> *Provider 5: We have got a set in Spanish as well as English.*
> *Provider 2: We also distribute [the fliers] to our families.*

Committees and Workgroups. Participants described the CPT as larger and more diverse than the executive team, including caregivers, a broader set of organizations and agencies, and frontline workers in addition to the top-level managers/administrators that are on the executive team. Participants expressed desire to include representatives of all stakeholders relevant to coordination with the county's children's mental health services. Participants described the CPT as continually assessing gaps in its membership and acknowledged the need to strive to involve more children's mental health providers as well as the local office of the Department of Children and Family Services. Participants expressed concern that attendance at CPT meetings has dropped:

> *There's been a big drop off in participation when we moved meetings online.… We went from a very intense planning phase where people had a clear sense of what they were contributing to implementation, where it's been less clear where people fit in and their role.…The work moved more to one-on-one or one-on-two relationships than working together.… Even with the best of technology…it's been difficult for the meetings to be more than presentations with some reaction. We've tried small group breakouts…but it just hasn't worked…We're hopeful we can meet in person.*
>
> *I think…the community planning committee…is so big. It's like you have all these people together at one time and it's just a lot…to try to…get anything accomplished.… There's so many people from so many places and all of their opinions are important.… You've got…a two-hour meeting.*

Participants explain that communication with non-attending members has indicated that the decline in attendance may also be attributable to constrained staffing of member agencies. However, interviewees also report on a constant stream of new arrivals that results from the external communication efforts of staff, the new involvement of college students engaged in

racial equity activities, and recent grant awards made to local agencies that required their signing agreements to attend CPT meetings.

The CPT used to meet once a month but shifted to quarterly meetings. Its function is described as "advisory." Staff identifies the value of getting others' perspectives on the work of the SOC and of having cross-sector conversations:

> *We use our CPT meetings to get…feedback. We ask…"what was the most impactful thing we've done in six months? Where do you want to see our efforts move forward in the next six months, and what could we have done differently?" We get some really good, constructive criticism that is very helpful in moving forward.*

Participants report that the CPT is asked to weigh in on the strategic plan every six months. Additionally, participants report that at CPT meetings, members are encouraged to join workgroups of interest.

Participants explain that several strategies are used to keep CPT members involved. These strategies are described to include formal agreements, posing substantive open-ended questions at meetings, and asking for feedback from CPT members at six-month reviews of the strategic plan. Project SUN staff ask for a formal commitment, a signed, agreement of collaboration, from CPT organizational members and offer two options: 1) a three-year commitment that designates someone in the organization for information-sharing with Project SUN and 2) a one-year commitment designating a person and an alternate who will attend CPT meetings.

Project SUN also has several workgroups that have been created to discuss various initiatives and activities. Site visit participants describe that most workgroups were formed to implement specific aspects of the strategic plan. They also described the formation of some smaller short-lived ad hoc work groups, such as the KAN-I-Help information group, a group formed to review applications for funding, and a group formed to make nominations to the executive team. Participants reported that workgroups have included: 1) System of Care Navigation Assistance Services, which has focused on the KAN-I-Help information database and flex funding requests; 2) Data Collection and Evaluation, which has worked on the Project SUN annual report; 3) Cultural Competence, which administered a racial equity assessment; 4) Mental Health Workforce Development, which administered surveys to the workforce; 5) Family and Youth Engagement, which has focused on parent/caregiver leadership development, caregiver appreciation, hosting 'Let's Talk: Breaking the Silence' events for youth, forming a teen mental health council, and Theraplay training; 6) Prevention and Early Intervention, which has focused on Parent Cafes, community conversations, and social media campaigns; and 7) Sustainability, which has focused on obtaining a referendum to establish a 708 Mental Health Board.

Participants described that each workgroup has a chair who has the experience to lead in their area. Participants share that chairing a workgroup provides opportunity for leadership and participation in decision-making. Workgroup chairs report to the Executive Team. Staff

collaborate with and support workgroup chairs, attend workgroup meetings, and participate in the work of the group. Workgroup chairs facilitate meetings and report on progress and decision points to the executive and community planning teams. Decisions are made in workgroups via discussion and voting. A parent shared:

> *The committees…I've participated in…everybody has an equal voice.… The Project SUN staff are always extremely receptive to what everyone has to say.… I always say, I am 'just a parent.'… They value my thoughts and opinions as much as someone with a doctorate.… Decisions are made through majority rule.… Everyone talks and agrees.*

Decision-making. Participants reported a collection and use of process data and difficulty with locating data that would enable the SOC to determine whether their efforts are "moving the needle."

> *The data that we have been using has been more process data than any summative data [for] a lot of reasons.… Our community planning team spent a lot of time the first part of this year looking at datasets and trying to find indicators that are out there that we could actually feel that there could be some causal relationship between what Project SUN was doing and moving the needle.*
>
> *Our committee developed some poor man's versions of dashboards to look at different key metrics within our community related to children's mental health...to…look at…on a regular basis…and see where we have opportunities.… The broad categories are intake (when calls go into Project SUN, what kind of person is calling, why are they calling, the demographics), things about implementation, things about the workgroups, like how many meetings, outreach, community navigation, a lot of data points from the…Illinois Youth Survey.*

Participants described the administration of community surveys and focus groups as means through which information has been gathered for decision-making:

> *One of the committees that I work on…is the family involvement.… We have focus groups…feedback…surveys…We try to get feedback from different participants, not just the agencies or organizations, but from families and children.*
>
> *Asking for feedback from participants, after topics are presented, such as at the Parent Café. "What do you want to include in open discussion in the community?"*
>
> *They're constantly doing surveys with the community.*

They described practices of eliciting feedback to guide action from people participating in an SOC-sponsored activity, such as asking Parent Café participants what topics they would like future cafés to focus on. Participants described that students in a local college are involved in a collaboration with the Cultural Competence workgroup to analyze data from a community

survey which will be used by the workgroup, in addition to information on other communities' strategies, to plan a series of community roundtables to determine what can be done to promote "racial equity and equitable access to services."

> *The intention is that the data analysis and…reports…the students will be producing will be used as background material for a series of roundtables that we want to host this spring with community leaders in different sectors to look at…[how] racial inequality impacts the child's mental health and what can we do to eliminate racial inequality? What can we do to promote…racial equity and access to services?… We will be using that data from the community survey responses, to show the community leaders, together with information about what other strategies have worked in other communities…what can we do to create commitments from the various institutions about what they can do to promote racial equity and how the system of care can support those efforts.*

Staff, the executive team, and workgroups play key roles in decision-making processes. Staff described that the role of the CPT in decision-making is "purely advisory." In addition to identifying agenda items for meetings, the Project Director reports responsibility for bringing proposals to the attention of the SOC Executive Team.

Participants explain that the executive team is considered the final decision-maker on items pertaining to SOC policy and expenditures. It considers recommendations made by work groups and staff and is described as being able to make its own recommendations. Participants express that staff have represented recommendations to the executive team from any Project SUN participant:

> *They're very approachable.... I've brought them ideas that they've brought to the executive team…to incorporate NAMI services…to be more pure parent-driven.... They've been really open and had meetings with me.*

Participants reported that the executive team makes decisions by voting. They also explained that SOC decisions must conform to lead agency policy and meet with approval from the community foundation's board of directors.

Participants report regular use of the strategic plan to guide decision-making:

> *Our strategic plan…typically every six months…we gather…with our community planning team, our leaders on the executive team…and we go over what we had originally put together, which is activities…broken up into the strategic areas…. We have a timeline…. When we come back together every six months, we identify these and say, "Hey, we're … behind on these. What can you give us for input as far as moving forward?"*

7.4 Parent Involvement and Leadership

Participants in the Project SUN site visit were asked several questions about parent involvement, including how parents have been involved and what things facilitated that involvement and posed a barrier to involvement. Almost all of the participants described that Project SUN has had a group of parents who have been involved with the SOC implementation since the planning stages and who have remained involved throughout the pandemic:

> *I was thinking back to before COVID when we had—remember when we had the whole room full and we were doing our focus groups, there were so many parents, I felt, involved, and were giving their voice and being heard. And we do have parents on our planning committee. I just feel that getting the parent voice has been very important, and reaching out, reaching out even through the schools, other youth-serving organizations, for parental involvement.*
>
> *We have them [parents] on each of those levels that I said, internally, our Project SUN staff, our executive team, and our community planning team. We have parents that serve on all of those different parts of leadership. And then additionally, for our work groups there is always a parent or caregiver on that work group to be able to provide insight for those activities and decisions made for those activities.*
>
> *They've provided training for the parents, as much training as we want pretty much. They've been very supportive there. And then the parent cafés are another kind of casualty of COVID right now. But those were running really well, with opportunities for the parents to serve and decide what should be discussed in the topic, things like that.*

The parents who participated in the site visit discussed how it was initially hard for them to feel comfortable speaking up and giving feedback during meetings, but after receiving continued encouragement, they did become more comfortable with it, even if it was providing information that things were not going as well in the SOC as the providers thought:

> *I said, "I just don't think that this committee is for me," because I was sitting there getting angry and feeling all these feelings and I didn't, I didn't at the time feel like I could speak up. Now I could know I can speak up. So, the next meeting I go to if that happens again I feel confident enough that I can speak up and say, "That's not my real-life experience with your organization, so how about let's take it down a notch, or up really." But I mean that's how it felt to me as a parent. Just like there was a survey done and the survey results were…there were answers to those questions that blew my mind. People that thought we had all these things available to us and I'm like, "Well where they, because I don't see them."*
>
> *There's been a few times in the meetings where somebody will speak up and say, "Um, I don't think so" or and I used to feel that way also at first, but I would finally speak up and Deb would always encourage me and say, "We need to know" and that's the biggest thing is they need to know that they're missing the mark, because what they're trying to do is great, but if they're not really hitting it then they need to know. I agree with [other*

parent] that is a hard thing to do until you learn to speak up, but all it takes is once and then you learn to open your mouth [laughs].

The parents also felt less comfortable in the bigger meetings that had many agency leaders:

Parent 1: What were you there for? that's exactly how you feel.
Parent 3: Yeah, I mean I kind of felt like, "What was I there for?"
Parent 1: "Why am I here?" Only in the meeting, only in that group. The other groups I have done I've never felt that way one time. I think it's just because you have all these executives.
Interviewer: Which group was that? Which group was that where you felt that way?
Parent 3: The community plan, like the quarterly, the big quarterly one. I mean that's the one where everybody seems to attend, all the directors of the agencies and all these sorts of things. I felt like it was just a big, "Let's all pat ourselves on the back. We're doing a great job." And the night's over. And I was like so yeah. I mean I honestly felt like I was there for no reason. I mean because I was like, I certainly am not going to, I don't know, I don't have control of those sorts of things.

Multiple participants described an example of parent involvement in which one of the parents, who initially was involved in the planning committee, was developing a therapeutic craft class for other parents and was given support by Project SUN to develop and implement the class.

Well like I said we encourage people to participate in the leadership development. We hired a peer parent mentor from among the group, from among the parents that have been a part of the planning process and the implementation process. She's been hosting craft classes as a means to draw people in and then it becomes an informal support group.

She came on as a parent, and she wanted to do these crafting nights with other caregivers to give support to one another.… As a parent, that was her idea, and that's what she wanted to do. We thought it was great. This was, you know, get more parents involved, and we get to interact with them as well. They, so that's been one way that we've gotten parents involved and getting them to think outside the box and come up with ideas to help.... Then we ended up hiring her, because we wanted to pay her for the time and effort that she was putting in to make those craft classes happen.

I was applying for a grant to get the craft classes started and they said that was a good idea and then they hired me on as a peer mentor instead and then that's what I'm doing as a peer mentor. So, it's like people that are in the meetings they get an idea and if everybody thinks it's a good idea they just jump on it and get people involved to work on it. And everybody's idea is important. Some of them don't take off, but some branch into something else and it's been a real highlight of my life lately.

There are some barriers to having parents participate in SOC implementation activities. Some of these barriers are related to the pandemic and may not be alleviated any time soon, but others are structural things that could be modified to allow parents to participate more fully:

> *A challenge with the involvement of parents are their lives are just so unpredictable. So I'm thinking of two of our parents in particular, well actually three, because one did finally say, "I'm sorry I just can't make a commitment and I feel more stressful every time I have to say I can't participate in something. So maybe you know when my son's life is less volatile I can come back and be a part of the planning, the leadership part of things."*
>
> *People are just exhausted. I think it's more, especially when your child is going through a mental health challenge, it's difficult to make extra space. But they are showing up for the community planning teams.*
>
> *I know like, yeah with like my situation I mean it's been kind of like underwater here lately, like we've had lots of issues. So, like I am encouraged to do things or ask and I just don't always have the capability to do it or the time or even the mental space sometimes, but it's like a lot of…So like a lot of the times the meetings are during the day. If my kid's having an issue I can't do anything during the day. Like if I'm at the school or if I'm trying to get them to school or if I'm whatever I've got going on that day. So, it's like it's hard sometimes to I think bring all that together. It's encouraged but it's also really hard as a parent like to think, "Oh, like I could be in charge of this" or I whatever. So, for me it's my own stuff sometimes that holds me back and I think, "Oh, maybe someday, but not right now." I'll participate, but I can't like take a leading position. It's encouraged but I don't know how many parents actually have the bandwidth and I don't.… I don't know how many of us are parents who are employed in the system of care that attend these meetings. There's not a bunch of us I know. So, if you're not employed it's hard to make that focus I guess sometimes.*

The parents felt that scheduling the meetings during mealtimes was a barrier to participation:

> *Parent 1: And a lot of times they schedule all the meetings at mealtime.*
> *Parent 3: Yes.*
> *Parent 1: It's at noon or at 5:00 and it's like, "Hey folks." [Laughter] I mean I started out listening to meetings because I was busy fixing supper, so it was like, "Come on people we eat at that time."*
> *Parent 3: And I see a lot of the parents, a lot of us that are involved, to say myself, the parents that are involved we are the primary caretaker even if it's more than one parent or adult in the household. we still are the main caregiver. So it's like if we are the main like those times just don't work for us. I mean my kids aren't going to wait until 7:00 for dinner, they're just not [Laughs].*

Parents very much appreciated the stipends that are given out for participation in meetings and other SOC implementation activities. However, there was some confusion about whether or not the stipends were still being giving out because some parents have not received them recently:

> *At first it was boring and confusing for me, it was the stipend that made me come. I'll be honest. But here I am, I'm still here. I'll tell you what, I'm still here because of COVID, because everything went to online and virtual and I have taken classes and I have done so many things online, learning how to do this stuff online has been an opening for me, it really has been.*
>
> *We do provide stipends for our parents that attend all meetings no matter what level of leadership they're on. And it's not necessarily a level. I mean, it is a level, but we like to look at them not like a ladder, just kind of side by side. But we do provide them stipends. We provide appreciation gifts throughout the year.… We want to make sure that they know that we appreciate them, that they're highly involved in the decision-making that Project SUN has. So that is how we have retained the parents and caregivers that we've had.*
>
> *Well I think we're supposed to [receive a stipend]. I haven't received any and I actually just reached out…about that and I don't know if, I don't know exactly what meetings you get stipends for and if you don't get, like I don't understand.*
>
> *I've seen stipends for going to the meetings, but I think they were I don't want to say "overworked," I think they needed more staff so that they could stay up-to-date with all that kind of stuff. But I'm pretty sure that when we first started we were getting stipends for the meetings. I don't remember how much, but I almost always had to re-ask, "When do I get paid for going to these meetings?"*

In summary, there is a core group of parents who have been involved with the Project SUN implementation efforts to date. These parents attend meetings and have been encouraged to share their ideas for additional avenues to be involved and take leadership roles. Certain meetings feel more welcoming than others to parents, and the tumultuous nature of their lives and the exhaustion of parenting during the pandemic was sometimes a barrier to becoming more actively involved. One parent summed it up nicely:

> *As a parent I feel very heard, and I have plenty of, I feel as equal as far as leadership and voice. And, but translating that to empowering parents on a larger scale, I don't think we have the answer to that yet. We're still in planning and discussion.*

7.5 Youth Involvement and Leadership

Like many of the sites, youth involvement and leadership in the SOC implementation has been difficult to obtain in Project SUN.

> *Unfortunately, our youth involvement has been very low. We have our most recent intern who just left, who helped a lot to drive trying to get more youth involved, but we're trying to take a new road now that school's back in place and we're working with the schools to develop, which we've talked about before, is a teen or young adult youth mental health board.*
>
> *They were encouraged to come at the beginning, but they just all fell off and wouldn't come anymore*
>
> *Provider: We did, at the beginning stages, have two youth involved on the planning team.*
> *Interviewer: Oh, wonderful. And how did that go, do you know?*
> *Provider: Yes, they enjoyed it as much as we enjoyed learning from them. They are in college now, but, you know, as I said, just, bringing them to the table is so important, we realize that.*

Prior to the pandemic, Project SUN involved youth in organizing a mental health fair that was very well received. The pandemic put plans for another mental health fair on hold, but they were able to organize a street festival in 2021 that involved the youth.

> *But by partnering with other organizations, we hosted a really successful Youth Mental Health Fair.… We did it two years ago where the schools…we recruited through the schools and each school sent, each of our high schools sent ten youth, as well as a chaperone, to participate in a summit. It was very successful during our planning process, so we wanted to repeat that this year.*
>
> *So in early May, we had a big street festival…we had different youth doing different things as alternatives stress reducers, just healthy, healthy things for teenagers to do to promote good mental health. Agencies had tables and tents and it really was very successful.*
> *And again, as I mentioned earlier, we had that Meeting of the Minds Teen Mental Health and Wellness Summit, to name one thing. We had some Let's Talks where we hosted Zooms and we had conversation around mental health and keeping your body healthy and staying away from alcohol and marijuana. So, we're just trying to involve the youth within our county and getting their voice heard.*

Project SUN had plans to partner with other agencies to develop a youth advisory board, but the pandemic forced these plans to pause:

Number one, we partner with other organizations that have youth advisory councils so that we're not starting from scratch. Although the Kankakee County Health Department had approached us about jointly sponsoring a Youth Mental Health Advisory Council, but COVID hit and almost all of their staff got pulled off the focus on meeting COVID demands. Then some staff did leave. So that initiative while we had an intern working on it this summer and we just, things just were still so rocky going back to school…. So our schools are still so in-and-out and so we have not been able to form that youth advisory body.

7.6 Barriers and Facilitators of Implementation

Unlike the other CMHI 2.0 sites, Project SUN was a new organization in the community and therefore did not have pre-existing relationships with the mental health agencies in the county. Several participants mentioned this as one of the barriers for implementation of the SOC:

So, it took us forever to get partners to share their consent forms to share information…. We needed to do much foundational work, developing a brochure that spoke to what the project was about, developing a PowerPoint that could be taken to…anywhere, to have a five-minute version and a half-hour version and…getting business cards. I mean just all of these very fundamental foundational things that, when you walk into an existing organization, it's all in place, you're just reordering. And that's why I'm so exhausted, we have rarely had the chance to do the same thing over. It's just a constant evolution and next step, next step. But a reinvention of learning, okay, "Oh, we didn't have all the information we needed for that."

I feel like we have a lot of challenges, because being unique in that we're maybe the only site, or one of the only sites that isn't a direct provider. So I think being aware of that, if we could have had more in place in the beginning. Knowing that and knowing if we could focus and maybe have agreements in place and know exactly how we were going to execute that with maybe one provider. Like our largest mental health provider for children in the community. Or even if it's multiple providers. But have that in place at the beginning, so we're not like three years into it and still, we're not, I don't think we are where we want to be as far as really impacting that system of care.

Similar to other sites, the mental health workforce crisis was mentioned as a big barrier to SOC implementation:

Right now, funding is not—funding and the salaries for the mental health professionals, both the availability of professionals and what the community is able to pay them, are problems. Because we are so close to Chicago, people will graduate U of I, all of that, with a bachelors in social work, they'll get some experience here, a year or two, and then they move to where they can make more money. And so, we have, like I said, a long history of workforce issues, workforce shortage issues. So, having more money available

will help that, but that's not all. I mean, we just need to attract and retain people in the community.

I think right now in this moment is the lack of work force that we have in our community makes it really hard for us to tell families we can help them and then we get them connected with somebody and it's a three-week wait before they can talk to somebody.... I think that's a big barrier right now is the lack of mental health providers that we have in our community, the lack of Spanish-speaking providers that we have in our community.

I think there's been some turnaround too, within the executive committee. Like the workgroup leaders turnaround, turnover, at different mental health agencies. So then, that's really impacted things.

But it's like those are the barriers I think that still exist. Eventually having Project SUN in the community hopefully brings more awareness and brings more people to the community who want to do this sort of work. But right now I mean even an emergency visit to a psychiatrist is two months out here, even three months as an established patient. So, it's just don't have enough resources as far as we look at the system of care we have one partial out-patient program, one in-patient program, not enough psychiatrists, not enough mental health professionals, on down the line.

And even our behavioral schools they don't have their own counselors. So when these kids are running—when they're brains are frying in school and they're having a crisis moment—they have nobody to go to.

And, of course, the COVID pandemic has been a huge barrier to implementing mental health SOC:

And the fact that COVID has kept us from doing the outreach work that we need to do for face-to-face contact, whether it's with the office of special education at a school district, so that she knows we're out here. All of that had to be placed on the back burner for almost all of last year, and so…so I just feel like we're so behind in building the relationships beyond the executive team and our little staff.

One specific example has been the difficulty to go into schools and meet with staff, since the pandemic, because they're being pulled in every which direction, so that you can't—they don't have time to even hear anything new. Doesn't matter who you are, if you're a warm body, you're being pulled in to substitute in a classroom, because the teacher's kid is now home from school, because there were too many COVID cases in their child's school. The staff that we would most likely communicate with just don't have time to talk about—they're just trying to get through the day of what they minimally have to do to keep things functioning in the schools. That was one very big problem to grow our relationships beyond those who were involved beforehand.

Second area was, as I mentioned, these parent cafés that we intended to host multiple formats for them. One was a countywide format once-a-month, where we brought in the speakers, based on what the parents wanted to talk about. But part of the time there was to also give the parents the opportunity to interact and identify parents who wanted to form support groups for each other and identify parents who would become involved in our parent engagement planning activities. Well, when we had to move to the online parent café format, you lost the interaction between the parents, and we lost 50 percent of the participants. Half of the people who came in person then joined online, but they didn't meet anybody; they could ask some questions, they could get some information. So, we couldn't build relationships with those people, to grow our parent constituency, if you will.

Well, that, because, not being able to meet in person, and quite often, when you're meeting in person, you're more able to effectively build relationships. So that, I think, did create some barriers and…for people being able to meet.

Obviously, COVID put a big barrier. Even though the need was higher, seeing a lot of people that were just so drained with it that they chose not to just reach out. That they're just, "I'm so overly exhausted, I'm just going to sit here and ride it out." So I think other barriers are people are just tired, in general. If they're unsure what Project SUN is, they think it's something else added to their plate and they are so already overworked that they are just, "I'm not really trying to hear this right now."

Site visit participants were also asked if there was anything they thought facilitated the implementation of the SOC in their community. Interestingly, one participant felt that housing the CMHI grant in a non-mental health agency was a facilitator in addition to being a barrier:

Having an entity outside of a particular service provider leading the efforts. So it's not an initiative of one of the hospitals, it's not an initiative of one of the mental health service providers. I think, while that has been extremely difficult, it's also, I think, going to be better in the long run, because it's not tied to one place. It really is an effort to engage all of the mental health providers. I mean, we try to communicate with all of them on some—maybe not monthly—we do a monthly newsletter and send that out to about 300 people who…it's a wide range of people. But I think because we don't represent one place and we're not direct service providers, we're not in competition with them, so I think that distance makes us more credible. Does that make sense to you?
Interviewer: Yes, because it seems that your mission is to build a system, rather connect to deliver your services.

8. Cross-Site Discussion and Recommendations

As part of the implementation evaluation of the Children's Mental Health Initiative 2.0, the Children and Family Research Center conducted virtual site visits in each of the five sites at the end of their second year of implementation. The goal of the site visit data collection is to provide detailed descriptions of the activities and processes employed in each site to implement children's mental health systems of care. The site visits also document successful strategies for and barriers to implementation. For each site visit, the evaluation team reviewed the site's implementation applications and progress reports and conducted interviews and focus groups with individuals involved with the implementation efforts.

The information provided paints a picture of five very different communities that have attempted to change their children's mental health systems of care in the midst of a global pandemic that began approximately five months after implementation began. The pandemic had a significant detrimental impact on the implementation process in all five sites, a theme that we heard repeatedly during the focus groups and interviews. The following sections summarize information across the five sites regarding progress made to implement systems of care and the barriers that sites encountered, including the pandemic. We also discuss the infrastructure and processes that guided and supported implementation, including governance and leadership, planning and decision-making, and communication. Finally, we discuss parent and youth involvement and leadership in the system of care implementation and make recommendations drawn from recent literature on how to increase these.

Before discussing the cross-site findings and recommendations, it is important to consider the limitations of the site visit study. The data collection methods likely rendered participation inaccessible for those with limited access to the internet, primarily parents. The previous site visits were conducted in person, and parents at one site were provided rides to the agency in order to participate. One site had no parent participation in the site visit and only one site had youth participation in the data collection. As a result, these perspectives are underrepresented in the findings. Additionally, we chose to obscure participant roles in SOC implementation to provide some protection for people's identities. In doing so we integrated the words of parents and youth without distinguishing them from other SOC stakeholders.

Another limitation relates even more broadly to the methods. The value of youth and family participation and voice at every level of a system of care should by extension include some connection to evaluation. Youth and family voice can provide insight and shifts in perspective that might otherwise go unrecognized by researchers who do not themselves possess lived experience in the area of study. For example, perspectives on what to measure may be very different between client groups and provider/professional groups.[39] Additionally, the evaluation methods utilized could have been more informed by youth and caregiver input.

[39] Friesen, B. J., Koroloff, N. M., Walker, J. S., & Briggs, H. E. (2011). Family and youth voice in systems of care. *Best Practices in Mental Health*, *7*, 1-25.

Implementation Progress and Barriers

Site visit participants were asked to revisit the goals and activities of their SOC initiative and describe the progress that had been made during the first two years of the implementation grant. Participants from all of the sites were able to highlight parts of their strategic plans that had been started. Progress in all of the sites was substantially impacted by the COVID pandemic, which began five months after the implementation grant period began in November 2019. Some activities in the strategic plans of the sites had to be put on hold indefinitely because of the pandemic; for example, some sites were forced to delay implementation of High Fidelity Wraparound (HFW) care coordination. The Foundation encouraged the sites to repurpose the funds that had been earmarked for HFW training and use them for other SOC activities. Some of the sites did this by implementing "mini-grants" to community organizations that were operating during the pandemic to provide needed services or supports. Another way that several of the sites made progress during the pandemic was to provide online trainings to providers in their communities.

There is no question that the pandemic greatly limited the amount of progress that sites achieved during the first two years of implementation. The impacts were felt in numerous ways. For instance, mental health and other service providers had to adapt to providing services virtually. Many clinicians and professionals who were on the implementation teams in the sites were being asked to take on additional duties during the early months of the pandemic, such as contact tracing. School systems are important partners in most SOC initiatives, and school personnel became largely unavailable to assist in implementation efforts as they transitioned to online learning. The pandemic affected the ability of implementation teams and SOC workgroups to meet and collaborate, and many sites reported that attendance at meetings declined following the stay-at-home order. Importantly, the pandemic took a significant toll on individuals' mental health. A common theme that came up during the site visits was that people felt exhausted and traumatized, and just did not have the capacity to devote as much attention to the SOC initiative as they would have before the pandemic.

Another barrier that impacted progress in all the sites is the mental health workforce crisis, which existed prior to the pandemic but was greatly intensified following its onset. The workforce crisis impacted all five of the CMHI 2.0 sites in various ways, and many of the projects lost key staff in the lead agencies or partner agencies. Turnover on implementation teams and workgroups slowed progress, with many of the teams' positions remaining vacant for months. Several of the mental health service providers in the communities became short-staffed and had to reduce the number of new clients that they could serve or pause enrollment of new clients. Although the state is working on solutions to address this critical worker shortage, nothing on the horizon is poised to bring immediate relief.

Implementation Infrastructure Supports

Studies of large-scale system change efforts tell us that the presence of certain infrastructure supports facilitates the success of implementation efforts.[40] Primary among these supports are the presence of effective leadership structures, collaborative implementation teams, clear communication, and data-informed decision-making and feedback loops.

Leadership. Site visit participants were asked to discuss who provided leadership for the SOC initiative in their site. Some sites had one clearly defined individual who provided the majority of the leadership for all of the implementation activities. These individuals recruited new members for community implementation teams; engaged with parents and youth; organized most meetings, created agendas, and led discussion for them; initiated most communications with team members and the community at large; and played a major role in strategic planning and decision-making. In other sites, participants mentioned several individuals who functioned as leaders in the SOC; these individuals were typically project staff who were employed at the lead agency. Parents and youth were not mentioned as leaders in any of the sites (more on this in the parent and youth involvement discussion below).

Numerous books and articles have been written about developing effective leadership within organizations. These traditional leadership models focus on developing individuals' competencies in order to improve organizational performance. Some have speculated that these traditional and hierarchical leadership models are inadequate when attempting to change complex systems such as children's mental health services and have proposed that community or collaborative leadership may be more effective.[41] A useful precedent comes from a previous system of care initiative for justice system-involved youth with substance abuse problems. This initiative developed a strategic leadership framework that prioritized recognizing and reinforcing existing leadership, identifying untapped local leadership capacity, and promoting strategic cooperation and collaboration among individuals from multiple systems and disciplines as well as youth and their families. The leadership program that emerged included opportunities and coaching that were intended to increase confidence among existing and emerging leaders, increase skills such as presentation skills and working with the media, increase the ability to make data-driven decisions, and bring diverse perspectives to problem-solving.

In her SOC implementation primer,[42] Pires makes a distinction between governance, which she defines as "decision-making at a policy level that has legitimacy, authority, and accountability" and administration, which has more to do with overseeing and managing the everyday

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[40] Permanency Innovations Initiative Training and Technical Assistance Project. (2016). *Guide to developing, implementing, and assessing an innovation.* Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau.

[41] Nissen, L.B., Merrigan, D.M., & Kraft, M.K. (2005). Moving mountains together: Strategic community leadership and systems change. *Child Welfare*, *84*, 123-140.

[42] Pires, S. (2010). *Building Systems of Care: A Primer*. Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development.

functioning of an agency or system. Pires discusses the importance of shared governance and accountability among all stakeholders involved in an SOC. The site visit findings showed that participants in all sites placed a high value on the principle of shared governance with client constituencies but mixed results around its implementation. In order to ensure this key characteristic is present in an SOC, it is recommended that specific strategic planning efforts be aimed at this goal. Logic modeling or another goal operationalization model would be helpful for sites to think through and plan for measurable steps toward cultivating leadership capabilities among all stakeholders and ensuring accountability.

According to Pires, a crucial foundational condition for realizing shared governance is ensuring that stakeholders, including youth and caregivers, receive information, training, and ongoing mentoring to support their roles in leadership. Sites can help to ensure this is met by first defining and clearly communicating a shared model of governance. For instance, is the role of the project director clearly defined and differentiated from other roles? Are leadership roles at different levels (i.e., community implementation team, leadership team, committee leadership) clearly articulated and agreed upon? Do opportunities exist for participation in leadership that are widely and clearly communicated? Is there a process for new stakeholders involved in leadership to ensure the shared understanding that undergirds shared governance?

As with other goals and processes, proactive, sustained, and purposeful efforts are required to develop shared governance and leadership in the SOC. Pires talks about this as a vital premise of the structure of an SOC: "certain functions must be organized to implement systems of care successfully; that is, they cannot be left to happenstance. For example, if there is no structure—that is, no defined arrangement—for how care is to be managed, then it is unlikely that care will be managed" (p. 47). Based on this premise as well as the findings from the site visits, additional training is needed for leaders from all stakeholder groups in the SOC focused on not only the *whys* of shared leadership, but also the *hows*. Technical assistance in this area would support professionals in their efforts to engage a shared leadership model when it's not the business-as-usual model they were likely taught or that exists in the wider systems environment.

The complexity, novelty, and challenges of the type of leadership conducive to building a system of care point to the potential helpfulness of securing on-going coaching for SOC sites. Coaching for leadership and other aspects of building children's mental health systems of care is available from the Institute for Innovation and Implementation at the University of Maryland School of Social Work[43] or from Suzanne Fields Consulting, LLC. Coaching in collaborative systems change efforts is also available from The Collective Impact Forum.[44]

[43] https://theinstitute.umaryland.edu/
[44] https://collectiveimpactforum.org/

Teaming, Collaboration, and Communication

A team that guides an initiative and attends to key implementation functions is critical to successful implementation of any system change effort. Developing other teams to complete time-limited tasks and attend to specific implementation functions can also be helpful, as can a clear team structure and a communication strategy that links the teams. Team members need to have common goals and objectives and a commitment to the overall work. They need to bring skills, authority, and expertise to move the initiative forward.[45]

The importance of collaboration is also stressed in the system of care primer by Sheila Pires: "Collaboration is at the heart of system building. Children, youth, and families depend on multiple agencies, providers, community supports, and funders, as well as their own internal resources. When one hand does not know what the other is doing, inefficiencies, frustration, and ultimately poor outcomes result at both system and service levels. Building systems of care requires resources from across agencies and among partners. Without collaboration, effective system building cannot occur.... Effective collaboration does not just occur because stakeholders are well meaning. It takes time, energy, and attention to relationship building, trust building, capacity building, team building, conflict resolution, mediation, development of a 'common language,' and communication" (p. 244).[46]

Large scale system change efforts require a level of collaboration that goes beyond what is typically required when implementing one intervention in a single agency. The non-profit sector frequently operates using an approach that has been termed *isolated impact*, which is oriented toward finding and funding a solution within a single organization with the hope that other organizations will replicate or extend its impact more widely. However, most social problems require *collective impact*, which involves the commitment of individuals from multiple sectors to solve a complex problem.[47] Research on successful collective impact initiatives shows that they shared five conditions: a common agenda, shared measurement systems, mutually reinforcing activities, continuous communication, and backbone support organizations.

All five of the CMHI 2.0 sites created a community implementation team that had constituents from multiple service sectors, although the implementation team in one site stopped meeting after the pandemic began. Participants at the sites that continued to meet reported that the pandemic affected their momentum, especially at the beginning of the pandemic, but that technology allowed them to continue to meet, plan, and implement activities. Most of the sites have created ad hoc workgroups that work effectively to focus on specific tasks such as increasing diversity and inclusion, implementing flexible funding, and developing a parent council.

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[45] Permanency Innovations Initiative Training and Technical Assistance Project. (2016). *Guide to developing, implementing, and assessing an innovation.* Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau.

[46] Pires, S. (2010). Building Systems of Care: A Primer. Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development.

[47] Kania, J., & Kramer, M. (2011). Collective impact. *Stanford Social Innovation Review, Winter,* 35-41.

Some sites placed emphasis on the importance of existing relationships to successful SOC collaboration. Studies have concluded that informal relationships are the most critical predictor of successful collaboration among professionals.[48] Informal relationships among professionals have also been found to be more significant to sustained collaboration than attendance at regular meetings, even when that attendance was mandated by agency or statute. This supports our findings here related to both the importance of existing networks as well as relationship-building with stakeholders. Sites discussed strategies such as utilizing various communication methods (email, touching base by phone) and program directors engaging stakeholders not just during but outside of more formalized meetings.

Participants in two sites discussed the strength of the partnership between the SOC and a local school district as a critical facilitator for enhanced access to mental health screening and referral. In some cases, building that partnership required more effort than in others, and we found that existing relationships as well as the ability to demonstrate the benefit of a partnership were key pieces in bringing schools to the table. Blasinsky and colleagues (2006) discuss facilitators for the sustainability of collaborative service systems, with the most important factor being the ability to demonstrate the benefits of the model to partners and the community.[49] We recommend that sites continue their strategy of demonstrating value of the SOC for an organization as well as for children and families.

Data-Informed Decision-Making

All of the implementation guides referenced in this section stress the importance of using data to guide decisions about the effectiveness of the implementation efforts.[50] In the implementation science framework developed at the National Implementation Research Network (NIRN), decision-support data systems are described at one of the key implementation supports required for successful implementation.[51] The CMHI 2.0 evaluation is currently collecting data on intermediate and distal outcomes, but the evaluation does not collect data on the individual project outputs. Outputs are the products of the activities that have been implemented. Examples of outputs for a SOC initiative might include the number of children given mental health screenings in schools, the number of clinicians trained in an evidence-based practice, or the number of children served in community-based agencies.

During the planning period, the evaluation team spent a considerable amount of time working with each site to develop a logic model that included each activity that was planned and the

[48] Gillam, R. J., Counts, J. M., & Garstka, T. A. (2016). Collective impact facilitators: How contextual and procedural factors influence collaboration. *Community Development*, *47*, 209-224.
[49] Blasinsky, M., Goldman, H. H., & Unützer, J. (2006). Project IMPACT: A report on barriers and facilitators to sustainability. *Administration and Policy in Mental Health and Mental Health Services Research*, *33*, 718-729.
[50] See, e.g., Pires (2010), Kania, J., & Kramer, M. (2011), Permanency Innovations Initiative Training and Technical Assistance Project. (2016).
[51] Fixsen, D.L., Blase, K.A., Naoom, S. F., & Wallace, F. (2009). Core implementation components. *Research on Social Work Practice, 19*, 531-540.

associated output measures. Information gathered during the site visits indicates that some of the activities originally planned may have been updated in the past two years. If so, then the logic models should be updated as well. Once this has been done, it is critically important that sites collect data on outputs and review that data on a regular basis. Some of the sites reported that they are collecting some data on outputs, but this should be expected for all sites and should be directly tied to the activities that are reported in the progress reports. Regular review of output data will assist the sites' implementation teams to monitor progress toward goals and provide accountability to the funder. It will also contribute valuable information to the evaluation team, which will aid in the interpretation of the outcome analyses.

Youth and Family Engagement and Leadership

It is widely believed that youth and their families have deep knowledge and understanding of their own experiences with the mental health service system and that involving them in implementation efforts and sharing power with them will enrich and strengthen SOC development and sustainability. Engagement is the intentional, meaningful, and sustained involvement of youth and their families in actions to create positive social change. Youth and family engagement strategies exist along a continuum that includes:

- Youth/family support—the process of equipping youth/parents with the tools to gain authority and agency;
- Youth/family input—the integration of you/parent ideas, opinion, and feedback into planning and implementation; and
- Youth/family leadership—the structuring of initiatives so that youth/parents are leads or co-leads with equal power to adult facilitators in determining actions.[52]

Participants in each of the sites were asked to describe how parents and youth were involved in their SOC implementation activities. Most of the sites had one or more parents who participated in their community implementation teams, which is a form of parent input, and one site had recently formed a Parent Council where parents were taking on more of a leadership role in strategic planning in the SOC. This site was successful in increasing the level of parent engagement in part because they devoted adequate resources to supporting this engagement, including a full-time parent engagement specialist who has responsibility for supporting parents before and during implementation team meetings. This site has also contracted with COFI (Community Organizing and Family Issues) to provide parent leadership and community organizing training to parents in their community. A review of the sites' implementation grant applications revealed that at least two other sites have allocated grant money to family engagement positions, but the positions have been vacant. We recommend that the sites utilize the funds for their intended purpose and also recommend that the other sites consider collaborating with COFI to bolster their parents' leadership skills.

[52] Shakesprere, J., O'Brien, M., & Harrison, E. (2020). *Youth Engagement in Collective Impact Initiatives: Lessons from Promise Neighborhoods.* Washington, DC: Urban Institute.

Despite its importance for SOC implementation, site visit participants acknowledged that youth engagement is perhaps the shared goal with the least progress to date. Study participants identified logistics like meeting times and locations as well as motivational factors such as effective incentives and sustaining interest as some of the primary challenges to youth participation. The sites' experiences of such challenges and the existence of common barriers to family and youth participation are widely shared.[53] At the same time, participants discussed youth involvement as a continued goal and expressed commitment to it but were mostly uncertain about how to do it. We recommend devoting additional resources to this goal. In support of that aim, as well as the importance of using evidence-informed practices, we provide a brief review of relevant literature and resources.

Sites can receive guidance from a robust literature on youth engagement, youth empowerment, and youth-guided services, in such areas as juvenile justice and residential treatment. A first recommendation is for systems to operationalize broad goals such as youth engagement with specific aims—such as the number of youth to be involved, in what ways, over what period of time, as evidenced by what indicators. As with any goal, youth involvement in leadership and planning must be measurable, there must be buy-in from stakeholders, and some element of accountability should be built in as well. One key element of cultivating that buy-in with staff can be a process of acknowledgement of the practice of shared power and perceived loss of control experienced by service providers.[54] What this means is that professionals working in an SOC must embrace a shift in the usual structures of power in which system, program, and implementation decisions are made for and not with or by service recipients. Meaningful and lasting shifts in power and influence are a critical prerequisite to successful incorporation of youth voice in systems of care[55] and for youth empowerment at a system level using a co-design approach.[56] For some, a true paradigm shift is required for the

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[53] Canas, E., Lachance, L., Phipps, D., & Birchwood, C. C. (2019). What makes for effective, sustainable youth engagement in knowledge mobilization? A perspective for health services. *Health Expectations*, *22*, 874-882.
Gyamfi, P., Keens-Douglas, A., & Medin, E. (2007). Youth and youth coordinators' perspectives on youth involvement in systems of care. *The Journal of Behavioral Health Services & Research*, *34*, 382-394.
Matarese, M., McGinnis, L., & Mora, M. (2005). Youth involvement in systems of care: A guide to empowerment. Technical Assistance Partnership for Child and Family Mental Health (TA Partnership). https://nwi.pdx.edu/NWI-book/Chapters/App-6e.3-Youth-Involvement-In-Systems-Of-Care.pdf.
Rudd, C., Kalra, S., Walker, J., & Hayden, J. (n.d.). How can organizations assess their readiness to co-design? Annie E. Casey Foundation. https://caseyfamilypro-wpengine.netdna-ssl.com/media/21.07-KM-LFOF-ChiByDesign.pdf.
[54] Blau, G. M., Caldwell, B., Fisher, S. K., Kuppinger, A., Levison-Johnson, J., & Lieberman, R. (2010). The Building Bridges Initiative: Residential and community-based providers, families, and youth coming together to improve outcomes. *Child Welfare*, *89*, 21.
Miller, B. D., Blau, G. M., Christopher, O. T., & Jordan, P. E. (2012). Sustaining and expanding systems of care to provide mental health services for children, youth and families across America. *American Journal of Community Psychology*, *49*, 566-579.
[55] Friesen, B. J., Koroloff, N. M., Walker, J. S., & Briggs, H. E. (2011). Family and youth voice in systems of care. *Best Practices in Mental Health*, *7*, 1-25.
[56] Rudd, C., Kalra, S., Walker, J., & Hayden, J. (n.d.). How can organizations assess their readiness to co-design? Annie E. Casey Foundation. https://caseyfamilypro-wpengine.netdna-ssl.com/media/21.07-KM-LFOF-ChiByDesign.pdf.

ability to create systems that include youth in substantive ways in leadership and decision-making.

As with other elements of building an SOC, proactive steps and ongoing commitment are necessary to ensuring this goal is achieved.[57] Staff may also need additional and ongoing training to support their ability to motivate youth and focus on their strengths and assets, to ensure basic needs are met for those youth participants, and to support them in managing this role.[58] Further, in meeting the aim of cultural and linguistic competence, professionals may also need to expand their understanding of culture beyond race and ethnicity to other areas of identity that may have importance to the youth being served (e.g., the LGBTQIA2+ community) to help ensure a welcoming and equitable experience.

A similar paradigm shift must also occur among families and youth who, in a system doing business as usual, are constrained to nonexpert status reliance on others to make choices for them. This is the very definition of disempowerment and is commonly the experience of mental health consumers. The concepts of power and empowerment lie at the heart of the literature and program work in this area. The framework of Positive Youth Development (PYD) has been applied to children's mental health systems of care, youth empowerment, Youth Civic Engagement, youth-guided services, and Youth Peer Support Specialists in related areas such as child welfare and juvenile justice as well as the specific application of PYD in a system of care.[59] A full discussion of these strategies and tools is beyond the scope of this report, but a list of resources is provided in the appendix and we encourage sites to review them. Additionally, sites need additional technical assistance around youth and parent engagement in SOC implementation and should seek out speakers, consultants, evidence-based models, and/or other avenues to build capacity. Sites have provided training for professionals in such areas as evidence-based practice, wraparound services, and affirmative practice with the LGBTQIA2+ community and can utilize that commitment to learning by focusing future training on youth and parent involvement.

Friesen and colleagues identified six factors that have demonstrably contributed to an increase in youth and family involvement in systems of care. These are 1) offering some manner of incentive, 2) establishing accountability around participation of families, 3) providing clear policies and processes that support participation, 4) providing information about the value and importance of such participation, 5) sharing and cultivating knowledge and skills, and 6) building relationships.[60] These broad supportive elements have applicability for any SOC and

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[57] Youth.gov (n.d.). Key Principles of Positive Youth Development. https://youth.gov/youth-topics/key-principles-positive-youth-development

[58] Miller, B. D., Blau, G. M., Christopher, O. T., & Jordan, P. E. (2012). Sustaining and expanding systems of care to provide mental health services for children, youth and families across America. *American Journal of Community Psychology*, *49*, 566-579.

[59] Matarese, M., McGinnis, L., & Mora, M. (2005). Youth involvement in systems of care: A guide to empowerment. Technical Assistance Partnership for Child and Family Mental Health (TA Partnership). https://nwi.pdx.edu/NWI-book/Chapters/App-6e.3-Youth-Involvement-In-Systems-Of-Care.pdf.

[60] Friesen, B. J., Koroloff, N. M., Walker, J. S., & Briggs, H. E. (2011). Family and youth voice in systems of care. *Best Practices in Mental Health*, *7*, 1-25.

should be localized to best function in its unique context. Sites reported activities related to many of these identified supports. We recommend that they discuss further what is already in place and consider how to integrate what needs to be added.

According to Youth Power!, a group of young people engaged with the New York System of Care, there are five key values that must inform partnering with youth: cultivating and maintaining a strength-based focus; sharing power and empowering young people; recognizing and avoiding adultism; valuing cultural and linguistic competence; and valuing youth culture.[61] Another insight from these youth is that participation in an SOC and the mental health system is developmental for each individual, that knowledge and skill for the role must be built and supported. The *Youth Power! How To's of Youth-Guided Practice* is an excellent resource for insight into the thinking of engaged youth. It also provides useful information on organizational self-assessment and concrete steps to increase youth engagement. It offers localized program examples and worksheets to help guide engagement in other SOCs.

Gyamfi and colleagues conducted focus groups with youth involved with SAMHSA-funded SOC and found that a focus on strengths, youth empowerment, and commitment to a PYD framework were essential foundations.[62] The youth respondents also stressed the importance of relationship-building, not only with adult professionals but also with one another, noting the value of the social element in sustaining youth involvement. The biggest identified barrier to youth participation was perceived lack of authentic adult buy-in and commitment.

A critical step in the cultivation of youth engagement and leadership in an SOC is the provision of training and support. Simply inviting youth to the table does not actually equip them with the knowledge, skills, and confidence necessary to make a substantive contribution in a professional setting. Proactive and sustained efforts are needed to engage and build the trust necessary for youth to raise their voices in the context of a mental health system, and to help youth express their views in ways that are productive in a professional context. Educating youth on parliamentary process, communication, technology, program evaluation concepts, service delivery models, and policymaking not only enables meaningful participation in SOC implementation processes but also equips them with knowledge and skills that are transferable to other areas of life such as employment or higher education.

Useful examples and models for youth engagement in decision-making are available. One model is the youth leadership council or advisory board that can allow youth meaningful opportunities to engage with planning, evaluation, and governance of an SOC.[63] Another strategy for implementing youth-guided services is to involve youth in the planning and delivery

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[61] Valesey, B. & Orlando, S. (n.d.) The How To's of Youth Guided Practice. Youth Power! https://nyssoc.com/wp-content/uploads/2021/10/How-To-YG-Training-Guide_Final.pdf.

[62] Gyamfi, P., Keens-Douglas, A., & Medin, E. (2007). Youth and youth coordinators' perspectives on youth involvement in systems of care. *The Journal of Behavioral Health Services & Research*, *34*, 382-394.

[63] Miller, B. D., Blau, G. M., Christopher, O. T., & Jordan, P. E. (2012). Sustaining and expanding systems of care to provide mental health services for children, youth and families across America. *American Journal of Community Psychology*, *49*, 566-579.

of staff training. Youth voice in evaluation of the SOC has received less attention in the literature, but there are examples.[64] National resources and organizations can support local chapter of engaged youth. Youth Move National is a national organization with regional chapters in Minnesota and Wisconsin (https://youthmovenational.org/).

Finally, youth involvement at the policy advocacy level is as important as their engagement at other levels of the children's mental health system. As with other facets of youth involvement advocacy activities would require capacity-building through training and support, but with great potential rewards for meaningful youth voice in the systems that impact them. The National Consortium on Leadership and Disability for Youth, also youth-led, has created a guide to legislative advocacy for youth. Though not explicitly focused on children with mental health concerns, it offers helpful examples of concrete steps and activities to increase youth empowerment for advocacy.[65]

[64] Henderson, J. L., Hawke, L. D., & Relihan, J. (2018). Youth engagement in the YouthCan IMPACT trial. *Canadian Medical Association Journal*, *190*(Suppl), S10-S12.
[65] National Consortium on Leadership and Disability for Youth (2007). Retrieved at http://www.ncld-youth.info/Downloads/legislative_policy_guide.pdf.

Appendix A – Focus Group/Interview Protocol

1. Changes and Progress on SOC Goals:

- What would you say are the strategic goals of the SOC project that is funded by ILCHF in your community? Can you be as specific as possible and describe what those goals are?
- How does the strategic plan guide implementation efforts?
- What changes, if any, have been made to the plan since implementation started?
- What processes has your SOC used to decide on plans and activities?
- In what ways have different members participated in these decision-making processes?
- What progress have you made on your strategic goals?
- What changes have been made in organizations, policies and practices to implement the SOC?

2. Implementation Barriers and Facilitators

- What has supported implementation of the SOC?
- What barriers have affected implementation of the SOC?
- If COVID isn't mentioned, ask specifically about its impact.
- How has the pandemic affected the implementation of SOC in your community?
- In what specific ways has the pandemic affected implementation?
- What effects of the pandemic are temporary and which permanent?
- If workforce issues aren't mentioned, ask about impact.

3. Implementation Processes and Supports

We are interested in learning about the different **ways** stakeholders worked together to implement and further develop the SOC. We have a series of questions to learn more about that.

Leadership (individuals and groups)

- Can you describe the structure for management of SOC implementation? Has it changed over time?
- Who provides leadership or coordination during the past two years of implementation?
- What kind of guidance and coordination have they provided for the project?
- Is there a leadership team? What is their role in the implementation effort?
- What leadership have parents provided?

Community planning team

- What changes in membership or commitment have there been since the last site visit?

- What processes are used to keep members engaged during the last year?
- What processes have been used to gain buy-in for the SOC implementation and planning process from different child- and family-serving agencies?
- What organizations/agencies, if any, have not been involved but should be?
- Have there been any challenges to working effectively together as a team? If so, what were they? (Alternatively, what lessons you are learning about effectively working together?)
- Were subcommittees/working groups formed? What was their purpose? Who joined them? How have they contributed to implementation?

Parent and Youth Involvement

- How have parents been involved in planning and implementation processes? What strategies were used to recruit and involve them in meaningful ways? Which strategies were most successful? What are the barriers to involving parents? Do you have resources dedicated to partnership strengthening?
- How have youth been involved in planning and implementation processes? What strategies were used to recruit and involve them in meaningful ways? Which strategies were most successful?

Communication:

- How is information about the SOC implementation communicated both internally (within the project teams) and externally (with the wider community)?
- Was the information that you received through these communications adequate, in terms of frequency and content? In other words, did the communication allow you to contribute in effective ways to SOC implementation and planning?

Data Support

- Have any data been collected to inform decisions? If so, what data, and how were they used?

Evidence-based practices

- What evidence-based practices have been implemented? Please describe the progress in implementing each practice

- Is there anything else you think it is important for us to know to understand your community's experience of implementing the system of care?

Appendix B – Additional Resources

Youth empowerment and family engagement

Massachusetts Family Engagement Coalition (2020). Strengthening Partnerships: A Framework for Prenatal through Young Adulthood Family Engagement. https://www.doe.mass.edu/sfs/family-engagement-framework.pdf

Matarese, M., McGinnis, L., & Mora, M. (2005). Youth involvement in systems of care: A guide to empowerment. Technical Assistance Partnership for Child and Family Mental Health (TA Partnership). https://nwi.pdx.edu/NWI-book/Chapters/App-6e.3-Youth-Involvement-In-Systems-Of-Care.pdf.

National Consortium on Leadership and Disability for Youth (2007). http://www.ncld-youth.info/Downloads/legislative_policy_guide.pdf.

National Federation of Families for Children's Mental Health. (2010). *Publications: Family-driven—defined.* http://ffcmh.org/what-you-can-do/r2/publications2/family-driven-defined/.

Rudd, C., Kalra, S., Walker, J., & Hayden, J. (n.d.). How can organizations assess their readiness to co-design? Annie E. Casey Foundation. https://caseyfamilypro-wpengine.netdna-ssl.com/media/21.07-KM-LFOF-ChiByDesign.pdf.

Valesey, B. & Orlando, S. (n.d.) The How To's of Youth Guided Practice. Youth Power! https://nyssoc.com/wp-content/uploads/2021/10/How-To-YG-Training-Guide_Final.pdf.

Youth.gov (n.d.). Key Principles of Positive Youth Development. https://youth.gov/youth-topics/key-principles-positive-youth-development

Program and goal development using logic models

Kellogg Foundation guides:

Logic Model Development Guide: Logic Model Development Guide (issuelab.org)

Guiding Program Direction with Logic Models: Guiding Program Direction with Logic Models (issuelab.org)