WCCMHB

Winnebago County Community Mental Health Board

STRATEGIC PLAN 2.0

PROGRAM YEAR 2025-2027

DRAFT - 7.28.2023

CONTACT INFORMATION

WCCMHB

Winnebago County Community Mental Health Board

COMMUNITY IMPACT | REGION 1 PLANNING COUNCIL / R1

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For the purpose of this report, the following terms are interchangeable:
Substance Abuse Disorder and Substance Use Disorder
Serious Emotional Disturbances and Severe Emotional Disturbances

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About Winnebago County Community Mental Health Board (WCCMHB)

History of Community Mental Health Boards

The deinstitutionalization movement of the 1950s and 1960s led to the creation of Community Mental Health Boards. The closure of state and national hospitals for people with mental illnesses due to reports of poor conditions in the 1950s created a need for a new method of mental health programming. Mental health boards envisioned the development and coordination of local mental health systems of care that could provide all needed services for individuals with mental illness to live and recover in their community rather than in institutions. Funding issues and varied programming from state to state did not translate into the community centered, comprehensive healthcare as originally imagined.

Community Mental Health Boards are now more ubiquitous across communities in the US, providing a range of services and funding opportunities that aim to increase the quality and availability of services and frameworks to keep those struggling with mental health or substance use independent. In 1967, the State of Illinois established the Community Mental Health Act (405 ILCS 20), which provides local municipalities the authority to establish Community Mental Health Boards and lays out the responsibilities of such boards. As of July 2023, there are 79 Community Mental Health Boards throughout the State of Illinois, including counties, townships, and municipalities.

Purpose of Winnebago County Community Mental Health Board

Winnebago County Resolution 19-128 established the Winnebago County Community Mental Health Board (WCCMHB). The purpose of WCCMHB is to plan, implement, and monitor a system of mental health and substance use services for Winnebago County residents suffering from serious mental illness and substance use. WCCMHB distributes sales tax proceeds to provide services to individuals whose illness prevents their functioning in age-appropriate social roles. The use of clinical, evidence-based practices allows individuals with serious mental illnesses and substance use disorders to remain in the community while meeting their care needs.

Half-Cent Sales Tax

WCCMHB receives funding through a half-cent sales tax which was approved by Winnebago County residents in March 2020 with 61.7% voter support.[1] Previously, Winnebago County was the largest county in Illinois with no local funding for mental health care, despite one in five individuals meeting the criteria for a mental health diagnosis. This sales tax is set to sunset in 2026 and generates approximately $18 million annually for mental health and substance use services across the county. WCCMHB oversees the mental health sales tax fund and administers funding according to a strategic plan to develop, improve, and maintain critical services in the county.

Board Member Biographies

Mary Ann Abate, President

Mary Ann Abate, currently President of the Winnebago County Mental Health Board, is a former Licensed Social Worker in Illinois. She received her MS in Community Mental Health from Southern New Hampshire University with an emphasis on clinical services for individuals with co-occurring disorders of substance abuse and psychiatric disabilities. Abate began her career at the Janet Wattles Mental Health Center, where she was a director before becoming the Vice President of Public Health Policy at Rosecrance.

Dick Kunnert, Vice President

Dick Kunnert is currently Vice President of the Winnebago County Community Mental Health Board. He previously served as Director of the Singer Mental Health and Developmental Center for 11 years. Prior to that, he was Assistant Regional Administrator for Mental Health Programs (1971-1987). Kunnert has served on the state board of NAMI and the Mental Health Association of Rock River Valley and chaired the Mayor's Homeless Task Force for 18 years. Prior to the creation of the WCCMHB, he served six years on the Winnebago County Mental Health Advisory Board.

BOARD MEMBERS BIOGRAPHIES

Dr. Bill Gorski, Secretary

Dr. Bill Gosrski is currently the Secretary of the Winnebago County Community Mental Health Board. Before completing his residency at the Illinois College of Medicine, Dr.Gorski graduated from Kenyon College and the University of Cincinnati Medical School. After 21 years practicing family medicine at a SwedishAmerican clinic, he was appointed CEO of the health system for 16 years before retiring. He works to increase access to care, especially for those who experience vulnerability in our community.

Wendy Larson-Bennett, Treasurer

Wendy Larson-Bennett is currently serving as the Treasurer of the Winnebago County Community Mental Health Board. She has a BA in English and Secondary Education from the University of Illinois and a Juris Degree from Northern Illinois University. Bennett was a Court Appointed Special Advocate before attending law school. She has served on the boards of Family Advocate and Children's Home and Aid (President), among other community groups. Before retirement, she was a Winnebago County prosecutor and fiercely advocates for childhood mental health and trauma-informed practice. Bennett aims to ensure our community members have access to the tools necessary to achieve mental wellness.

Dr. Reverend K. Edward Copeland

Reverend Dr. K. Edward Copeland is the lead pastor at New Zion Baptist Church. He is a graduate of the University of Illinois, Urbana-Champaign (B.A. in English/Rhetoric), the University of California, Berkeley (J.D. 1987), Golden Gate Baptist Theological Seminary (M.Div. 1992), and Trinity Evangelical Divinity School (D.Min. 2017). He serves on several state and national boards. He is a consultant on issues of criminal justice and public education.

Dr. Terry Giardini

Dr. Terry Giardini is a Rockford native and proud East High E-RAB. He earned his master's degree at National Louis University and his doctorate from California Southern University. Dr. Giardini served as a beloved special education teacher at East High for 35 years prior to retirement, as well as leading group therapy and performing forensic fieldwork.

Timothy Nabors, Freedom of Information Act (FOIA) Officer

Timothy Nabors received degrees from Rock Valley College and the Worsham College of Mortuary Science. He serves as the Funeral Director at Carl E. Ponds Funeral Home and is the County Board Member for District 14. Tim is an advocate for mental health.

Linda Sandquist

Linda Sandquist is serving as Vice President of Advancement at Rockford University. Her career includes past roles as a stay-at-home parent, marketing and communications professional, and grantmaker at two multi-million dollar companies. Sandquist believes that physical and mental health is foundational to the pursuit of a happy and productive life, and having access to physical and mental healthcare is a fundamental human right.

Mohammad Yunus

Mohammad Yunus was appointed to serve on the Winnebago County Community Mental Health Board in March 2023. He has been a faculty member of the University of Phoenix's John Sperling College of Business since 2003 and has authored over a dozen business articles. From 1991 to 2005, he served as Singer Mental Health Center's Chief Financial Officer and then as its Hospital Administrator from 2005 to 2012. In 2012, the U.S. Secretary of Health and Human Services appointed Yunus to serve on the SAMHSA CSAT Advisory Council for a five-year term. Additionally, he served on the Evaluation & Improvement Council of the University of Phoenix from 2015 to 2016. Yunus was a grant reviewer for the U.S. Department of Health & Human Services Access to Recovery Committee in 2004 and 2007 and served as a Panel Member of the Higher Learning Commission of the North Central Association of Colleges and Schools from 2005 to 2009.

VISION, MISSION VALUES AND PRINCIPLES

Vision

Our hope for the community

We see a community where residents are knowledgeable about mental health and have access to high quality mental health and substance abuse services when and where they need them.

Mission

What we are doing about it

We are an appointed group of community leaders who are passionate about improving mental health and substance abuse services in Winnebago County and coordinate them through planning, funding, evaluation, and communication.

Values

Why we do what we do

Wellness – We support the Community Support System framework because it focuses on providing an array of services that bring people from illness to health.

Awareness – We believe mental illness and substance abuse disorders can occur at any age and can affect individuals across all domains, including race, ethnicity, income, geography, religion, gender identity, language, sexual orientation, and disability, so we strive to educate all members of our community about mental health and substance use to increase mental health literacy and prevent mental illness and substance abuse disorders.

Collaboration – We believe that relationships are foundational to coordination, so we practice teamwork and breaking down silos.

Transparency – We believe the best way to gain trust is to be truthful, so we practice open and consistent communication about our work.

Diversity – We believe complex problems require perspectives from all areas of the community, so we practice listening and cultural humility.

Client-Centered – We believe that people with mental illness and substance abuse disorders are important members of our community, so we promote services that support them with compassion and unconditional positive regard.

Intersectional - We believe that mental health is interconnected with other parts of community life and personal identity, so we promote solutions that address a combination of factors.

Trauma-Informed - We believe that no one who has experienced trauma should ever be re-traumatized during the process of seeking out or receiving mental health or substance abuse services, so we promote trauma-informed care in all areas of service delivery.

Accessibility – We believe mental health and substance abuse services should be accessible for all people irrespective of race, ethnicity, income, geography, religion, gender identity, language, sexual orientation, and disability, so we promote ADA compliance, language access, and effective communication in all areas of service delivery.

Principles

How we operate

Evidence-Based - Our decisions are driven by the best available empirical evidence and data.

Process-Oriented - We use best-practice processes to guide planning, funding, evaluation, and communications.

Outcomes-Informed - We evaluate the results of our efforts by collecting and analyzing data in order to continuously improve and maximize impact.

Equity - We fund and measure results with equity in mind, analyzing needs and outcomes by race, ethnicity, income, geography, religion, gender identity, language, sexual orientation, and disability or other demographic breakdowns.

Urgent - We operate with a sense of urgency, knowing that gaps in care affect real people.

Emergent - We stay flexible in order to identify and address new issues in the service delivery system as they are developing.

Network-Driven - We work diligently to establish a broad and diverse coalition of community stakeholders dedicated to improving the mental well-being of our community

COMMUNITY SUPPORT SYSTEM FRAMEWORK

LOOKING BACK

COMMUNITY SUPPORT SYSTEM

Community Support System Framework

The purpose of community mental health is to provide an array of services that allows individuals with mental illness to live and recover in their community. The Community Support System (CSS) framework is rooted in Community Support Program (CSP) research that dates back to 1977. The CSP launched as a pilot program to simulate and assist states and communities to improve opportunities and services for adults with serious mental health concerns. The CSS created a basis for municipalities to use for comprehensive, community-based mental health systems planning and organizing and meets Federal (P.L. 99-660) requirements. Over time, the components of the CSS framework have remained constant. The components of CSS represent the *array of services and opportunities that an adequate community service system should include* for the target populations, all to be provided in the community. As such, WCCMHB adopted this framework and uses it to guide its organizational planning and services.

The 11 components of the framework are:

- Client Identification and Outreach
- Mental Health Treatment
- Crisis Response Services
- Health and Dental Care
- Housing
- Income Support
- Peer Support
- Family and Community Support
- Rehabilitation Services
- Protection and Advocacy
- Case Management

The order of these components on the wheel do not indicate priority or value. The components are represented in the visual as "spokes" in the wheel; while case management is not represented as a "spoke," it is a component that affects all the other components. For some of the components, there are corresponding service areas listed. For example, the "Mental Health Treatment" component includes the service areas of Diagnostic Evaluation, Supportive Counseling, Medication Management, and Substance Abuse Services. The components and their included service areas are shown with the corresponding color based on the framework. The colors of the components in the wheel correspond with the colors of service areas in charts used later in this report.

The previous Strategic Plan identified six components as "Priority Areas," which will be listed in the next section.

Community Support System Framework

Client Identification and Outreach
- Client Identification
- Outreach
- Transportation Assistance

Mental Health Treatment
- Diagnostic Evaluation
- Supportive Counseling
- Medication Management
- Substance Abuse Services

Crisis Response Services
- Crisis Telephone Services
- Walk-In Crisis Services
- Crisis Outreach Services
- Crisis Residential Services

Health and Dental Services

Housing
- Supportive Housing
- Residential Assistance for Homeless Mentally Ill

Income Support

Peer Support
- Self-Help
- Consumer-Operated Services

Family and Community Support
- Assistance to Families
- Education for the Community

Rehabilitation Services
- Social Rehabilitation
- Vocational Rehabilitation

Protection and Advocacy

Case Management

Looking Back

The WCCMHB Strategic Plan for 2021-2023 outlined six priority funding areas for funding. The priority areas were:

- Priority 1 - Mental Health Treatment
- Priority 2 - Case Management
- Priority 3 - Crisis Response Services
- Priority 4 - Family & Community Support
- Priority 5 - Client Identification & Outreach
- Priority 6 - Housing

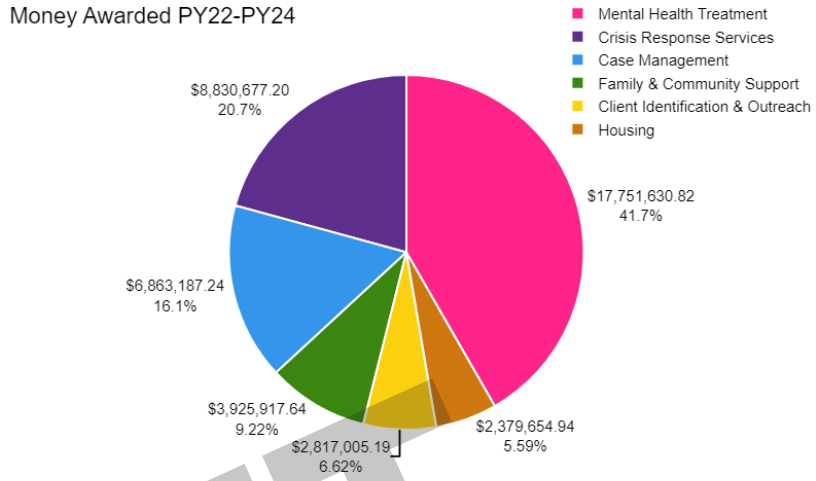
In Program Year 2021-2022 (PY22), WCCMHB funded 15 programs with funding totaling $8.8 million. Priority 1 received $3.8 million (44%); Priority 2 received 1.2 million (14%); Priority 3 received $3.3 million (38%); and Priority 4 received $313,145 (4%). Priority 5 and Priority 6 received funding in PY23. By the end of PY22, WCCMHB programs completed 96 outcomes, 50 outcomes were in progress, and five outcomes had not yet started. WCCMHB programs served a total of 6,196 clients in PY22. For more information about PY22 funded programs, please see the Impact Report, Issue 1 Program Year 22.

In Program Year 2022-2023 (PY23), WCCMHB funded 30 programs with funding totaling $14.6 million. Fifteen (15) of the 30 programs were previously funded in PY22, and the 15 other programs were newly funded in PY23. Priority 1 received $5.6 million (38%); Priority 2 received $2.6 million (18%); Priority 3 received $2.7 million (19%); Priority 4 received $1.5 million (11%); Priority 5 received $1.3 million (9%); and Priority 6 received $582,854 (4%).

For more information about PY23 funded programs, please see the PY23 Mid-Year Report.

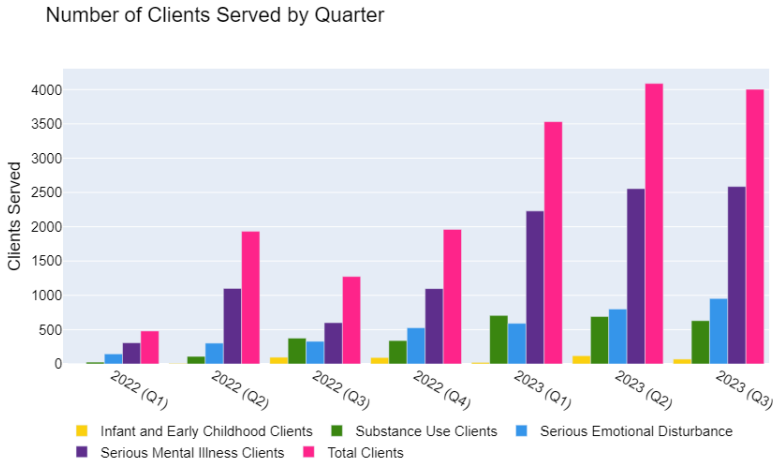
Funds Awarded

Between PY22-PY24, over $39 million has been awarded by WCCMHB across the previous six priority areas. Mental Health Treatment received the most funds, followed by Crisis Response Services, Case Management, Family & Community Support, Client Identification & Outreach, and Housing. Priorities five and six were not prioritized in the first program year, causing totals to be slightly lower than the other priority areas.



Number of Clients Served PY22-PY23

Across each program year and quarter, the number of total unduplicated clients increased, except for PY22 Q2 to PY23 Q3, where it slightly decreased. Similarly, the number of clients served with serious mental illness rose almost every quarter. The number of substance use disorder and serious emotional disturbance clients served increased from PY22 to PY23, but has remained fairly consistent over each quarter. The number of infant and early childhood clients served has remained under 250 across all quarters.



THE PURPOSE AND PLANNING OF A STRATEGIC PLAN

TERMINOLOGY

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The Purpose and Planning of a Strategic Plan

The Association of Community Mental Health Authorities of Illinois (ACMHAI) defines community mental health as "the people of the community tak[ing] responsibility for the design and organization of a local system of care," and defines the duties of mental health boards as assessing the needs of the community on a continuous basis, inviting input from consumers and families, strategic planning, coordinating funding, and evaluating results (ACMHAI, 2023).[2] WCCMHB will use this strategic plan to guide funding and evaluation of success according to the goal, sub-goals, objectives, strategies, and measures of success.

The outline of this strategic plan differs from the previous WCCMHB strategic plan in its structure and terminology. The priorities in this strategic plan are not taken from the CSS framework as they were previously.

Environmental Scan

An environmental scan surveys and interprets data to identify external areas of strengths, weaknesses, opportunities, and threats. WCCMHB conducts an environmental scan every three years as a part of its strategic planning process. The Environmental Scan (ES) administered by WCCMHB surveyed the local mental health service delivery system.

Public Participation Survey

The Public Participation Survey (PPS) collects data on the utilization of services, access to services, and ways to increase service utilization. WCCMHB conducts a public participation survey as part of the strategic planning process. The PPS administered by WCCMHB surveyed residents of Winnebago County from three perspectives: individuals with lived experience, mental health workers, and community members.

Data Synthesis

Qualitative and quantitative data were analyzed from WCCMHB and other community surveys, studies, reports, etc. Results of the environmental scan and Public Participation Survey were evaluated according to components within the CSS framework. The results of the scan and the survey were used to inform this plan.

Terminology

Goal -
The goal of this plan is the desired result or end that effort is directed towards. The goal for this Strategic Plan is to develop and maintain a Community Support System for Winnebago County.

Sub-Goals -

The sub-goal areas determine the three main functions and responsibilities of WCCMHB. The sub-goals outline the tasks that must be maintained or achieved in order to reach the goal.

Objectives -

Objectives define the desired improvements or outcomes within each sub-goal.

Strategies -

Strategies are different steps that will be taken to meet each objective.

Measures of Success -

Measures of success will be used to determine how well each strategy is implemented in order to meet each goal. These also provide insight to what the desired outcomes are overall.

Key Implementation Activities -

The key implementation activities are strategies that will be prioritized within the next three years.

TARGET POPULATIONS

WCCMHB RESEARCH

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TARGET POPULATIONS

Target Populations

For all Community Support System components and service areas, the focus is on residents of Winnebago County who experience functional impairments in daily living due to mental illness or substance use disorders. This general definition falls into the target populations outlined below.

Serious Mental Illness (18+)

Serious Mental Illness (SMI) is defined as someone over the age of 18 who has (or had within the past year) a diagnosable mental, behavioral, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities.[3] SMIs usually refer to psychotic disorders such as bipolar disorder, major depressive disorder, or schizophrenia.[4] However, SMIs can also include anxiety disorders, eating disorders, and personality disorders if the degree of functional impairment is serious.[5] SMIs are long-term illnesses that can lead to the inability to maintain employment, poor social support, psychiatric hospitalization, homelessness, incarceration, or co-occurring substance use disorders.[6] There are an estimated 14.1 million adults in the US with a SMI, which is about 5.5%.[7] The Illinois Department of Human Services provides a list of diagnoses that qualify as Serious Mental Illness.[8] Other DSM-5 diagnoses may be acceptable under this target population when the symptoms cause significant impairment in social, emotional, or occupational functioning.

Serious Emotional Disturbance (3-21)

A Serious Emotional Disturbance (SED) is defined as the presence of a diagnosable mental, behavioral, or emotional disorder that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities.[9] The State of Illinois defines SED for MH funded services as 0 through 17, but for the purposes of WCCMHB, the age range for SEDs is defined as the age range of 3 to 21. Typically those in the age range of 18-21 received services prior to their 18th birthday, were diagnosed with a SED, and demonstrate a continued need for services.[10] There is also an overlap of target populations between SED and early childhood and infant mental health between the ages of three to five. Most, if not all, of the diagnoses for SED are not age appropriate before the ages of three to five and the interventions below age three are different. These overlaps in age ensure there is no hard cut-off of services for children, to avoid regression of symptoms, and account for age variances in diagnostic tools.

SEDs have characteristics such as: hyperactivity, short attention span, impulsivity, aggression, self-injurious behavior with others, avoidance of social interactions due to fear or anxiety, immaturity characterized by inappropriate tantrums, poor coping skills, and learning difficulties exhibited by academic performance below grade level.[11] Nearly all DSM-5 diagnoses except for substance use, neurodevelopmental disorders (except ADHD), medication induced movement disorders are included within SEDs.[12] SEDs have a prevalence rate of 10%, or roughly 6 million individuals will have a SED at some point in their lifetime.[13] IL Department of Human Services provides a list of diagnoses that qualify as SED. Other DSM-5 diagnoses may be acceptable under this target population when the symptoms cause significant impairment in social, emotional, or occupational functioning.

Infant and Early Childhood Mental Health (0-5)

Infant and Early Childhood Mental Health (IECMH) can be defined as the capacity of infants and young children to regulate their emotions, form secure attachments, and explore their environments.[14] Among mental health providers, infant mental health generally refers to the ages of zero to three while early childhood mental health refers to the ages of three to five.[15] IECMH is important because an individual's earliest relationships and experiences influences brain development, socio-emotional and cognitive skills, and future health and success in school.[16] Every dollar invested in an IECMH program returns $3.64 back in prevented treatments later in life.[17] Including IECMH as a target population marks Winnebago County as an innovator for community mental health and serves a vulnerable and often overlooked population of community members.

Early intervention programs help children under the age of three meet developmental milestones. Some early childhood interventions have been found to return anywhere from $1.80 to $17.07 to a community for each dollar spent on the program.[18] Many early intervention programs have significant benefits in at least one of the following domains: cognition and academic achievement, behavioral and emotional competencies, educational progression and attachment, child maltreatment,

health, delinquency and crime, social welfare program use, and labor market success.[19]

The first eight years of a child's life are important for later health and development. Positive or negative experiences can affect a child's development and have lifelong effects.[20] When caregivers are responsive, protective, and stable, children build foundations for all emotional, cognitive, and social development; these early relationships are correlated with an individual's lifelong health.[21] When a child is living in a constant state of toxic stress caused by extreme poverty, abuse or neglect, household dysfunction, and food scarcity, cortisol levels are continually in a peak state which has neurodevelopmental consequences that have the ability to cause lifelong damage.[22]

Delays across the social-emotional and behavioral functional domains lead to changes in the way children see their social world and their ability to differentiate and express emotions, as well as perceive the emotions of others.[23] Although the data on an official threshold for delays remains inconsistent, multiple screening tools may be utilized in assessments to make a conclusion, including the Ages and Stages Questionnaire (ASQ) and Parents' Evaluation of Developmental Status (PEDS). Clinical judgment is often the deciding factor if there is a significant delay in social-emotional or behavioral domains. As with other population groups, the focus for this target population group is children who have a significant impairment in their ability to function at age-appropriate levels due to a serious functional delay in social-emotional or behavioral function domains, assessed through clinically appropriate, evidence-based methods.

Substance Use Disorders (all ages)

A substance use disorder (sometimes referenced as substance abuse or SUD) occurs when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.[24] A SUD can occur at any age. Substance related disorders include 10 classes of drugs: alcohol; caffeine; cannabis; hallucinogens; inhalants; opioids; sedatives, hypnotics, and anxiolytics; stimulants (amphetamine-type substances, cocaine, and other stimulants); tobacco; and other (or unknown) substances.[25] SUDs can range from mild, to moderate, to severe depending on the number of symptoms criteria endorsed. In terms of severity, substance abuse disorders are categorized as mild, moderate, or severe. The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) details that "Substance use disorders occur in a broad range of severity, from mild to severe, with severity based on the number of symptom criteria endorsed. As a general estimate of severity, a mild substance use disorder is suggested by the presence of two to three symptoms, moderate by four to five symptoms, and severe by six or more symptoms. Changing severity across time is also reflected by reductions or increases in the frequency and/or the dose of substance use, as assessed by the individual's own report, report of knowledgeable others, clinician's observations, and biological testing. The following course specifiers and descriptive features specifiers are also available for substance use disorders: "in early remission," "in sustained remission," "on maintenance therapy," and "in a controlled environment."[26]. As with other target populations, the focus should be on disorders that cause significant impairment in age appropriate functioning and should be assessed through clinically appropriate, evidence-based methods.

Trauma

Individual trauma is an event or circumstance resulting in physical, emotional, and/or life-threatening harm; additionally, the event or circumstance has lasting adverse effects on the individual's mental, physical, and/or emotional health and/or their social and/or spiritual well-being.[27] The impact of trauma can be subtle to destructive.[28] The most common diagnoses with trauma are PTSD and ASD but trauma can be associated with the onset of other mental disorders such as substance use, mood disorders, anxiety disorders, and personality disorders.[29] Further, trauma typically exacerbates symptoms of preexisting disorders and can precipitate the onset of mental disorders for those who are predisposed to it.[30] There can be many different types of trauma such as: historical, community, complex, early childhood, intimate partner violence, medical, and more.

More than two thirds of children reported at least one traumatic event by the age of 16.[31] Trauma is a risk factor of nearly all behavioral health and substance use disorders.[32] Children who do not have a safe or stable home may develop coping mechanisms that allow them to survive and function day to day.[33]

Common effects of complex childhood trauma include attachment and relationship issues, body dysregulation, difficulty expressing and managing emotions, dissociation, issues with thinking and learning, and much more.[34] Adverse childhood experiences, or ACEs, are potentially traumatic events that occur in childhood (0-17); also included are aspects of a child's environment that can alter their sense of safety, stability, and

bonding.[35] ACEs are common and preventable.

Signs of traumatic stress are typically different at different age groups of children. Preschool children often fear separation from their caregiver, cry and scream, have nightmares, and eat poorly. Elementary school children can become anxious or fearful, feel guilt or shame, have a hard time concentrating, and have difficulty sleeping. Middle and high school children can feel depressed or alone, develop eating disorders or self-harming behaviors, use alcohol or drugs, or become involved in risky sexual behavior.[36]

All the target populations mentioned in this plan include recognizable trauma that significantly impacts functioning and does not include risk factors alone.

Client Unit

While it is individuals who are diagnosed with mental illness and substance use disorders, families, providers, and communities share in experiencing their effects. The client unit is not necessarily limited to an individual, but the impact should benefit individuals within the target population.

WCCMHB Research

Environmental Scan

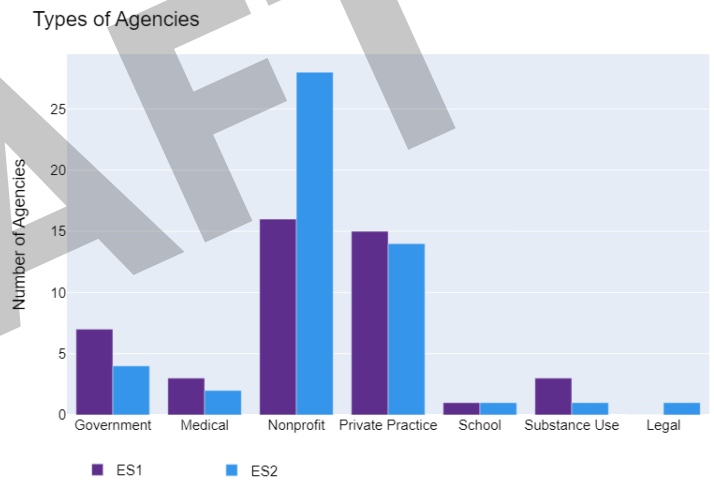
The WCCMHB Environmental Scan survey (ES) was created in order to understand more about the community from service providers in Winnebago County. From the survey, WCCMHB collected feedback from service providers related to their capacity, accessibility, availability, target populations, payment options, and practices within each service area in the CSS framework. The ES survey is sent out every three years as a part of the Strategic Plan update. The term ES1 refers to the Environmental Scan completed in 2020, while ES2 refers to the Environmental Scan completed in 2022.

WCCMHB Environmental Scan, 2022

ES2 resulted in 51 completed surveys and four partial surveys, creating 55 responses in total. ES1 resulted in 44 completed surveys and eight partial surveys, creating 52 responses total.

Type of Agency

Agencies who completed either ES were categorized as government, medical, non-profit, private practice, school, substance use, and legal. This gives a sense of the composition of the ES agencies and how this can relate to reported services offered. More non-profit agencies completed ES2 than ES1. Non-profit agencies and private practices were the two most common types of agencies to complete both ES1 and ES2. Fewer government, medical, and substance use agencies completed ES2 than ES1.

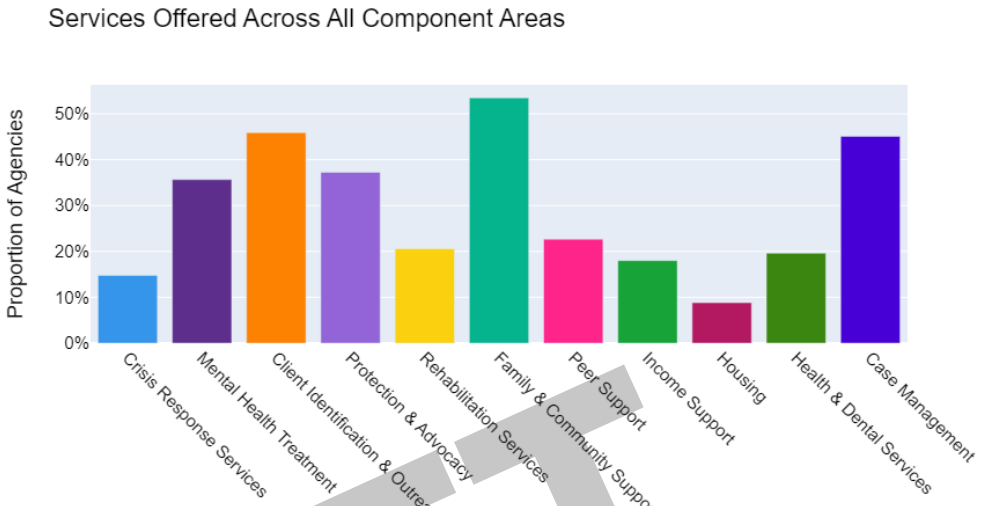


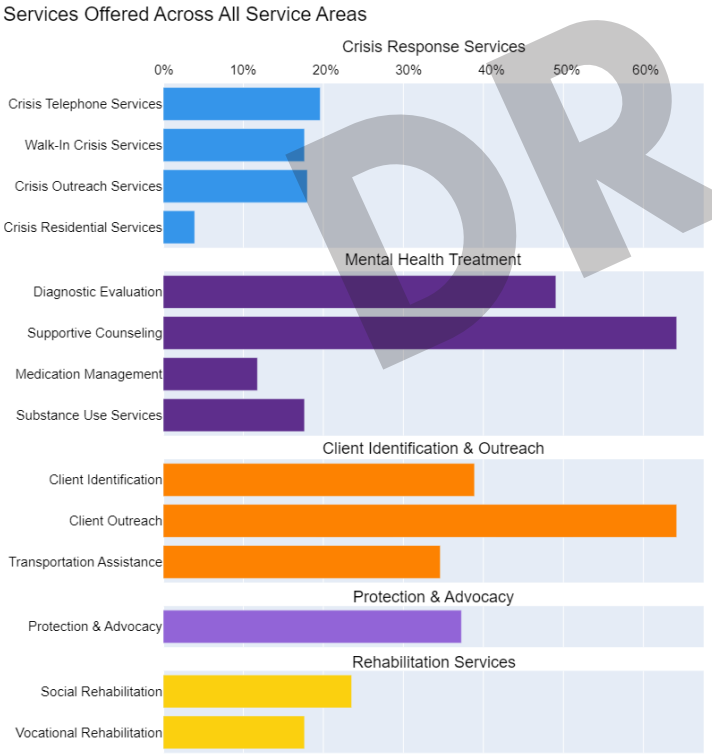
Services Offered Across CSS Component and Service Areas

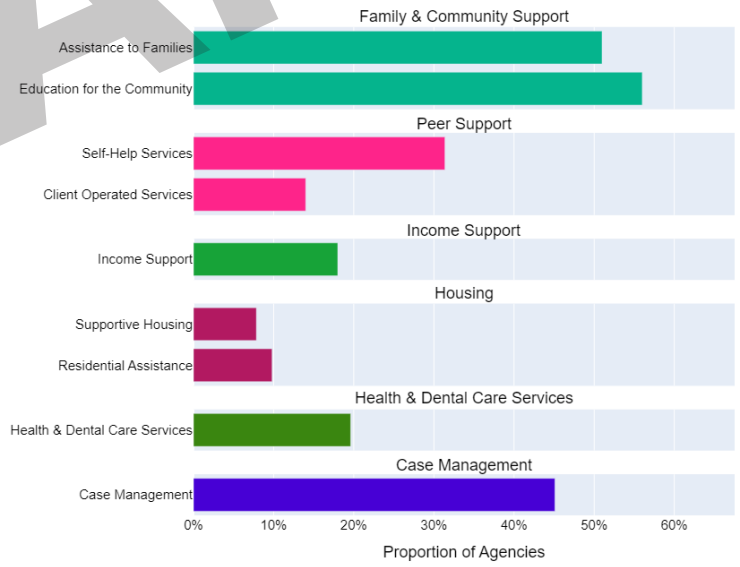
Across all 11 CSS component areas, family and community support was the most frequently offered service with 53% of agencies responding that they offer this service to clients. Closely following was client identification and outreach and case management at 46% and 45% respectively. As shown in the service areas figure below, both assistance to families and education for the community had significantly higher percentages of agencies reporting that they provide this service, driving the results for family and community support. Client outreach was the primary driver of the component area client identification and outreach.

Conversely, housing, crisis response services, and income support all had less than 20% of agencies reporting that they provide this service. Both residential assistance for homeless mentally ill persons and supportive housing had very low percentages, leading to the overall result for the housing component area. Crisis response services had very low percentages across the board for its corresponding service areas; however, the lowest was crisis residential services at only 4%.

Across all 23 CSS service areas, supportive counseling and client outreach were the most offered services, followed by education for the community. Residential assistance, supportive housing, and crisis residential services were the three least offered services, which also reflects in their respectively low component area percentage.



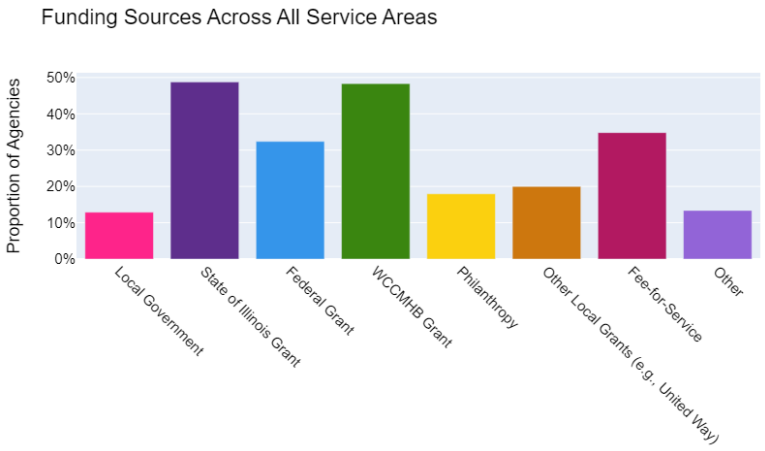




WCCMHB
RESEARCH

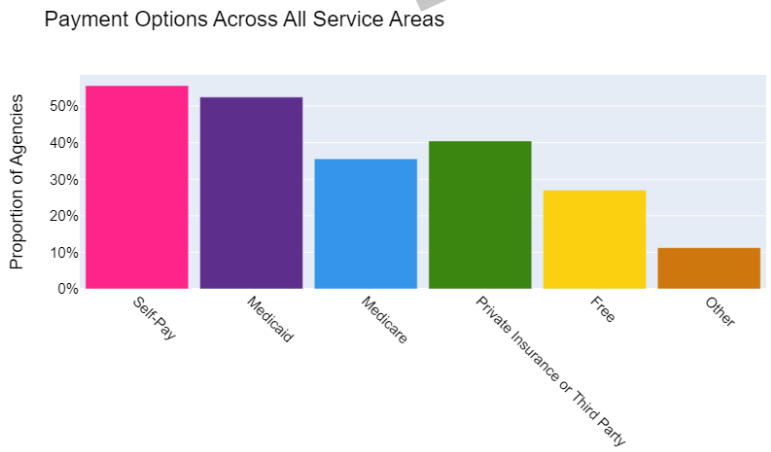
Funding Sources

The most common funding source across agencies was either from WCCMHB or the State of Illinois grant. Fee-for-service was selected by about 35% of entities. Common "other" responses included tuition, private donations, insurance, retail funding (Goodwill), and DCFS/Archdiocese of Chicago.



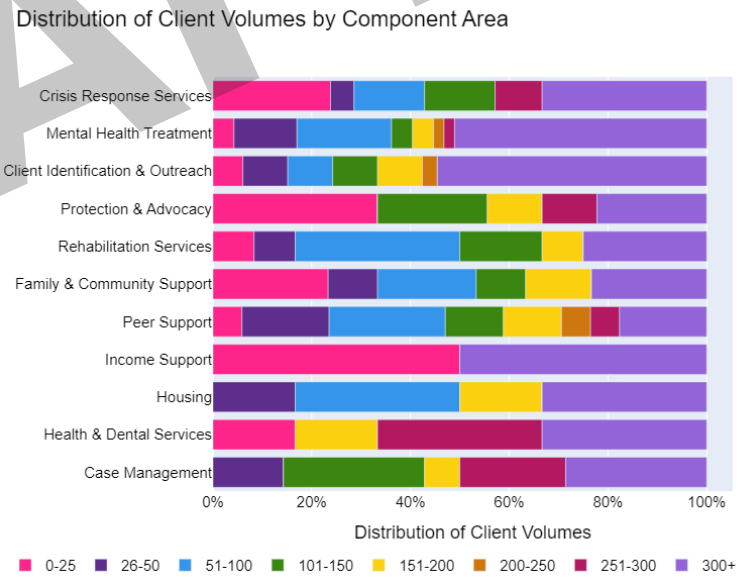
Payment Options

The most common payment option across all CSS services areas from ES2 was self-pay, which includes cash, credit cards, checks, and other self-pay options. Medicaid was accepted more often than Medicare and other private insurances. Nearly 25% of services offered were free. Entities were asked to select all forms of payment that they accept. Payment options provided in the "other" category included tuition, employee assistance programs, or DCFS contracts.



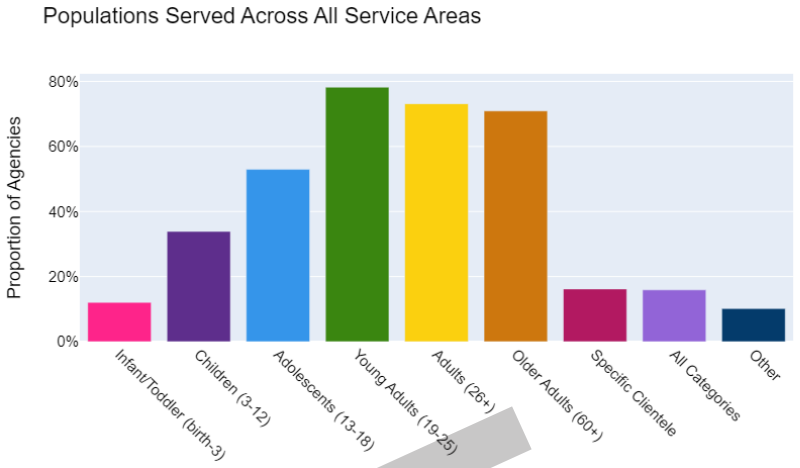
Client Volumes Across Component Areas

In ES2, agencies were asked to estimate how many clients they serve annually for each CSS service area. The resulting data was aggregated into the 11 different component areas and the distribution of responses was grouped into the different client volume categories as shown in the figure below. Client identification and outreach, mental health treatment, and income support had the highest proportion of "300+" responses, indicating a large volume of clients served annually. However, income support in particular had a nearly even split between agencies reporting client volumes of "0-25" and "300+", making this component area particularly uneven between high and low client volumes. Health and dental services also had a large amount of client volumes with approximately 50% of agency responses indicating 250+ clients per year. Conversely, other component areas such as rehabilitation services, family and community support, peer support, and housing had agencies reporting a much smaller amount of client volumes per year with a significant proportion being between 0 and 100 clients per year.



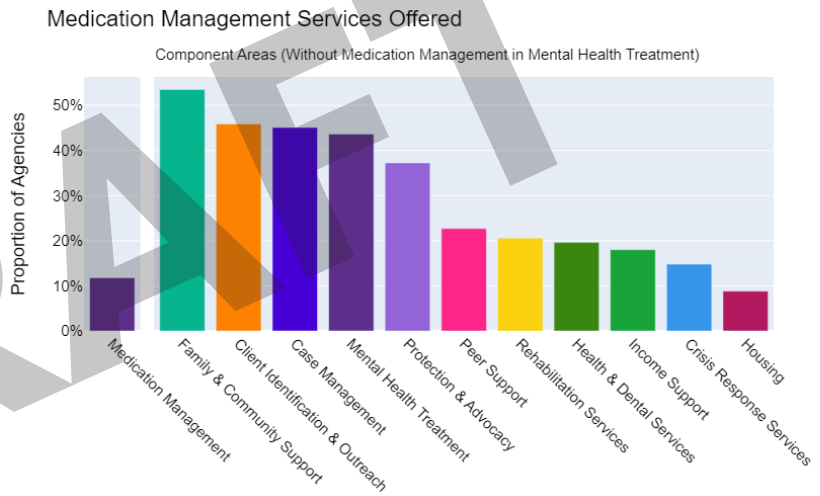
Populations Served

Across all service areas, young adults were the most frequent population served, followed closely by adults and older adults. Adolescents were the highest age group served under the age of 18. Infants and toddlers were the least served group across all population groups. Importantly, there is considerable overlap between the different populations with many agencies offering services to a variety of clients of all ages. For the "other" category, frequent responses by agencies included serving populations such as the homeless, survivors of sexual assault and abuse, veterans, and those with disabilities.



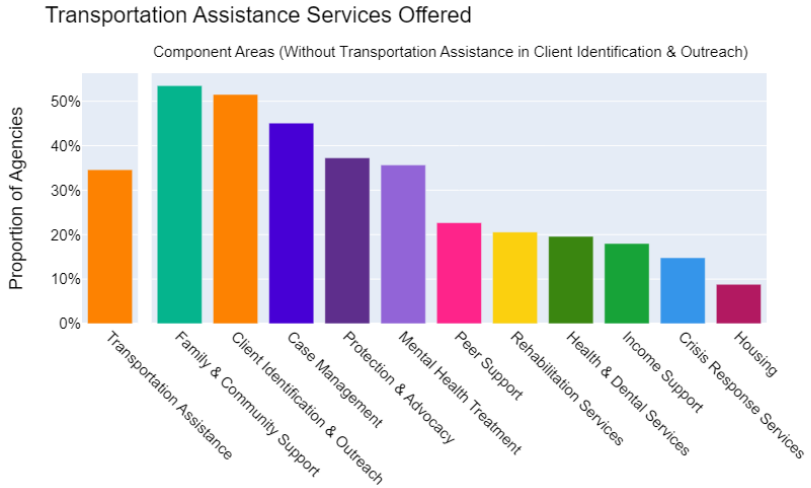
Medication Management

Based upon other community research, feedback, and input, providers who can prescribe mental health medication in Winnebago County are needed. Only about 12% of surveyed entities in ES2 provided medication management services. Providers who can prescribe mental health medication to children is also a great need in Winnebago County. The State of Illinois ranks 29th in the country in mental health workforce availability and wait times for appointments with psychiatrists can be as long as four to six months.[37] Additionally, 40% of psychiatrists nationally work in cash only practices.[38]



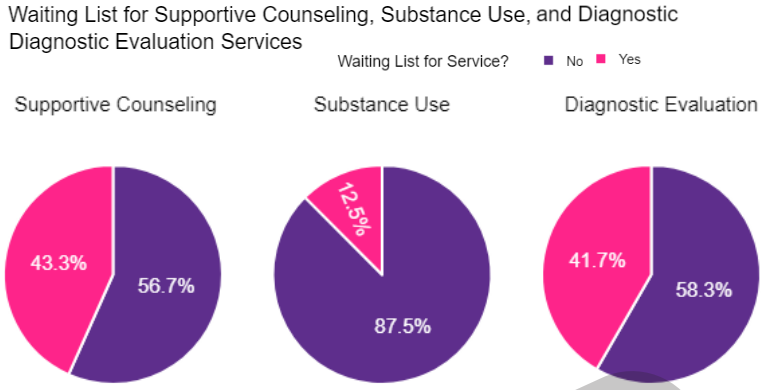
Transportation Assistance

Transportation is consistently named as a barrier to access of mental health services in community surveys and outreach in Winnebago County. Potential transportation issues can include lack of vehicle access, inadequate transportation infrastructure, long distances, and costs.[39] Transportation issues can lead to delayed care due to missed appointments. The transportation assistance service area is included in the client identification and outreach component. It can be seen in previous graphs that this service area was offered by about 45% of agencies in ES2. When removing transportation assistance from this component area, the average of entities offering client identification and outreach increases to over 50%. Therefore, fewer entities offer transportation assistance.



Wait Times

Wait times for mental health services are commonly reported as being too long in Winnebago County. Therefore, wait times as reported in ES2 were analyzed to gain an understanding of wait times from an agency perspective. Across services in supportive counseling, substance use, and diagnostic evaluation, more than 50% of agencies report having no wait list for services. Only 12.5% of agencies with substance use services report having a waiting list for services.

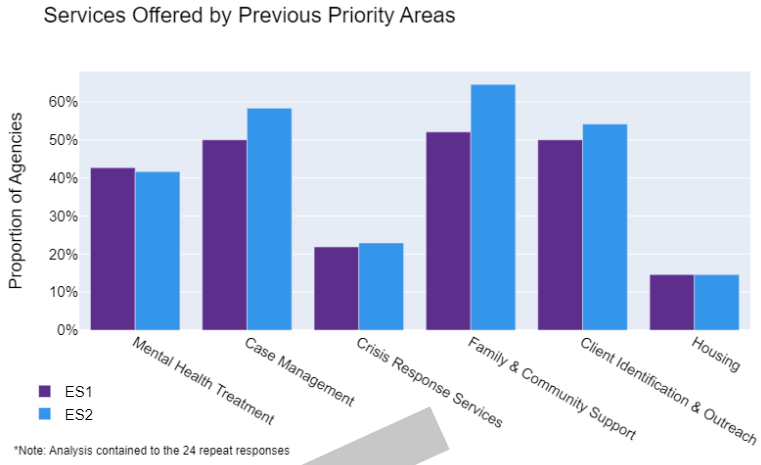


2022 Comparison to 2020 WCCMHB Environmental Scan

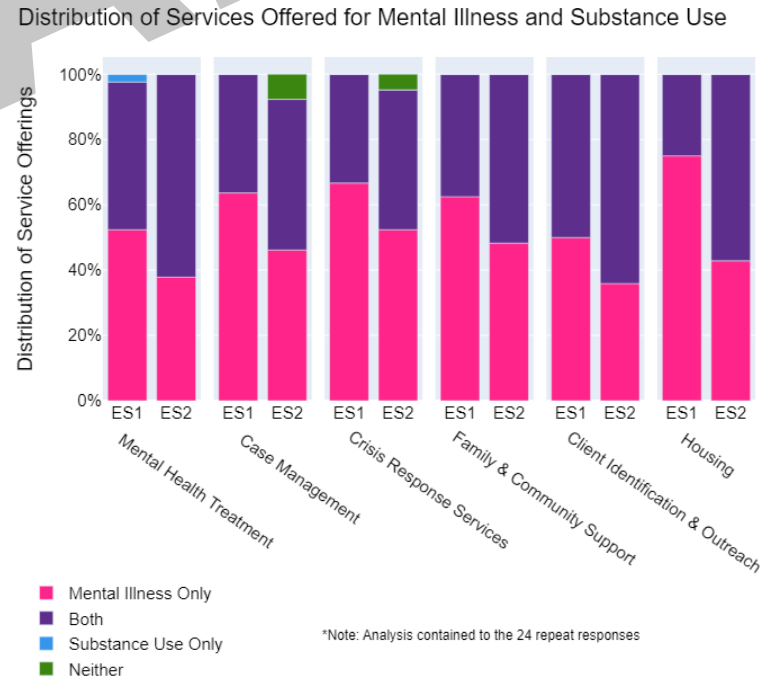
A repeat respondent is a respondent that completed ES1 and ES2. Between each ES, there were 24 repeat respondents. These agencies were chosen to be analyzed in order to look at a change over time in the mental health system of care in Winnebago County.

The following visuals show change between the first and second ES between the priority areas selected in the previous WCCMHB Strategic Plan (PY22-PY24). A comparison between the two ESs was done in order to show progress made in the previously selected priority areas within the past three years.

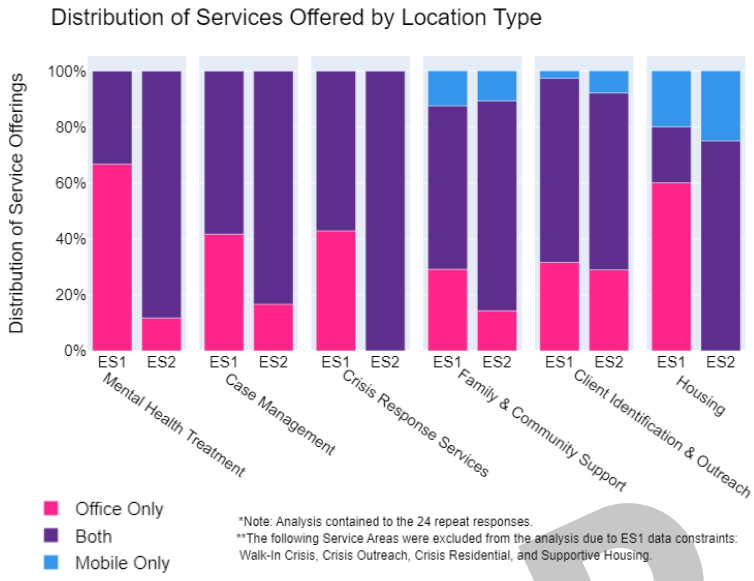
Four of the six priority areas showed an increase in the percentage of agencies that offered those services while one stayed the same and one decreased. Priority 4, family and community support, had the largest percentage increase (13%) across all six priority areas. Case management, crisis response services, and client identification and outreach also increased over the three year period. The availability of housing services stayed the same, while mental health treatment services decreased by 1%.



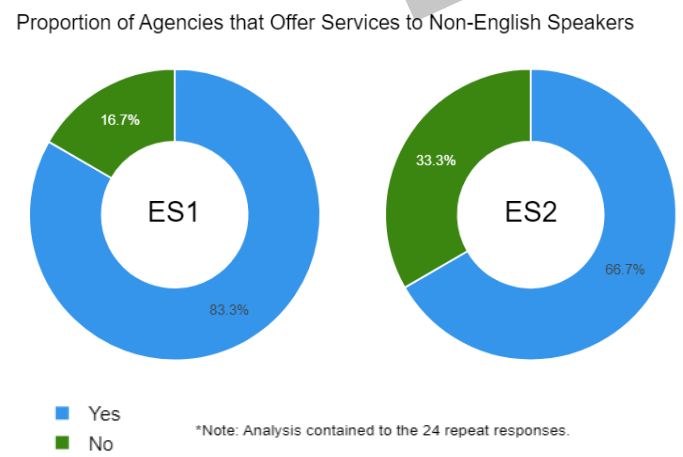
Most mental health services fall into the category of mental illness treatment, substance use treatment, both, or neither. Across all six priority areas, the percentage of agencies offering both mental illness treatment and substance use services increased. More agencies only offered mental illness treatment during the first ES. Therefore, the number of agencies offering substance use services increased across all six service areas.



Services can primarily be located in-person at an office or through mobile or virtual services. The graph below compares where services are offered between the first and second ES. Across all six priority areas, the number of services offering both in-office and mobile services increased.



Between the first and second ES, the number of agencies offering services to non-English speakers changed by 17%, but this may be due to the format of each survey. In the first ES, "Do you serve non-English speakers?" was asked for each of the 23 Community Support System service areas, while in the second ES, this question was asked once at the beginning of the survey.



Public Participation Survey

The Public Participation Survey (PPS) is designed to engage community member perspectives related to mental health service needs in the community. The PPS focuses on the social and logistical factors that impact the daily lives of individuals who live with mental health and/or substance use disorders and their family members/caretakers (lived experience), administrators and direct service staff at agencies who serve individuals who have mental illness and substance use disorders (mental health workers), and community members.

Respondents with lived experience were asked to select all of the services that they or someone in their household utilized in the past 12 months; what services they needed but could not receive; and what resources would have helped them receive the services they did not receive. Mental health workers were asked to select all services that are easily accessible in the area and what resources would increase access to services. Community members were asked to select what services they would like to learn more about.

The survey included demographic questions and allowed respondents to select "Prefer Not to Answer" in the event they did not wish to disclose. Finally, a section where respondents could express any feedback, comments, or concerns was provided. The service answer options were based on the eleven service areas of the Community Support System Framework.

The 2022 PPS collected 258 complete responses and 100 partial responses. Of these responses,

- 24 were from an administrator of an agency providing mental health or substance use services
- 40 were from direct service staff working with clients at an agency providing mental health or substance use services
- 97 were from individuals living with a mental illness or substance use disorder
- 73 were from a family member/caregiver of an individual living with a mental illness or substance use disorder
- 124 were from community members

PPS Quantitative Data

Lived Experience

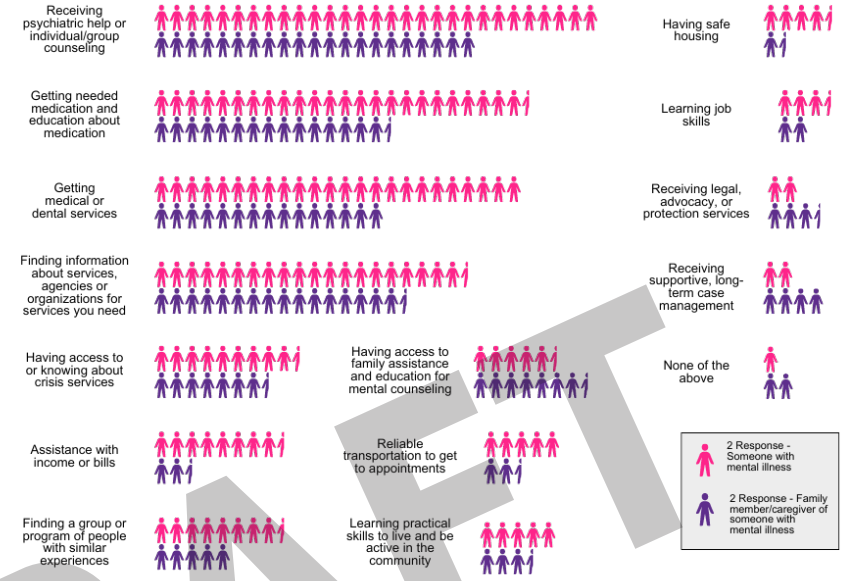
Respondents with lived experience were asked to select all services they or someone in their household had used in the past 12 months. The top five answers selected were:

- Receiving psychiatric help or individual/group counseling (59%)
- Getting needed medication and education about medication (47%)
- Getting medical or dental services (45%)
- Finding information about services, agencies, or organizations for services you need (43%)
- Having access to or knowing about crisis services (telephone services, walk-in services, residential services) (20%)

Respondents with lived experience were asked to select all services they or someone in their household needed but could not receive. The top five answers selected were:

- Receiving psychiatric help or individual/group counseling (37%)
- Assistance with income or bills (20%)
- Finding a group or program of people with similar experiences (18%)
- Getting medical or dental services (17%)
- Having access to family assistance and education for mental health, counseling, or respite care (16%)

In the past 12 months, which of the following services did you or someone in your household use?

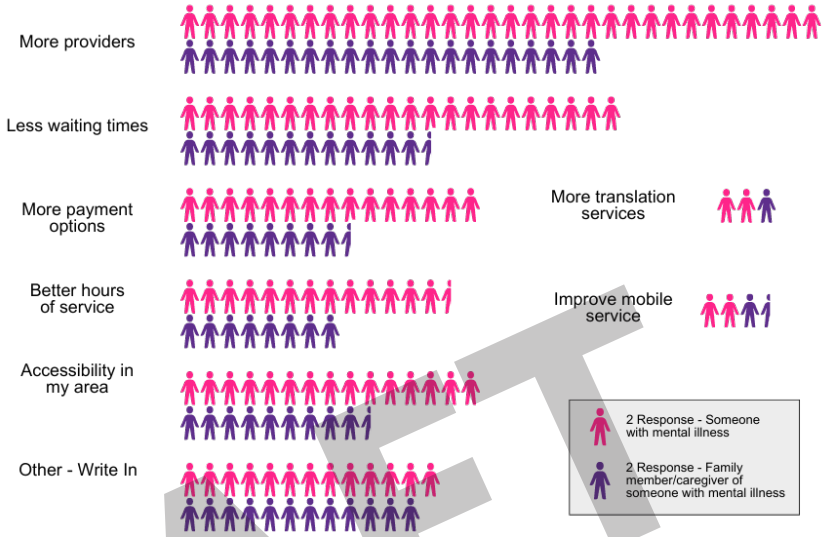


In the past 12 months, which of the following services did you or someone in your household need but could not receive?

Respondents with lived experience were asked to select all answer options that would have helped them receive services. The top five answers selected were:

- More providers (62%)
- Less waiting times (41%)
- Better hours of service (25%)
- More payment options (28%)
- Accessibility in my area (29%)

What would have helped you or someone in your household receive these services?

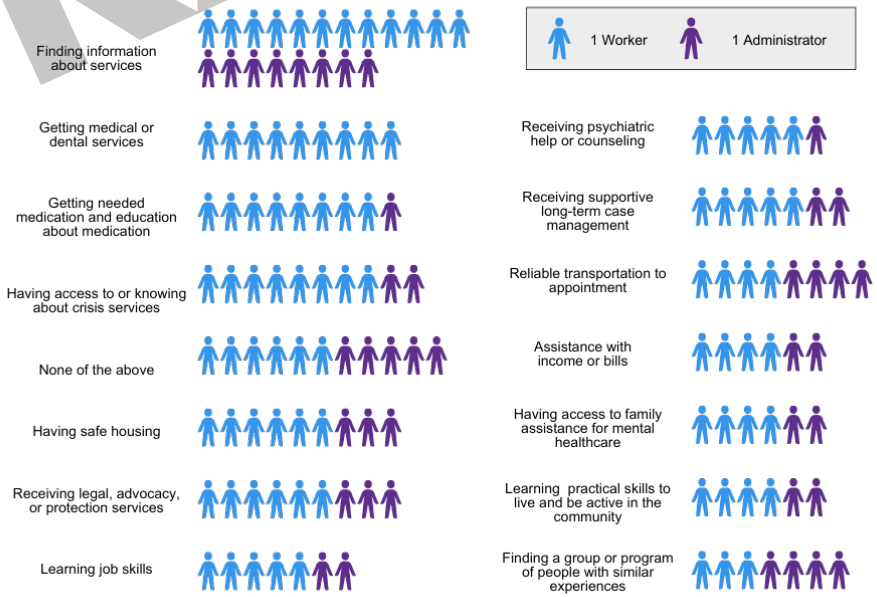


Mental Health Workers

Mental health workers were asked to select all services they believed were easily accessible. The top five answers selected were:

- Finding information about services, agencies, or organizations for services you need (31%)
- None of the above (17%)
- Having access to or knowing about crisis services (telephone services, walk-in services, residential services) (16%)
- Getting needed medication and education about medication (14%)
- Getting medical or dental services (14%)

As a mental health worker, what services are easy for clients to access in Winnebago County?



Mental health workers were asked to select all answer options that would increase the accessibility of services. The top five answers selected were:

- More providers (56%)
- Less waiting times (52%)
- More payment options (28%)
- More translation services (25%)
- Accessibility in my area (30%)

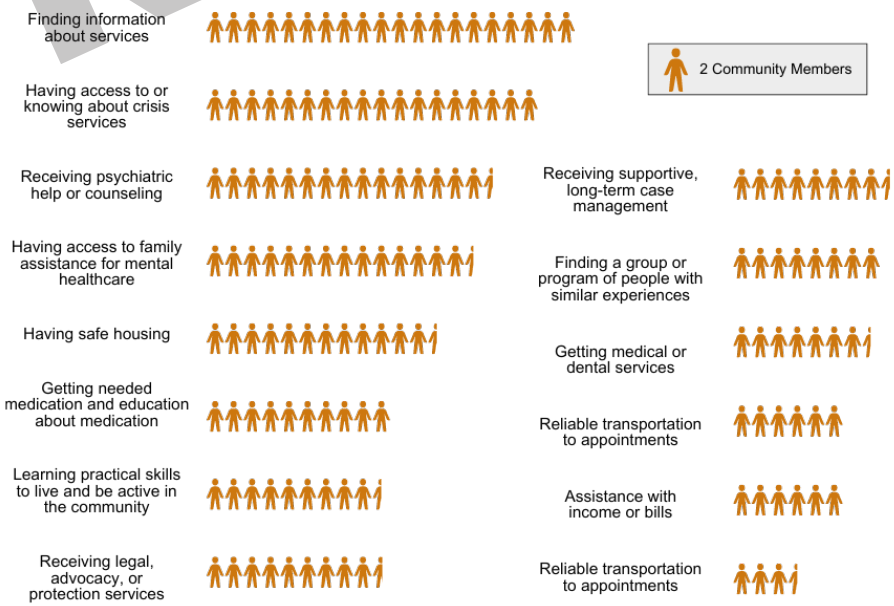
As a mental health worker, what do you think would increase access to mental health treatment in Winnebago County?

Community Members

Community members were asked to select all services they would like to learn more about. The top five answers selected were:

- Finding information about services, agencies, or organizations for services you need (33%)
- Having access to or knowing about crisis services (telephone services, walk-in services, residential services) (29%)
- Receiving psychiatric help or individual group counseling (25%)
- Having access to family assistance and education for mental health, counseling, or respite care (23%)
- Having safe housing (domestic violence shelters, homeless shelters, short-term housing, long-term housing) (20%)

Which of the following types of services would you like to learn more about?



Comparing the Perspectives of the PPS

To determine if there was a difference in perspectives, responses from those with lived experience and mental health workers were compared.

Services Used versus Easily Accessible

Some overlap exists between the services respondents with lived experience reported that they used, and the services that mental health workers reported were easily accessible. In no particular order, both groups selected the following services in response to their respective questions: "getting needed medication and education about medication", "getting medical or dental services", "finding information about services, agencies, or organizations for services you need", and "having access to or knowing about crisis services (telephone services, walk-in services, residential services)".

Needed but Unreceived Services versus Easily Accessible Services

Respondents with lived experience and mental health workers had one instance of differing responses regarding services respondents with lived experience needed but could not receive, and what services mental health workers reported was easily accessible. Respondents with lived experience reported "getting medical or dental services" as fourth in their top five services they needed but could not receive. Mental health workers ranked "getting medical or dental services" as fifth for services they reported were easily accessible.

Increase Service Access: Lived Experience versus Mental Health Workers

Both groups were asked to select what they believed would either help them receive services or what would increase the accessibility of services. Out of each group's top five answers, they shared four answers: "more providers", "less waiting times", "more payment options", and "accessibility in my area". These answers share a similar ranking, with "more providers" and "less waiting times" being the top two for both groups. The answer option "accessibility in my area" ranked third for respondents with lived experience and fourth for mental health workers. Respondents with lived experience ranked "better hours of service" as fifth, and mental health workers ranked "more translation services" as fourth. The answer "more translation services" may have appeared in the top five of mental health workers because they may work with individuals that speak a different language from them.

Perceived Gaps

The above answers were compared to the services agencies reported on in the second Environmental Scan (ES). The following are the top five answers individuals with lived experience reported they or someone in their household needed and could not receive, compared to the percent of agencies that report to provide a service that falls under each of the answers.

Services respondents reported that they or someone in their household needed		Percent of agencies that reported they provide this service	
37%	Receiving psychiatric help or individual/group counseling	51%	Diagnostic evaluation
		63%	Supportive counseling
20%	Assistance with income or bills	17%	Income support and entitlements
18%	Finding a group or program of people with similar experiences	32%	Self-help services
		15%	Consumer-operated services
17%	Getting medical or dental services	20%	Health and dental care
16%	Having access to family assistance and education for mental health, counseling or respite care	51%	Support and assistance to families
		56%	Support and education for the community

In the second ES, over 50% of agencies reported that they provide diagnostic evaluation, supportive counseling, support and assistance to families, and support and education for the community, while "receiving psychiatric help or individual group counseling" ranked 1st and "having access to family assistance and education for mental health, counseling, or respite care" ranked 5th as services respondents with lived experience needed but could not receive.

It is not possible to compare the responses from the PPS and the second ES on a 1-to-1 scale, so these services may be perceived as gaps by respondents with lived experience for reasons other than their actual availability. Agencies may wish to increase their promotion and awareness of services or investigate why these services may be inaccessible, whether that be due to transportation, affordability, or payment options provided to clients.

PPS Qualitative Data

Respondents could write in answers to multiple choice questions throughout the PPS, and provide any feedback, comments, or concerns at the end of the survey. The qualitative data received from respondents was analyzed and categorized for recurring themes that were identified throughout the data.

Lived Experience

Twenty-five respondents with lived experience selected "Other

- Write In" as their response to the "What would have helped you, or someone in your household, receive these services?" question in the PPS. Their answers were categorized under two major themes, accessibility and provider-focused. Accessibility here refers to availability and access, not disability accessibility.

Accessibility was the most common theme among individuals with lived experience, which can be broken down into two sub-themes, affordability and technology. When it comes to affordability, respondents reported they had a difficult time accessing services because services were not affordable. Individuals reported they did not qualify for Medicaid based on their income, even though they struggle to cover the cost of living. Others reported that there are not enough provider options that accept their insurance. As for technology, respondents said that telehealth or virtual appointments would increase their access to services. Respondents that had provider-focused answers reported that providers lack the services they need, there is a lack of diversity and options in providers, and access to services would increase if providers were more knowledgeable and followed up with clients.

Mental Health Workers

Eleven mental health workers selected "Other - Write In" as their response to the "As a mental health worker, what do you think would increase access to mental health treatment in Winnebago County?" question in the PPS. Their answers were categorized under three major themes, accessibility, provider-focused, and medically-focused.

Accessibility was the most common theme among responses, which can be broken down into two sub-themes, transportation and affordability. Respondents cited that an improved public transportation system would increase access to mental health treatment. As for affordability, respondents said an increase in service providers accepting Medicaid and more affordable services for those who do not qualify for Medicaid would increase access to mental health treatment. Provider-focused answers called for an increase in diversity in providers and collaboration among service providers. Medically-focused answers reported that clients need medical assistance for their mental health, such as medication distribution and services for medical needs for those with chronic mental illness.

PPS Feedback, Comments, or Concerns

At the end of the PPS, respondents could fill out with feedback, comments, or concerns. Three major themes were identified in the data from this section; accessibility to services, provider-focused, and specific populations.

Accessibility to Services

Accessibility to services was the most common theme in responses and can be broken down into four sub-themes; affordability, information, Medicaid and insurance, and wait times. Regarding affordability, respondents reported a lack of affordable services for low-income individuals and families. Respondents reported that there is a general lack of information about services in the areas and that respondents have received incorrect or outdated information about services. Respondents indicated that it is difficult to navigate the system without accurate information about services, and are unsure who they can contact. Respondents reported that they could not access care because few providers accept Medicaid or their insurance. Respondents reported that wait times were too long, having to wait for services for weeks or months for services. Some respondents experienced significant wait times because the provider they selected was the only one in the area or the only one that accepted Medicaid or their insurance.

Provider-Focused

Provider-focused answers can be broken down into two sub-themes; psychiatry and workforce. Respondents reported a lack of psychiatric services, as there are few options for them to choose from, and that there are not psychiatric services that meet their needs. There were eight instances in which respondents described the lack of providers and psychiatric services. There were nine instances in which respondents specifically reported the lack of child and youth psychiatric services. Respondents expressed concern over the workforce, citing high turn-over rates and fearing that the current workforce is overburdened, which may cause members of the workforce to leave the area. Respondents reported that the high turn-over rates force them to change services and experience high wait times.

Specific Populations

Respondents reported three specific populations that need increased services; children/youth, seniors, and unhoused people. Respondents reported a lack of services for children or youth, specifically mental health, psychiatric, and medical services. Three respondents reported that seniors are experiencing a lack of services for mental health, dental care, and medical care. Eight respondents specifically expressed concern for unhoused people; specifically that there is a need for housing services and mental health services specifically for this group.

OTHER COMMUNITY RESEARCH

OTHER COMMUNITY RESEARCH

Other Community Research

To learn more about the system of mental health in Winnebago County, this report includes other community health studies conducted within the past five years. Summaries of each are provided below with hyperlinks to access the full reports.

Community Needs Assessment, Community Action Agency, 2022

A Community Needs Assessment (CNA) is conducted every three years to collect information about housing, child care, employment, physical and mental health, education, food and nutrition, financial issues, and transportation. This data is used to identify services and strategies that will make a positive impact on individuals, families, and communities. Not only does this study use its own survey data, but also data from other local reports and studies.

Mental Health

Mental health can have many barriers to care, such as but not limited to, stigma, cost, availability, and lack of education. In Winnebago County, 88% reported stigma of mental illness in the community. From the CNA survey respondents, 38.4% reported they themselves or someone in their household needed help getting mental health treatment. Only 52% of Winnebago County residents stated they knew how to access treatment for a behavioral health disorder. Additionally, 44% of survey respondents reported seeking mental health, substance, or disability services and finding help, while 14% reported being unable to find help in Winnebago County.

Substance Use

From CNA survey respondents, 9.96% reported they or someone in their household needed help getting drug or alcohol treatment. In 2020, there were an estimated 18.60% of adults in Boone or Winnebago County drinking excessively. Excessive drinking is defined as more than two drinks a day on average for men and more than one for women. Out of 47 direct service agencies responding to a survey conducted in 2020 by WCCMHB, only eight reported that they offer substance use services, and only one reported having detoxification services. Additionally, there were only 24 detox beds reported available in Winnebago County.

Provider Shortages

At a rate of 167 healthcare providers per 100,000 people, Boone and Winnebago County both fall below State (at 230) and National (at 202.80) rates. Winnebago County is a Designated Low Income Population Primary Care Health Professional Shortage Area (Primary Care HPSA) while Boone County has three Census Tracts that are Low Income Population HPSA.[40]

Medical Care

There are nine federally qualified health centers (FQHC) in Winnebago County. An FQHC is defined as a community-based healthcare provider that receives funds from the Health Resources & Services Administration (HRSA) Health Center Program to provide primary care in underserved areas. These centers must provide care on a sliding fee scale based on the ability to pay and be governed by a board that includes patients.

Health Insurance

Lack of health insurance is a main reason that people are unable to access or receive health care. Being uninsured leads to less access to recommended care, poorer quality of care, and worse health outcomes. The percentage of uninsured residents in Winnebago County is 6.55%. Similarly, 35.28% of respondents needed assistance finding affordable health insurance. Additionally, 16.5% of the Winnebago County population is on Medicare, while 19.9% are on Medicaid.

Adverse Childhood Experiences

According to the Centers for Disease Control and Prevention (CDC), adverse childhood experiences (ACEs) are potentially traumatic events that occur in childhood, ages 0-17 years old. These include forms of abuse (physical, emotional, or sexual), neglect (physical or emotional), and household dysfunction (mental illness, a mother being treated violently, divorce, incarcerated relative, or substance use). ACEs are linked to chronic health problems, mental illness, and substance use problems in adulthood. ACEs have also been shown to negatively impact education attainment, job opportunities, and income potential. The rate of child abuse and neglect in Winnebago County is 19.80 per 1,000.

OTHER COMMUNITY RESEARCH

Food Assistance

There are three food assistance agencies in Winnebago County, 15 food pantries/soup kitchens, and over 20 full-service grocery stores.

Education Inequalities

The Rockford Public School District 205 (RPS 205) graduation rate is 64.4%. Comparing this to the state graduation rate of 86.8%, the RPS 205 graduation rate is significantly lower. The graduation rates of the public Rockford high schools are as follows: Auburn (57%), East (62%), Guilford (74%), and Jefferson (63%). Based on the locations of the high schools, it is evident the schools with more students living in poverty have lower graduation rates.

Early Development Instrument (EDI), 2019,2022

Alignment Rockford, Rockford Public School District 205, and Harlem School District 122 partnered with UCLA's Center for Healthier Children, Families, and Communities to conduct a community-wide evaluation of the developmental readiness of children entering Kindergarten. The EDI is a validated and population-based measure of Rockford and Loves Park. The five domains measured are: physical health and well-being, emotional maturity, social competence, language and cognitive skills, and communication skills and general knowledge.

The future well-being and academic achievement of an individual are dependent on the first five years of human development. This time period influences a child's ability to succeed and learn over their entire life. Disadvantages at this age can multiply over time and contribute to social disparities. The EDI measures the well-being of the youngest and most vulnerable residents. To do this, they collected assessments of more than 2,000 public and private kindergarten students as well as neighborhood data. On top of the five measured domains, the EDI includes other indicators and community assets like household income, rate of domestic violence, childcare centers, and more.

The EDI can help communities identify areas of strengths and areas of opportunity across a geographic area. The data can be used to aid schools, municipalities, service providers, and other stakeholders in where to allocate effects and resources. Two waves of EDI data have been collected on kindergarten students. Wave 1 was conducted pre-COVID in 2019, while Wave 2 was collected post-COVID in 2022.

Below are the summarized results of the Early Development Instrument.

Domains Definitions[41]

A child is considered vulnerable if he or she scores in the lowest 10th percentile of the national sample.

Physical Health and Well-Being

This domain measures motor development, energy levels, preparedness for the school day, and restroom independence. Example considerations for this domain include things like if the child can hold a pencil or if they are able to manipulate other objects.

Social Competence

This domain measures behavior in structured environments, such as cooperation, respect for others, and socially responsible behaviors. Example questions in this domain include "Is the child able to follow class routine?" or "Is the child self-confident?"

Emotional Maturity

This domain measures behavior in less formal environments and focuses on helping others, tolerance, and demonstrating empathy. Example contemplations are "Does the child comfort a child who is crying or upset?" or "Does the child help clean up a mess?"

Language and Cognitive Development

This domain measures a child's interest in books, reading, language skills, literacy, and math-related activities. Example considerations are if the child is reading and writing and if the child can count and recognize numbers.

Communication Skills and General Knowledge

This domain measures a child's ability to communicate their own needs, participate in storytelling, and general interest in the world. Example questions are "Can the child tell a story?" or "Can the child communicate with adults and children?"

Summary of Findings[42]

Child well-being improved in four of the five developmental domains. Developmental vulnerability improvements are indicated by a reduction in percentages. Each domain changed as follows:

- Physical Health and Well-Being vulnerability decreased by 3% (from 17% to 14%).

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- Emotional Maturity vulnerability decreased by 2% (from 14% to 12%).
- Language and Cognitive vulnerability decreased by 1% (from 20% to 19%).
- Communication Skills and General Knowledge vulnerability decreased by 2% (from 13% to 11%).
- Social Competence vulnerability increased by 1% (from 13% to 12%)

The overall composite measure (children vulnerable on one or more domains) increased by 1% (from 34% to 35%). The following paragraph references "critical differences," which is a threshold that aims to elevate the complexities and uncertainties in population-level data and indicate more confidence. This is designed to be used as a guide for local stakeholders.

Thirty of the 51 neighborhoods saw a worsening trend from Wave 1 to Wave 2 on the composite measure and 11 of these met the critical difference threshold. More specifically, 30 neighborhoods saw worsening trends. Oppositely, 20 neighborhoods saw improvement on the composite measure, with three neighborhoods meeting the critical difference threshold. A cluster of neighborhoods that saw the critical increase in vulnerable children were along US Highway 20 and included the neighborhoods of Rolling Green East, Sandy Hollow, Swanson Park, and Atwork. Neighborhoods that saw a decrease in vulnerable children include Brendenwood and Forest Hills.

	Wave 1	Wave 2
% of children vulnerable in only one domain	14%	18%
% of children vulnerable in two to five domains	20%	17%
% of children vulnerable on one or more domains	34%	35%

Healthy Community Study, 2020

The Rockford Regional Health Council conducts a Healthy Community Study every three years as a part of their community health needs assessment, which informs the community health improvement plans of local healthcare systems. This survey includes both Boone and Winnebago County, as well as other open-source data.

The following paragraphs are the summarized results of the Healthy Community Study 2020.

Mental Health

Access to mental health providers is much lower in Winnebago County (167 providers / 100,000 residents) than in Illinois (230/100,000) or the US (202/100,000). The percentage of people on Medicare who experience depression in Winnebago County (17.9%) matches that of the US (17.9%) but is higher than the state (16.9%). This percentage is rising steadily. Suicide rates in Winnebago County are also rising. The rate for the County (13.6%) is higher than Illinois (10.3%) but almost the same as the US (13.4%).

About 60% of survey respondents answered the behavioral and mental health questions. About a quarter (27%) of survey respondents reported having at least one mental illness or behavioral health issue. The highest reported mental health diagnoses included anxiety (19%), depression (17%), PTSD (7%), ADHD (6%), and bipolar disorder (6%). Some mental health barriers for minorities include language, stigma, insurance, lack of diversity in providers, lack of trust in the healthcare system, and more.

Substance Use

Alcohol consumption metrics continue to trend positively both for expenditures and excessive drinking. Excessive alcohol consumption in Winnebago County (17.9% of the population) is lower than the state average (20.4%) but higher than the US percent (16.9%). Slightly more than half (53%) of adults in the region are current drinkers (drank at least one alcoholic beverage in the past month), and 42% are non-drinkers (drank no alcoholic beverages in the past month). The percentage of adults in the region who are current drinkers is more favorable than the state rate (61%) and is similar to the national rate (56%). The adults in the region who are more likely to be current drinkers (although high rates of "prefer not to respond" or skipping the question were high, especially for Black respondents) are: male; White or Hispanic; higher-income; more educated.

Drug overdoses have risen sharply since 2012, with the rate in Winnebago County being (32.4 deaths / 100,000 residents) more than double that of the state (14.1/100,000) or the US (15.6/100,000). The percentage of adults in the region that report using drugs is around 27%, consistent with the state rate. Women reported more frequently than men that they used prescription opioids and withdrawal relieving products. Men reported more heroin use. Adults over 65 and those with incomes less than $25,000 were more likely to have used narcotics every day in the

past month (both at rates of 8%). Black respondents were more likely to have used barbiturates and marijuana. White respondents were more likely to have used cocaine or amphetamines and much more likely to have used heroin.

Healthy Community Study, 2023

Below are the summarized results of the 2023 Healthy Community Study.

Mental Healthcare Access

Respondents were asked if they were able to receive mental health care. Of those that indicated this question was relevant to them, 67.7% reported they could always get care, 19.4% reported they could sometimes get care, and 12.9% reported that they could not get care.

Core Health and Health Literacy

Respondents were asked if they had difficulty understanding medical information given to them by medical professionals. Most respondents (78.7%) reported that they did not have difficulty understanding medical information given to them by a medical professional, 13.1% reported that they sometimes had difficulty understanding, and 8.2% reported that they did have difficulty understanding.

When it came to trusting medical advice and information from medical professionals, 65.2% reported that they did trust the advice and information they received, 28.3% reported they sometimes trusted the advice and information they received, and 6.6% said they did not trust the advice and information they received.

Substance Use

Most respondents reported they do not use tobacco products, but those that did reported using cigarettes, cigars, cigarillos, or any other tobacco product (17%), followed by electronic vaping products (8.6%) and smokeless tobacco (5.7%).

Nearly 80% of survey respondents reported drinking at some level throughout the month, while 21.7% reported having a drink containing alcohol two or more times a week.

The majority (77.6%) of respondents reported that they had never used non-medical marijuana. Of those that did report that they had used non-medical marijuana, 63.4% reported that at least one person in their household had a mental illness, and 80.5% reported that at least one person in their household had a chronic condition. Respondents that reported non-medical marijuana use were more likely to rate their health as fair (30.9%) or poor (10.6%).

The HCS asked respondents about other drug use, with the most frequently reported class being cocaine or crack (3%), followed by LSD or hallucinogens (3%); amphetamines and opioids (2%); and tranquilizers, meth, MDMA, and/or barbiturates each at 1%.

Behavioral and Mental Health

Respondents were asked if they or anyone in their household had been told by a medical or mental health professional if they had any behavioral or mental health issues. Most (60%) selected "none of the above." Anxiety was the most frequent mental health condition reported by respondents, especially those in the 18-44 age group.

Cross-Cutting Themes

Association between Health Behavior and Health Status

There appeared to be a correlation between health behavior and reported health status, despite most people reporting their health as fair or good. Typically, individuals with more "healthy" health behaviors were more likely to rate their health as better than individuals with "unhealthy" health behaviors.

Association between Health Status and Health Literacy

An individual's health status appeared to show a correlation with their ability to understand medical information as well as trust in medical providers. Individuals who reported having issues understanding medical information were most likely to rate their health as fair or poor, while individuals who had no issues understanding medical information were most likely to rate their health as good. Additionally, those who trusted providers were more likely to have no issues understanding medical information as compared to those who did not trust medical providers.

Association between Food and Health Care Access and Location

Zip codes located more geographically central to the Rockford MSA appeared to have greater food and health care access.

Physical and Mental Health Morbidity Trends

The frequency of most physical health morbidities rose as respondent age increased. However, most mental health

morbidities peaked in the 18-44 age cohort, which is consistent with most research.

Winnebago County Health Department Illinois Project for Local Assessment of Needs (IPLAN), 2021-2023

The Illinois Project for Local Assessment of Needs (IPLAN) is required by the Illinois Department of Public Health (IDPH) in order to obtain certification to grant local agencies the authority to enforce public health codes, ordinances, and laws. The IPLAN includes the Community Health Improvement Plan (CHIP) as well as the Mobilizing for Action through Planning and Partnerships (MAPP). The MAPP process identified the 2021-2023 Health Priorities as maternal and child health, mental and behavioral health, and violence prevention.

The IPLAN consists of six phases followed by the CHIP: (1) organizing for success, (2) visioning, (3) four MAPP assessments, (4) identify strategic issues, (5) formulate goals and strategies, and (6) action cycle. The four MAPP assessments include the: Community Health Status Assessment (CHSA), Forces of Change Assessment (FOCA), Local Public Health System Assessment (LPHSA), and Community Themes and Strengths.

Below is an analysis of the IPLAN.

MAPP Assessments

The CHSA identifies community health and quality of life issues that are a priority to residents. This uses open source data to create a basis of awareness and knowledge in the community The FOCA examines forces like legislation, technology, social issues, and more to determine how the community and the public health system operate. The FOCA identified a lack of mental health resources as a critical concern. Disparities across services and programs is another point of concern, as well as an unequal impact on communities with the legalization of marijuana. Organizations and entities that contribute to the public's health are analyzed in the LPHSA. Areas of improvement identified are improving laws, assuring personal health linkages, and evaluation of the local public health system. Resident issues and concerns are assessed from the Community Themes and Strengths assessment. Across survey questions, there was a perception of disparity among race in terms of access, quality, healthcare options, and perceptions of care. The surveys also indicated a negative correlation between the level of education and health outcomes.

Maternal and Child Health

The average infant mortality rate rose to 7.0 from 2013 -2017 from 6.5 in 2010-2014. The infant mortality rate varies greatly across race/ethnicity, at 5.0 for White populations, 13.0 for Black or African American populations, and 4.0 for Hispanic populations. Low birthweight for infants also increased from 8.7% to 9.9% in 2018. Additionally, the severe maternal morbidity is 40.5/10,000. The FOCA identified concerns surrounding geographic disparities relative to access of care, resource allocation by health systems in an "east/west" divide with the Rock River as a point of reference, transportation challenges, and changes in family structure.

Mental and Behavioral Health

There were 280 drug-related emergency room (ER) visits and 2,480 hospitalizations for non-medical drug abuse in Winnebago County in 2014. In 2018, there were 149 deaths due to any drug and 129 were due to any opioid. There were 1,439 alcohol-related emergency room visits, with individuals aged 45-54 as the highest demographic of alcohol related ER visits.

Violence Prevention

Mortality rates for alcohol-impaired driving deaths, injury mortality, and the homicide rate are higher in Winnebago County than the State of Illinois.

Youth Mental Health Systems of Care (YMHSoC), 2022

The Youth Mental Health System of Care (YMHSoC) team is a collective of partners in Northern Illinois that creates awareness, structure, and action around youth mental health. The YMHSoC conducted an online survey of 118 individuals about the lived experience of youth and their interactions with mental health supports in order to gain a better understanding of the mental health system for youth in the region. Respondents were individuals who were a parent, family member, caretaker, youth or former youth who used or needed mental healthcare.

Respondents indicated numerous mental health treatment needs are not being met in the region. Psychiatric access and mental health therapy were expressed as two of the top needs of the region. Additionally, respondents indicated that services were difficult to access, lacked affordable options, had long wait times, and a scarcity of Spanish-speaking counselors. A lack of services for children was also expressed and a need to amplify children's voices. Services and resources for students and children

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with ADHD and autism are also an area of need. Finally, youth indicated that there needs to be more consideration when it is appropriate to maintain a youth's mental health care between them and their provider, and when to involve family members in a youth's mental healthcare.

Respondents indicated that they take many considerations when selecting a provider. Overall, respondents consider the qualifications of the provider; if the respondent's input will be considered; how far away services are or if they are virtual; the ease of scheduling appointments; and the intake process.

Youth Mental Health Systems of Care (YMHSoC), 2019

In 2019, the YMHSoC Community Planning Team worked with the Center for Governmental Studies (CGS) at Northern Illinois University to conduct a key informant survey about the community's children's mental healthcare system, including strengths and areas for improvement. An online survey was sent to 161 key informants, and 51 completed the survey, resulting in a 33% response rate. The key informants represented a variety of organizations, including mental health and substance use agencies, private counseling practices, hospitals, county health departments, social service agencies, government agencies, police departments, fire departments, and schools. Below are the summarized results of the Youth Mental Health System of Care 2019.

Funding

Lack of funding is mentioned as a barrier across all the areas of improvement.

Workforce Development

There is a shortage of service providers in the region, especially child psychiatrists. It is difficult to recruit service providers to the Rockford area, and wages are low and stagnant. There are high rates of staff burnout and turnover among existing staff leading to a lack of consistency for patients. Existing staff need additional training, including crisis intervention and trauma-informed training.

Access

Services are hard to access due to long waitlists. Additionally, services currently available in the Rockford area are not affordable or accessible to all residents, especially low-income residents, Latinos, and African Americans. There is a need for more Spanish-speaking service providers and interpreters. Transportation and locations of current service providers are barriers to access to services. Additionally, more home-based services are needed.

Collaboration

To improve the current children's mental healthcare system, greater collaboration and coordination among organizations is needed. Silos exist between the organizations and there is a lack of communication between organizations about what each is doing. Currently, children must go out of town to receive inpatient mental health treatment, which makes a regional inpatient child unit a necessity. To address this need, collaboration among the health systems is recommended. The schools do not have the support or resources needed for the number of Rockford children with emotional or behavioral problems. Partnerships between the schools and agencies can help address this issue.

Engagement

It is essential to engage and educate the community about children's mental health and mental healthcare services available in the Rockford area. In particular, engaging and educating parents of children is essential. However, cultural barriers get in the way of accomplishing this.

GOAL, SUB-GOALS, OBJECTIVES AND STRATEGIES

KEY IMPLEMENTATION

GOAL, SUB-GOAL, OBJECTIVES AND STRATEGIES

Goal, Sub-Goals, Objectives, and Strategies

The Process of Determination

In order to formulate the objective and strategies in this plan, a rigorous research process and accompanying data analyses were performed.

This process began with a review and analysis of community research conducted within the past five years. Following this, WCCMHB conducted an Environmental Scan (ES) of agencies and other entities in Winnebago County and performed an analysis of the data collected. After this survey was completed, WCCMHB put out the Public Participation Plan (PPS) that surveyed the public about the mental health system of care in Winnebago County.

Based on research and data analysis performed, objectives and strategies were determined for each major component of the CSS-programmatic, systems coordination, and promotion and awareness. For each of the sub-goals, measures of success were also determined in order to track progress and define what success in each of these areas would look like.

On June 15th, 2023 WCCMHB met to review their previously set vision, mission, values, principals outcomes, and direction. Feedback provided by board members was taken into consideration and added to the plan.

Goal

The primary goal for the Winnebago County Community Mental Health Board is to develop and maintain a Community Support System for Winnebago County.

GOAL, SUB-GOAL, OBJECTIVES AND STRATEGIES

Sub-Goal 1: Programming

The purpose of the Programming sub-goal is to support the functions of WCCMHB as well as the larger community of mental health and substance use system of care in Winnebago County. This is accomplished through four main objectives: targeting and filling gaps in the Community Support System, funding mental health and substance use programs in Winnebago County, assisting WCCMHB funded programs, and evaluating both internal and external systems of mental health care.

Sub-Goal 1: Programming			
	Objectives	Strategies	Measures of Success
1.1	**Targeting and Filling Gaps** Convening consumers and key stakeholder to identity gaps within the Community Support System.	A. Conduct community research that encompasses both lived and professional experiences. B. Identifying population and service needs lacking in Winnebago County.	• Annual evaluation of Winnebago County mental health and substance use gaps and strengths. • Three Board Members review and score grant applications to strategically fill identified gaps. • Increase the percentage of programs who successfully complete all intended outcomes for the program year. • 100% of programs report on intended outcomes. • 100% of agencies have been assessed and assigned a tiered level of support and accountability. • 100% of organizations participate in a site visit. • All renewal program funding based on past evaluation data. • 100% of organizations utilize previous program year performance data to inform future program programming.
1.2	**Funding** WCCMHB members have a duty to be fiscally responsible and accountable to taxpayers through the strategic identification of programs need to address services or systems needs in the community.	A. WCCMHB members review and evaluate submitted and completed grant applications. B. WCCMHB members vote and approve funding decisions to organizations. C. Review and evaluate monthly financial submissions from funded organizations consistent with an expenditure based funding policy.	
1.3	**Grant Management** Provide support and guidance to programs seeking or receiving WCCMHB funding.	A. Create a multi-tiered system of support and accountability for funded programs. B. Maintain a Learning Network Collaborative encompassing leadership of funded programs to increase community knowledge and sharing of resources. C. Attend annual site visits to observe funded programs and discuss programming.	
1.4	**Evaluation** Determine the efficacy individual programs have on overall systems change within Winnebago County.	A. Collect program specific data regarding target populations and measurable outcomes. B. Measure the efficacy and impact of individual funded programs. C. Determine the efficacy individual programs have on overall change within the Community Support System.	

Sub-Goal 2: Systems Coordination

Systems coordination is the effort to bring stakeholders together to prioritize issues and outline systemic approaches to resolve them. The purpose of this sub-goal is to propose strategies that promote community collaboration across mental health service-providing organizations in order to eliminate barriers to care and increase service availability for all community members.

Sub-Goal 2: Systems Coordination			
	Objectives	Strategies	Measures of Success
2.1	**Access** Identify and improve the structural barriers to accessing mental health services.	A. Increase resources for limited English proficiency (LEP) individuals who need mental health or substance use services. B. Increase availability of navigable and consistent transportation for clients to travel to and from mental health and substance use services. C. Ensuring the affordability of mental health services	• Increase the percentage of mental health organizations that provide translation and interpretation services and the number of languages in which interpretation is provided. • Increase the percentage of residents who feel services are able to be reached in their area. • 100% of funded organizations do not turn-away residents based on ability to pay. • Referral platform utilized by all funded agencies. • Three career pathways exist for entrance into mental health careers. • 100% funded programs utilize cultural competency practices. • Increase the number of CRSS/PRSS credentials achieved from local program enrollment.
2.2	**Collaboration and Support** Improve network cohesion and coordination of services among funded programs.	A. Promote development of referral system(s) for mental health and substance use services and resources for patients to seamlessly transition from one service to another. B. Invest in a resource sharing platform to ensure all funded programs have access to evidence based literature, practice guides, training, etc. C. Ensure the quality of local services through promotion of accreditation providers and programs. D. Improve and maintain working relationships with local and state government officials. E. Be aware of new policies and their implications on local services.	
2.3	**Diversity, Equity, and Inclusion** Promote cultural competence and cultural humility practices in the mental health system of care.	A. Host and/or attend mental health fairs to educate and reframe community members' understanding of mental health and substance use services and keep them engaged and informed about treatment options. B. Pursue organizational cultural competence and humility in both WCCMHB and funded programs.	
2.4	**Workforce Development** Develop and retain an informed and robust mental health workforce.	A. Develop a career pathway for entrance into the social work field. B. Develop a career pathway for entrance into Certified Recovery Support Specialist (CRSS) / Peer Recovery Support Specialist (PRSS) credentialing. C. Develop a career pathway for entrance into medication prescribing licensures. D. Support retention of mental health workforce in Winnebago County.	

Sub-Goal 3: Promotion and Awareness

The WCCMHB aims to help the community become knowledgeable about mental health and have access to high-quality mental health and substance abuse services when and where they need them. A major function of the WCCMHB is "Promotion and Awareness," which includes access, awareness, and promotion of mental health and mental health services. In order to coordinate the strategies included in promotion and awareness, a communications working group was created. The function of the Communications Working Group (CWG) is to increase community and resident awareness about mental health and access to mental health services when needed. The working group aims to bring greater awareness to the Winnebago County Residents about mental health, specifically demonstrating the impacts of the programs funded by the WCCMHB 1/2 cent sales tax. The CWG will help to identify a core team of members from partner agencies. This team will support the development of the mental health fair and promote participation by funded agencies. The group will also work to create a toolkit/key messaging for a communications strategy to highlight the benefits to the community of the half cent sales tax.

Sub-Goal 3: Promotion and Awareness			
	Objectives	Strategies	Measures of Success
3.1	**Access** Ensuring that target populations (individuals and families) know how and where to access mental health services (including the funded programs).	A. Funded programs create quarterly social media posts to promote their program. B. Funded programs participate in the annual mental health resource fair. C. Funded programs promote programs through community referral systems (including resource guides, websites, and technology platforms).	• Increase the percentage of programs meeting the contract requirements. • Increase the percentage of programs' participation at the WCCMHB resource fair. • Increasing the number of attendees at events. • Increasing the number of events present at. • Resident survey showing increased awareness of WCCMHB and the funded programs. • Increase the social media analytic numbers for engagement. • Increase the number of website visits/clicks/etc. • Increase the number of handouts passed out. • Increase the number of Impact Reports handed out and/or viewed on the website.
3.2	**Awareness** Increasing overall community member awareness of the Community Support System and the funding strategies of the mental health board.	A. WCCMHB develops a toolkit for funded programs to promote cohesive messaging about CSS, funding strategies, and funded programs. B. Funded programs utilize toolkit to provide cohesive messaging in order to bring awareness to CSS, funding strategies, and funded programs. C. WCCMHB annual program handout and website highlights CSS, funding strategies, and funded programs. D. WCCMHB promotes CSS, funding strategies, and funded programs through multi-media strategies including social media, news media, and other communications methods. E. WCCMHB participates in community events to increase awareness of CSS, funding strategies, and funded programs.	
3.3	**Promotion** Community members know the impact of the funded programs.	A. WCCMHB Impact Report published annually featuring quantitative and qualitative program results. B. WCCMHB Annual Report published to show funding utilization. C. Funded programs record by video an annual impact presentation highlighting program outcomes. D. Programs share highlights of annual impact presentations and report with their stakeholders in various means.	

KEY IMPLEMENTATION ACTIVITIES

Key Implementation Activities

To make this plan actionable, certain strategies were selected to prioritize over the next three years. Key implementation activities were selected to emphasize the WCCMHB desired direction throughout the Strategic Planning process. Activities are listed in the table below.

	Action Description	Measures of Success
1.1B	Identifying population and service needs lacking in Winnebago County.	Annual evaluation of Winnebago County mental health and substance use gaps and strengths.
1.2B	WCCMHB members vote and approve funding decisions to organizations.	Three Board Members review and score grant applications to strategically fill identified gaps.
1.3A	Create a multi-tiered system of support and accountability for funded programs.	Increase the percentage of programs who successfully complete all intended outcomes for the program year.
1.4C	Determine the efficacy individual programs have on overall change within the Community Support System.	100% of organizations utilize previous program year performance data to inform future program programming.
2.1A	Increase resources for limited English proficiency (LEP) individuals who need mental health or substance use services.	Increase the percentage of mental health organizations that provide translation and interpretation services and the number of languages in which interpretation is provided.
2.2A	Promote development of referral system(s) for mental health and substance use services and resources for patients to seamlessly transition from one service to another.	Referral platform utilized by all funded agencies.
2.3B	Pursue organizational cultural competence and humility in both WCCMHB and funded programs.	100% funded programs utilize cultural competency practices.
2.4B	Develop a career pathway for entrance into Certified Recovery Support Specialist (CRSS)/Peer Recovery Support Specialist (PRSS) credentialing.	Increase the number of CRSS/PRSS credentials achieved from local program enrollment.
3.1B	Funded programs participate in the annual mental health resource fair.	Increase the percentage of programs' participation at the WCCMHB resource fair.
3.2B	Funded programs utilize toolkit to provide cohesive messaging in order to bring awareness to CSS, funding strategies, and funded programs.	Increase the percentage of programs meeting the contract requirements.
3.3A	WCCMHB Impact Report published annually featuring quantitative and qualitative program results.	Increase the number of Impact Reports handed out and/or viewed on the website.

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