WCCMHB

Winnebago County Community Mental Health Board

STRATEGIC PLAN 2022-2024

Updated Version November 2021

CONTACT INFORMATION

Prepared by **Region 1 Planning Council**

Jason Holcomb
Director of Community Impact

Chelsey Glatz
Community Impact Planner

Kristen Hayden
Health Equity Associate

Lauren Brun
Community Health Assistant

WCCMHB
Winnebago County
Community Mental
Health Board

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

For requests for accommodations, contact
Jason Holcomb, Director of Community Impact at **Region 1 Planning Council**
Email: jholcomb@r1planning.org
Phone: (815) 277-1022

Email: **info@mentalhealth.wincoil.us**

Website: **r1planning.org/wccmhb**

Email Sign Up: **MailChimp**

Facebook

@wccmh

YouTube

Winnebago County Community Mental Health Board

Instagram

@wccmhb

TABLE OF CONTENTS

BOARD MEMBERS

Mary Ann Abate, President

Mary Ann Abate is currently serving as the President of the Winnebago County Community Mental Health Board. She is a Licensed Social Worker in Illinois and received her MS in Community Mental Health from Southern New Hampshire University with an emphasis in clinical services for individuals with co-occurring disorders of substance abuse and psychiatric disabilities. Prior to her retirement, she started 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 serving as the Vice President for the Winnebago County Community Mental Health Board. He previously served as the director of the Singer Mental Health and Developmental Center for 11 years, and before that was the Assistant Regional Administrator for Mental Health Programs from 1971 to 1987. He has served on the board of NAMI and the Mental Health Association of Rock River Valley and chaired the Mayor's Homeless Task Force for 18 years.

Dr. Reverend K. Edward Copeland, Treasurer

Dr. Reverend K. Edward Copeland is currently serving as the treasurer for the Winnebago County Community Mental Health Board. He is the lead pastor at New Zion Baptist Church and author of Riding in the Second Chariot. Dr. Reverend K. Edward Copeland received his JD from UC Berkeley in 1987 and is extremely dedicated to improving the city's educational system.

Danielle Angileri, Secretary

Danielle Angileri is currently the secretary for the Winnebago County Community Mental Health Board. She is the Executive Director for the National Alliance of Mental Illness (NAMI) of Northern Illinois. She works to provide support, respite, and rest through extracurricular activities for people experiencing mental illnesses and increasing their access to care. She received her Bachelors in Psychology from the University of Wisconsin - Milwaukee and is an advocate of mental health awareness.

Dr. Terry Giardini

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

Dr. Bill Gorski

Before completing his residency at the Illinois College of Medicine, Dr. Bill Gorski graduated from Kenyon College and the University of Cincinnati Medical School. During his 21 years practicing family medicine at a Swedish American 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.

Timothy Nabors

Timothy Nabors received degrees from the Rock Valley College and the Worsham College of Mortuary Science. He serves as the Funeral Director at the 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 an Engagement Officer at Rockford University. Her career includes past roles as a stay-at-home parent, a marketing and communications professional, and a grantmaker for two multi-million dollar companies. She 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 basic human right.

Wendy Larson-Bennett, Advisor

Wendy Larson-Bennett serves as an advisor for 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. Wendy 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 her retirement, Wendy was a prosecutor in Winnebago County and fiercely advocates for childhood mental health and trauma-informed practice. She wants to ensure that our community members have access to the tools necessary to achieve mental wellness.

Jay Ware, Advisor

Jay Ware serves as an advisor for the Winnebago County Community Mental Health Board and is a current member of the NAACP of Rockford. He is a community activist and retired from Woodward Governor. Jay is a passionate advocate for mental health.

ABOUT

WCCMHB

ABOUT WCCMHB

Community Mental Health Boards were born out of the deinstitutionalization movement of the 1950s and 1960s. After state and national hospitals for people with mental illnesses were closed down in the 1950s due to reports of the poor conditions inside, a new method of mental health programming was needed. Boards were envisioned to develop and coordinate local mental health systems of care that could provide an array of services needed for individuals with mental illness to live in their community, rather than in institutions. Due to funding issues and varied programming from state to state, this did not necessarily translate into the community-centered, comprehensive healthcare as originally imagined.

Community Mental Health Boards are now more ubiquitous across different communities and provide a range of services and funding opportunities aiming to increase the quality and availability of services in communities and provide frameworks to keep those struggling with mental health or substance abuse independent. In the State of Illinois, the Community Mental Health Act (405 ILCS 20) was established in 1967, providing local municipalities the authority to establish Community Mental Health Boards and laying out the responsibilities of such boards. To date, there are more than 40 community mental health boards throughout the State of Illinois (Association of Community Mental Health Authorities of Illinois, 2020).

Prior to the establishment of the Winnebago County Community Mental Health Board (WCCMHB), Winnebago County was the largest county in the State of Illinois that did not have a Community Mental Health Board. WCCMHB was established by Winnebago County Resolution 19-128, with seven inaugural board members unanimously approved on February 27th, 2020, and two-at large appointments approved on March 12th, 2020. The mental health board additionally appointed two non-voting advisors. The Winnebago County Community Mental Health Board (WCCMHB) exists to improve community mental services in Winnebago County through planning, grantmaking, communications, coordination, and evaluation. Upon formation, the board crafted a vision, mission statement, core values, and operating principles to guide its work.

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 wellbeing of our community.

1/2 Cent Sales Tax

Winnebago County residents approved a ½ cent sales tax in March of 2020 with 62 percent of voters supporting the new tax. The tax is set to sunset in six years and is estimated to generate around $13 million per year to support mental health efforts in Winnebago County. Prior to this tax, there was no local funding for mental health support despite an estimated 20 percent of residents in the county meeting criteria for mental health diagnoses, affecting 40-50 percent of families. In fact, Winnebago County was the largest county in Illinois with no local funding for mental health care. The Winnebago County Mental Health Board oversees the mental health tax fund and administers funding according to a strategic plan to develop, improve, and maintain critical services in the county.

Purpose of a Plan

The Association of Community Mental Health Authorities (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 needs of the community on a continuous basis, inviting input from consumer and families, strategic planning, coordinating funding, and evaluating results (ACMHAI, 2020). WCCMHB has researched and adopted best practices in each of these areas.

WCCMHB will use the strategic plan to guide funding and evaluation of success according to the intended outcomes and measures defined in the plan. The results of the strategic plan will assist WCCMHB in determining which service areas in Winnebago County are the highest priority and most strategic to improve, for the purpose of building a robust system of mental health and substance abuse services in Winnebago County.

PLANNING

PROCESS

Planning Process

In order to gain a greater depth of understanding about mental health issues in our community and to prioritize them, WCCMHB issued Environmental Scan and Public Participation surveys to evaluate prevalent issues that the board should address in the three-year strategic plan. This information was used to define strategic issues, prioritize service areas, establish improvement goals, and define intended outcomes for success. Following best-practices in strategic planning, the board laid out a framework to guide the strategic planning process.

Environmental Scan – Scan of strengths, weaknesses, and trends that impact the local mental health service delivery system, both internal and external to the system. This was done through survey and review of other community researched to mental health.

Data Synthesis – Use of analytical tools to obtain a quantitative and qualitative understanding of the data that was collected in the environmental scan. Results of surveys were evaluated according to service areas within the Community Support System framework, and SWOT analysis was used for a comprehensive review of both internal and external factors.

Environmental Scan

Data Synthesis

Strategic Issues

Priorities

Goals

Intended Outcomes

Planning Process Continued

Strategic Issues - Framing critical issues that must be addressed in order to develop a comprehensive system of care for mental health in Winnebago County. Framing the issues has a powerful impact on how priorities and goals are formulated. For the purposes of this plan, the Community Support System framework was used to frame issues.

Priorities - Methodically weighing a decision based on its importance to establish priority areas that will be the focus of funding. Priorities were largely established on the basis of weighing the different perspectives of residents of Winnebago County living with mental illness and/or substance abuse disorders, family members of individuals living with mental illness and/or substance abuse disorders, direct service-providers working with individuals who have mental illness and/or substance abuse disorders, administrators of agencies providing mental health and substance abuse services, and community members.

Goals - Defining the types of improvements that are being sought within each priority area. This includes outlining specific service areas, defining target populations, and establishing intended outcomes for each priority. This part of the process specifically analyzed the community survey responses related to desired improvements within priority service areas.

Intended Outcomes - Within each goal, intended outcomes can further be broken down into metrics, measures, benchmarks, and targets. Metrics are high-level categories, such as poverty rate, which incorporates a number of measures (income, family size, etc.). Measures are unit-specific, such as income, family size -- or more specific to this plan, number of psychiatrists, number of clients served, etc. Metrics can be made-up of multiple measures, such as in the poverty rate example. Benchmarks can be the current status of a measure or a comparison being made to a peer, often used for new programming when there is no local benchmark. Targets are improvement goals for a specific measure, for example, increasing the number of clients served from 10 per month to 20 per month, the former of which would be the benchmark and the latter of which would be the target. Many of the intended outcomes are defined in this plan, while others will be proposed by organizations in their program proposals.

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

Health and Dental Services

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

Housing
- Supportive Housing
- Residential Assistance for
- Homeless Mentally Ill Persons

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

Community Support System Framework

As noted in the introduction, 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 the Community Support Program research that dates back to 1977, linked with the community mental health and deinstitutionalization movement. The CSS framework provides a framework for municipalities to use in comprehensive, community-based mental health systems planning. The components of CSS represent the *array of services and opportunities that an adequate service system should include* for the target population, all to be provided in the community.

As such, this model was adopted by WCCMHB and was used as a map to guide the planning process, from the environmental scan and public participation survey to the data synthesis, framing strategic issues, the establishment of priorities, and development of goals and intended outcomes. For each priority area, represented in the visual as a "spoke" in the wheel, there are corresponding service areas.

For example, the "Treatment" priority area includes the service areas of Diagnostic Evaluation, Supportive Counseling, Medication Management, and Substance Abuse Treatment.

The priority areas and their included service areas are shown with the corresponding color based on the framework.

The colors of the priority areas in the wheel correspond with the colors of service areas in charts 1, 2, & 3 later in this report.

WCCMHB RESEARCH

WCCMHB Environmental Scan Survey 2020

An Environmental Scan Survey went out to service providers in the community with a total of 44 completed surveys with 8 partials (n=52). This Environmental Scan is intended to understand more of the community from providers in the Winnebago County area. From the survey, WCCMHB was able to garner feedback from service providers related to their capacity, accessibility, availability, target populations, payment options, and practices within each service area in the CSS framework. Results from the Environmental Scan showed that 59% of mental health providers reported that they provided no translation services (33%) or clients had to provide their own translation services (26%) in *Diagnostic Evaluation (n=30)* of Mental Health Treatment. This reflection proved surprising as it became a recurring trend in four service areas under Mental Health Treatment (Avg Providers=19) reported they provided their own translation services 35% of the time.

In regards to Crisis Response Services, less than 13 agencies provide services such as *Crisis Telephone Services (n=12)*, *Walk-In Crisis Services (n=13)*, *Crisis Outreach Services (n=10)*, *and Crisis Residential Services (n=4)*. When reviewing Case Management, 19 agencies serve approximately 1200 daily clients in all of Winnebago County. It is also worth mentioning that of the target population they serve, 38.9% are adults, while they serve 61.1% of both adults and children in the community. Consistently throughout the environmental scan, fewer agencies reported treating children than adults, and fewer agencies treated substance abuse disorders, compared to those treating mental illness.

A breakdown of survey results, along with the definitions for all the focus areas and service areas in the Community Support System Framework, can be found in this full summary of the Environmental Scan.

WCCMHB Community Survey 2020

The Winnebago County Mental Health Board Community Survey (WCCMHB CS) was created with the intent to engage different perspectives in order to prioritize strategic issues. The questions asked in the WCCMHB CS focus on key strategic areas and topics that impact daily life of individuals who live with mental health and/or substance abuse disorders and their family members (lived experience), administrators and front-line staff at agencies who serve individuals who have mental illness and substance abuse disorders (providers), and community members (resident). To ensure public engagement in the strategic planning process, WCCMHB sought feedback from a community based survey that utilizes a Lickert scale (1-5 rating scale) question rating certain aspects of strategic areas on a priority scale, followed by a multiple-choice question in which respondents could select up to three "improvements' they'd like to see in a service area. This was followed by optional write-in potions that allowed respondents to elaborate on why they chose their selected prioritization. Demographic questions were placed at the end of the survey. The survey allowed respondents to respond "Prefer Not to Answer" in the event they do not wish to disclose demographic information. With more than 200 completed responses, the survey proved an excellent asset for forming priorities, goals, and intended outcomes.

A detailed analysis of these results is provided in the "Priorities, Goals, and Intended Outcomes" section later in this plan. For the results of service improvement responses for priority service areas, please see *Appendix A*. The results of service improvement responses are also discussed in greater detail in the "Priorities, Goals, and Intended Outcomes" section.

The service areas are colored according to their priority area explained earlier.

The chart are showing the percentage of "priority" or "high priority" responses for respondents, broken down by perspective and other key demographics, along with the aggregate percentage for all Winnebago County residents who completed the survey. Green indicates an above-average response for that particular "group" in any specific service area, using "mean" for average. Dark green and bold text indicates a significantly above average response (one standard deviation above the mean response for that group). Similarly, orange indicates a below-average response within a group, and dark orange shows a significantly below-average response.

Chart 1

Winnebago County Resident, Completed Survey Results	Perspective			Race/Ethnicity		Total	
	Lived	Provider	Resident	White	Non-White	Aggregate	Aggregate Rank
Client Identification	73.1%	58.5%	78.6%	72.1%	71.4%	72.5%	12
Outreach	72.0%	58.5%	**83.3%**	73.2%	78.6%	73.9%	10
Transportation Assistance	53.8%	61.0%	66.7%	59.0%	71.4%	60.1%	20
Diagnostic Evaluation	**88.2%**	**85.4%**	**86.9%**	**87.4%**	**82.1%**	**87.2%**	1
Supportive Counseling	83.9%	**87.8%**	**85.7%**	**86.9%**	71.4%	**85.3%**	2
Medication Management	**87.1%**	**87.8%**	79.8%	**86.9%**	71.4%	**84.4%**	4
Substance Abuse Service	79.6%	80.5%	**86.9%**	83.6%	75.0%	82.6%	5
Health & Dental Care	72.0%	70.7%	59.5%	67.2%	64.3%	67.0%	17
Crisis Telephone Service	76.3%	65.9%	61.9%	68.3%	71.4%	68.8%	15
Crisis Walk-in	**90.3%**	**85.4%**	78.6%	**85.8%**	78.6%	**84.9%**	3
Crisis Outreach Service	81.7%	73.2%	81.0%	79.8%	78.6%	79.8%	7
Crisis Residential Service	79.6%	75.6%	63.1%	73.2%	64.3%	72.5%	12
Supportive Housing	74.2%	75.6%	67.9%	72.7%	71.4%	72.0%	14
Residential Assistance	80.6%	70.7%	69.0%	76.0%	64.3%	74.3%	9
Income Support	74.2%	68.3%	51.2%	64.5%	64.3%	64.2%	19
Self-Help	51.6%	43.9%	45.2%	48.6%	42.9%	47.7%	22
Consumer Operational Service	40.9%	34.1%	27.4%	33.3%	39.3%	34.4%	23
Assistance to Families	75.3%	**87.8%**	75.0%	76.0%	**85.7%**	77.5%	8
Education to Community	78.5%	75.6%	67.9%	72.1%	78.6%	73.9%	10
Social Rehabilitation	72.0%	65.9%	61.9%	66.1%	75.0%	67.0%	17
Vocational Education	74.2%	65.9%	63.1%	67.2%	71.4%	68.3%	16
Protection & Advocacy	58.1%	53.7%	51.2%	55.2%	53.6%	54.6%	21
Case Management	83.9%	75.6%	79.8%	82.0%	75.0%	80.7%	6

Chart 2

Winnebago County Resident, Completed Survey Results	Education			Gender		Total	
	Graduated Degree	Bachelors Degree	No 4 Year Degree	Male	Female	Aggregate	Aggregate Rank
Client Identification	70.4%	80.3%	69.8%	76.2%	70.8%	72.5%	12
Outreach	67.4%	75.4%	84.9%	78.6%	72.0%	73.9%	10
Transportation Assistance	61.2%	49.2%	71.7%	47.6%	63.7%	60.1%	20
Diagnostic Evaluation	**86.7%**	**86.9%**	88.7%	**83.3%**	**88.1%**	**87.2%**	1
Supportive Counseling	**83.7%**	83.6%	**90.6%**	76.2%	**87.5%**	**85.3%**	2
Medication Management	**82.7%**	85.3%	88.7%	78.6%	**86.3%**	**84.4%**	4
Substance Abuse Service	**81.6%**	85.3%	84.9%	64.3%	**86.9%**	82.6%	5
Health & Dental Care	58.2%	73.8%	75.5%	59.5%	69.6%	67.0%	17
Crisis Telephone Service	57.1%	67.2%	88.7%	73.3%	68.5%	68.8%	15
Crisis Walk-in	**81.6%**	82.0%	**92.5%**	73.8%	**88.1%**	**84.9%**	3
Crisis Outreach Service	78.6%	82.0%	79.3%	**81.0%**	79.8%	79.8%	7
Crisis Residential Service	70.4%	73.8%	73.6%	59.5%	77.4%	72.5%	12
Supportive Housing	72.5%	72.1%	73.6%	61.9%	75.6%	72.0%	14
Residential Assistance	70.4%	73.8%	81.1%	59.5%	78.0%	74.3%	9
Income Support	53.1%	68.9%	79.3%	64.3%	63.7%	64.2%	19
Self-Help	40.8%	47.5%	58.5%	42.9%	50.0%	47.7%	22
Consumer Operational Service	29.5%	32.8%	45.3%	31.0%	36.3%	34.4%	23
Assistance to Families	75.5%	73.8%	84.9%	78.6%	77.4%	77.5%	8
Education to Community	65.2%	78.7%	81.1%	**83.3%**	72.6%	73.9%	10
Social Rehabilitation	58.2%	73.8%	73.6%	61.9%	67.9%	67.0%	17
Vocational Education	62.2%	73.8%	71.7%	59.5%	69.1%	68.3%	16
Protection & Advocacy	46.9%	50.8%	69.8%	54.8%	56.0%	54.6%	21
Case Management	79.6%	83.6%	83.0%	78.6%	82.1%	80.7%	6

Chart 3

Winnebago County Resident, Completed Survey Results	Age				Total	
	19-30	31-45	46-60	60+	Aggregate	Aggregate Rank
Client Identification	66.7%	64.4%	80.0%	73.2%	72.5%	12
Outreach	86.7%	63.0%	77.1%	78.6%	73.9%	10
Transportation Assistance	60.0%	64.4%	57.1%	58.9%	60.1%	20
Diagnostic Evaluation	93.3%	82.2%	**92.9%**	**83.9%**	**78.2%**	1
Supportive Counseling	93.3%	82.2%	**88.6%**	82.1%	**85.3%**	2
Medication Management	86.7%	79.5%	84.3%	**91.1%**	**84.4%**	4
Substance Abuse Service	93.3%	82.2%	81.4%	81.4%	82.6%	5
Health & Dental Care	80.0%	64.4%	67.1%	67.9%	67.0%	17
Crisis Telephone Service	73.3%	67.1%	68.6%	69.6%	68.8%	15
Crisis Walk-in	**100.0%**	**87.7%**	**87.1%**	76.8%	**84.9%**	3
Crisis Outreach Service	93.3%	76.7%	78.6%	80.4%	79.8%	7
Crisis Residential Service	80.0%	78.1%	71.4%	64.3%	72.5%	12
Supportive Housing	80.0%	68.5%	74.3%	75.0%	72.0%	14
Residential Assistance	86.7%	78.1%	71.4%	71.4%	74.3%	9
Income Support	80.0%	63.0%	65.7%	58.9%	64.2%	19
Self-Help	40.0%	50.7%	44.3%	50.0%	47.7%	22
Consumer Operational Service	53.3%	31.5%	32.9%	33.9%	34.4%	23
Assistance to Families	80.0%	75.3%	72.9%	**83.9%**	77.5%	8
Education to Community	93.3%	75.3%	68.6%	73.2%	73.9%	10
Social Rehabilitation	86.7%	61.6%	68.6%	66.1%	67.0%	17
Vocational Education	93.3%	67.1%	60.0%	71.4%	68.3%	16
Protection & Advocacy	66.7%	54.8%	55.7%	51.8%	54.6%	21
Case Management	86.7%	82.2%	81.4%	78.6%	80.7%	6

OTHER COMMUNITY RESEARCH

Several other community health studies have assessed mental health in Winnebago County within the past five years. Summaries for these reports are provided below, with a hyperlink to access the full report for anyone interested.

Winnebago County Resident Survey, 2016

This survey was developed in 2015 and published in 2016 by the Winnebago County Mental Health Advisory Committee to identify unmet mental health needs in the community. It is developed from three points of view; provider, referent, and community member. The survey was run online with some physical options. In particular, this survey revealed the need for more child mental health care and better accessibility.

Below are the summarized results of the Winnebago County Resident Survey 2016.

General

The majority of respondents had a member of their local household who had sought mental health, substance abuse, or intellectual/ developmental disability services. However, only 27% found services at the level of care needed. Only 29% had insurance that paid for the services for the length of time they were needed. Only 31% of the respondents were aware of the 2-1-1 system. Respondents believe there is a stigma associated with mental illness in our community and that the community is not aware of the challenges faced or the support services available. The majority of the respondents believe that behavioral treatment and services work. Only 52% of the respondents knew how to access treatment for a behavioral health disorder. Fewer respondents knew how to access other support services. Approximately one-third (32%) of the respondents have canceled an appointment for services. The reasons varied; however, most often the reasons were that the person did not have enough energy or feel well enough to go, involved insurance or payment, or the person had a time conflict.

Children

Approximately 13% of the respondents indicated that a child in their local household had sought help for a mental health, substance abuse, or intellectual/developmental disability. One-third of the respondents with a child seeking assistance were not satisfied with 1) the ability to find services, 2) treatment/ rehabilitation that was coordinated across several providers, 3) finding out how serious the situation/illness is, and 4) getting into treatment.

Winnebago County Resident Survey, 2016 Continued

Teens

Approximately 12% of the respondents indicated that a teen in their local household had sought help for a mental health, substance abuse, or intellectual/developmental disability. Approximately 30% of the respondents with a teen seeking assistance were not satisfied with: 1) the ability to find services, 2) treatment/rehabilitation that was coordinated across several providers, 3) finding out how serious the situation/illness is, and 4) access care during a crisis.

Young Adults

Approximately 20% of the respondents indicated that a young adult in their local household had sought help for a mental health, substance abuse, or intellectual/developmental disability. Approximately 30-35% percent of the respondents with a young adult seeking assistance were not satisfied with 1) finding out how serious the situation/illness is, 2) the ability to find services, 3) access to care during a crisis, and 4) treatment/rehabilitation that was coordinated across several providers. Permanent supportive housing is also an area of dissatisfaction for some.

Persons of Middle Age

Approximately 27% of the respondents indicated that a person of middle age in their local household had sought help for a mental health, substance abuse, or intellectual/developmental disability. The respondents indicated higher levels of satisfaction with services for middle-aged persons than they did for the other age groups. For most of the services, the percentage of respondents indicating satisfaction was greater than the percentage of respondents indicating not being satisfied.

Persons Aged 60 and Older

Approximately 9.5% of the respondents indicated that a person age 60 or older in their local household had sought help for mental health, substance abuse, or intellectual/developmental disability. At least 30% of the respondents indicated dissatisfaction with the ability to find services, finding out how serious the situation is, and access to care in crisis. Transportation is an area of dissatisfaction for some seniors.

Healthy Community Study, 2017

The Healthy Community Studies are produced by the Rockford Regional Health Council every three years and provide data analysis of various health metrics. The data they use comes from external sources, a random household survey in Winnebago and Boone Counties (with a return rate of 13%), and a key informant survey. This survey provides context to the mental health services in Winnebago County by comparing them to the state and national numbers. It should be noted that Boone County is also included in the Healthy Community Survey, but for the purposes of developing the WCCMHB Strategic Plan, only the data that was related to Winnebago County was considered.

Below are the summarized results of the Healthy Community Survey 2017.

Behavioral Health/Mental Health

In 2016, the report area had 127 mental health care providers, which includes psychiatrists, psychologists, clinical social workers, and counselors that specialize in mental health care, for every 100,000 residents. This rate was substantially lower than both state (180.2) and national (202.8) rates, indicating that there is a lack of mental health support in the report area. Key Informants commented that triage services for mental health are needed for individuals with acute mental distress. They also mention the need for pediatric and adolescent mental health services. The gap in service mentioned is a lack of providers. The barrier to service reported most frequently is funding.

Substance Abuse

In the report area, an estimated 53,203, or 21.1% of adults age 18 or older, self-report currently smoking cigarettes some days or every day. In comparison, the state percentage is 18.4%, while nationally it is 18.1%. Winnebago County skews the report area as the percentage is 21.7%, well above the averages, while Boone County is well below at 17.5%, in 2006 through 2012. However, just 7.5% of Household Survey respondents over age 65 report smoking at least some days. Nationally, the population aged 18 and older involved with illicit drugs (Marijuana, Cocaine, Crack, Heroin, and LSD) has steadily increased.

Youth Mental Health Systems of Care 2019

The Children's Mental Health System of Care Community Planning Team worked with the Center for Governmental Studies (CGS) at Northern Illinois University to conduct a key informant survey about the Rockford area's current children's mental healthcare system, including strengths and areas for improvement. An online survey was administered to 161 key informants. A total of 51 key informants completed the survey resulting in a 33% response rate. The key informants represented a variety of organizations, including mental health and substance abuse 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. The linked study has the executive summary and a presentation of the full results.

Funding

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

Workforce Development

The key informants report there are not enough service providers in the Rockford area, especially child psychiatrists. They state that there are long waitlists for services. The key informants comment that it is difficult to recruit service providers to the area and that wages are low and stagnant. They mention that there is a high rate of staff burnout and turnover among existing staff, which leads to a lack of consistency for patients. They think that the existing staff needs additional training, including crisis-intervention and trauma-informed training.

Equity/Access

The current services that are available in the Rockford area are not affordable or accessible to all residents, especially low-income residents, Latinos, and African Americans. The key informants indicate that there are not enough service providers that low-income residents can afford. There is a need for more Spanish-speaking service providers and interpreters. Transportation and the locations of current service providers are barriers to access to services. The key informants comment that more home-based services are needed.

Youth Mental Health Systems of Care 2019 Continued

Collaboration

To improve the current children's mental healthcare system greater collaboration and coordination among organizations is needed. The key informants think that there is a lack of coordination and systemic approach to service provision in the Rockford area that needs to be addressed. They state that silos exist between the organizations and that there is a lack of communication between the organizations about what they are doing. The key informants state that the Rockford area needs an inpatient child unit because currently, children have to go out of town for inpatient mental health treatment. To address this need they recommend that there be a collaborative approach among the health systems. The schools do not have the support or resources needed for the number of children in the Rockford area that have emotional or behavioral problems. The key informants indicate that partnerships between the schools and agencies can help address this issue.

Engagement

The key informants discuss the importance of engaging and educating the community about children's mental health and the mental healthcare services available in the Rockford area. In particular, engaging and educating parents of children is essential. However, according to the key informants, cultural barriers get in the way of accomplishing this.

Healthy Communities Study, 2020

The 2020 Health Community Study was conducted as part of the Rockford Regional Health Council's three-year community health needs assessment, which informs the community health improvement plans of local healthcare systems. As part of the study, more than 13,000 surveys were distributed to random households throughout the region, with an additional 5,000 surveys distributed to school districts and housing authorities.

Below are the summarized results of the Healthy Communties Study 2020.

Part I: This Community Analysis provides a comprehensive overview of Winnebago and Boone Counties and the Rockford Metropolitan Statistical Area (MSA) by describing the population through analysis of open source health data. Across the state of Illinois, Winnebago County ranked among the bottom for all health factors.

Key data: 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%). 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%). Drug overdoses have risen sharply since 2012, with the rate in Winnebago County (32.4 deaths / 100,0000 residents) is more than double either that of the state (14.1/100,000) or the US (15.6/100,000).

Healthy Communities Study, 2020 Continued

Part II: Approximately 60% of survey respondents answered the survey questions about mental and behavioral health. Self-reported zip codes reported by respondents who answered these questions were varied, indicating that there is not a clear tie between neighborhood, and willingness to discuss mental or behavioral health concerns. However, self-reported drug and alcohol use were higher in 61104, 61102, and 61115-all communities known to have lower median household incomes and lower levels of education. This suggests that there may be a relationship between behavioral health and one of the characteristics prevalent in all of these areas. Interestingly, there was a trend in skipping certain questions; white respondents selected prefer not to answer far less frequently on questions related to substance use than all other racial groups. Additionally, those with less than a high school degree and women reported prescription drug use more often.

Key data: A quarter (27%) reported at least 1 mental illness or behavioral health issue. 30% of respondents were male and 70% were female. Nearly 20% of people did not know if they had mental health/substance abuse insurance or not. Only half of the people in the region reported being able to access mental health/ substance abuse care. Black and Hispanic people report being able to access medical care less easily than white people. The region's rates are comparable to State and National findings, which show that 1 in 5 adults have been diagnosed with depression or a related disorder. Of those that responded, the disorders with the highest rates among adults of all ages were: Anxiety Disorder (19%); Depression (Major Depressive Disorder)(17%); Post-traumatic Stress Disorder(PTSD) (7%, much higher for women); Attention Deficit Disorder (ADD)/Attention Deficit Hyperactivity Disorder(ADHD) (6%); Bipolar Disorders (manic- depressive) (6%). Many inequities in the experiences of various mental health challenges exist. Although rates of anxiety and depression are similar between racial groups, anxiety in Black and Hispanic respondents reported was more persistent. Black residents were 1.5 times more likely to be diagnosed with Schizophrenia, although this is likely to be artificially inflated due to misdiagnosis of symptoms. Black respondents were also more likely to have Obsessive Compulsive Disorder (OCD) or a Substance Use Disorder and slightly more likely to report Autism Spectrum diagnoses than white respondents. Multiracial people experienced higher rates of almost all the mental illnesses reported. This report also notes the mental health barriers experienced by minorities, including lack of language access, stigma of mental health illnesses, poor recognition of symptoms as they appear in people of different cultures and backgrounds, lack of insurance, lack of culturally competent providers, lack of trust in the healthcare system, or not receiving appropriate information.

Healthy Communities Study, 2020 Continued

Alcohol Use: 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 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 (although Black respondents chose not to answer the question at higher rates); Higher-income; More educated.

Drug Use: 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 and used prescription opioids and withdrawal relieving products more frequently. 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.

Covid-19 Pandemic

It is worth noting that much of the community research referenced took place prior to the onset of the COVID-19 pandemic, which has disrupted and significantly impacted mental health services in the community. When reviewing what has occurred as a result of the pandemic, increases in demand for mental health services can be seen, as cases of depression, anxiety, and a plethora of other mental health issues are increasing the toll on service providers in the field (Sasangohar, Farzan et al., 2020). Service providers include psychologists, clinicians, social workers, psychiatrists, counselors, or any other professional that plays a role in assessment, intervention, treatment, and evaluation. Service providers are often overworked and underpaid, which leads to feelings of burnout and expedited turn-over rates and can have adverse effects on clients.

Additionally, many service providers struggle with vicarious trauma or emotional residue of exposure from working with individuals as they become witnesses to the pain, fear, and terror that trauma survivors have endured (American Counseling Association, 2011). The COVID-19 pandemic has caused service workers an additional level of stress and exhaustion. Feelings of loneliness, hopelessness, and depression caused by COVID-19 and isolation have been felt by individuals across the globe; these individuals often turn to service providers for help. As Joshi and Sharma (2020) have found, "Covid-19 presents health crises, the deleterious economic impact that the country will experience due to present and future anticipated lockdown may increase the risk of post covid stress and led to culmination of second wave of mental health crises thereby contributing to increased risk of burnout amongst mental health professionals," (pg. 1).

STRENGTHS, WEAKNESSES, OPPORTUNITIES, THREATS (SWOT) ANALYSIS

Strength, Weaknesses, Opportunities,Threats (SWOT) Analysis

SWOT Analysis was conducted to review internal and external factors and to assess the current and projected future status of the mental health system of care in Winnebago County.

Strengths

- Providers that provide *Client Identification* services (n=19) provide 75% of accessibility through combined mobile and in-person services to 850 daily clients

- In terms of *Medication Management* (n=11) in the Environmental Scan, 73% of the providers indicated they accept Medicaid, 82% provide service to the uninsured, and 64% work with non-payers to ensure clients needs are met while educating them and family members of the effects of the medication to ensure proper use of substances

- 69.2% of providers that completed the Environmental Scan (n=52) indicated they provide *Transportation Services* (n=36)

- In *Supportive Counseling* of the Environmental Scan (n=28), 67% of providers provided targeted services to both adults and children, with 27% serving adults and 7% serving children

- High rates of trauma-informed care and trauma-specific counseling were reported by agencies providing supportive counseling services

STRENGTH, WEAKNESSES, OPPORTUNITIES, THREATS (SWOT) ANALYSIS

Weaknesses

- An analysis from the WCMHB Environmental Scan and Community Survey indicates that there is a lack of translation services across the entire system of care.

- There is a lack of providers to serve children and young adults, especially child psychiatrists

- Several providers are operating in a limited capacity (mobile or in-person) and with COVID-19, it has disrupted many clients' ability to seek assistance.

- As identified in the Environmental Scan, providers (n=30) noted in *Diagnostic Evaluation* that only 26% of agencies provide translation services, where 33% provide no translation services at all. 26% of providers request that clients provide their own translation services *(Appendix A)*.

- In all prioritized Service Areas *(Outlined in Strategic Goals)*, Community Survey respondents (n=233) indicated that the number of providers in the community should be improved

- Mental health services are hard to find, uncoordinated, and often unaffordable

- Low provider to resident ratio than national averages

- Shortage of child psychiatrists and long wait times for child services

- High rates of staff burnout and turnover of existing staff

- 17.9% of people on Medicare experience depression, but Medicare as a payment option is generally accepted less than private insurance or Medicaid

- Non-white residents report less access to care than white residents

STRENGTH, WEAKNESSES, OPPORTUNITIES, THREATS (SWOT) ANALYSIS

Opportunities

- Passage of a 1/2 cent sales tax increase in Winnebago County to improve the availability and quality of services

- Due to the pandemic of COVID-19, the general public across the United States is seeing the importance of mental health services in communities

- Legislators are seeing the importance of mental health treatment and services are looking into policies to increase accessibility in communities, specifically related to increasing telehealth options

- Most community members believe that mental health treatment works

- Training for staff, including crisis-intervention and trauma-informed training

Threats

- As reported by the National Council for Behavioral Health (Majlessi 2020), demands for behavioral health is increasing (52%), capacity is diminishing due to COVID-19 (54% closed programs while 65% have to reschedule or cancel appointments), and mental health organizations are seeing a decrease in viability (organizations have lost nearly 23% of their annual revenues)

- COVID-19 has complicated the ability to get services while simultaneously increasing the need

- Stigma associated with mental illness at a community level, and many community members do not know how to access mental health treatment

- Higher than average rates of alcohol and drug use, with increasing national trends

- Difficulty recruiting service providers to the region

- Suicide rates and drug overdoses are rising in Winnebago County

PRIORITIES, GOALS, & INTENDED OUTCOMES

Priorities, Goals, and Intended Outcomes

As shown from charts 1, 2, & 3, in the Community Survey section, the highest priority areas across all perspectives and demographics were unequivocally in **Mental Health Treatment**, including Diagnostic Evaluation, Supportive Counseling, Medication Management, and Substance Abuse Services. **Case Management** was also rated as an above-average priority by every group. **Family & Community Support Services** were rated highly in aggregate within only a few groups raking the services below their average response. In aggregate, Assistance to Family and Community Support ranked as the 8th and 10th highest priority service areas, respectively.

Crisis Response Services had a mixed response, with Crisis Walk-in and Crisis Outreach being rated as an above-average priority across all groups but with Crisis Residential Services and Crisis Telephone Services ranking as only the 12th and 15th highest rated priorities overall. However, it is worth noting that individuals living with mental illness and substance abuse disorders and their family members rated both of these services more highly than aggregate. Crisis-Telephone services were also rated more highly by respondents who identified as non-white, with no 4-year degree, or male — all three categories were underrepresented in the overall number of survey responses and completions. Furthermore, Crisis Telephone Services and Crisis Residential Services are often integrated with other Crisis Walk-in and Outreach Services and are part of a continuum of crisis response services. Therefore, Crisis Telephone and Crisis Response services are included as priority services for this plan.

Client Identification & Outreach similarly had mixed responses and was the only area ranked as a higher priority by "residents" than "lived-experience" and "provider" groups. Considering the nature of these services as informing potential clients of the availability of services, it could certainly make sense that people who have less experience with the mental health system of care would see this need as more important. Furthermore, these services were rated higher by non-white respondents and males, both of which were under-represented in the overall survey responses. Based upon the Environmental Scan and SWOT analysis, with the predicted increasing mental health needs across the community in future years and limited system capacity of the current system, this service area is considered a priority. Transportation Services, which were ranked 20th in aggregate, should be reserved for individuals and families who have limited access due to disability, income, and/or living in a rural area within Winnebago County and otherwise meet the target population criteria. Client Identification & Outreach is considered a priority and will be funded in years two and three.

Housing was generally ranked highly with some mixed results. In aggregate, Supportive Housing and Residential Assistance for Homeless were ranked 14th and 9th, respectively. Supportive Housing was generally ranked less of a priority by residents than by those with lived experience and providers. Younger respondents also ranked it as less of a priority compared to their mean response than older respondents, although 80% of people between 19-30 found supportive housing to be a priority and 86.7%. The WCCMHB Environmental Scan Survey showed a total lack of supportive housing options for families. Housing is considered a priority and will be funded in years two and three.

As such, the next sections has the identified priorities and their respective service areas:

Priority 1: Mental Health Treatment

Diagnostic Evaluation

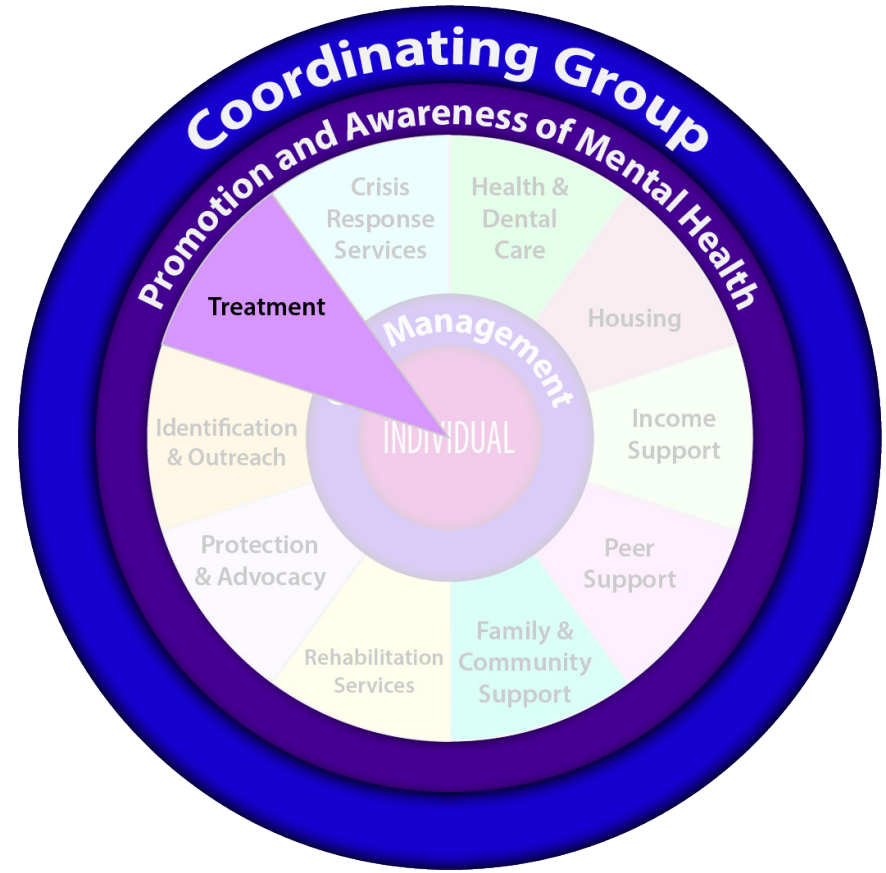
The ongoing assessment and monitoring to make an accurate diagnosis of psychiatric, co-occurring, and comorbid problems.

Supportive Counseling

Individual or group counseling directed at helping clients to cope with a variety of life problems and stresses.

Medication Management

Prescribing and ensuring medications are available, monitoring medication effectiveness and side effects, and educating clients and their family about medications prescribed.



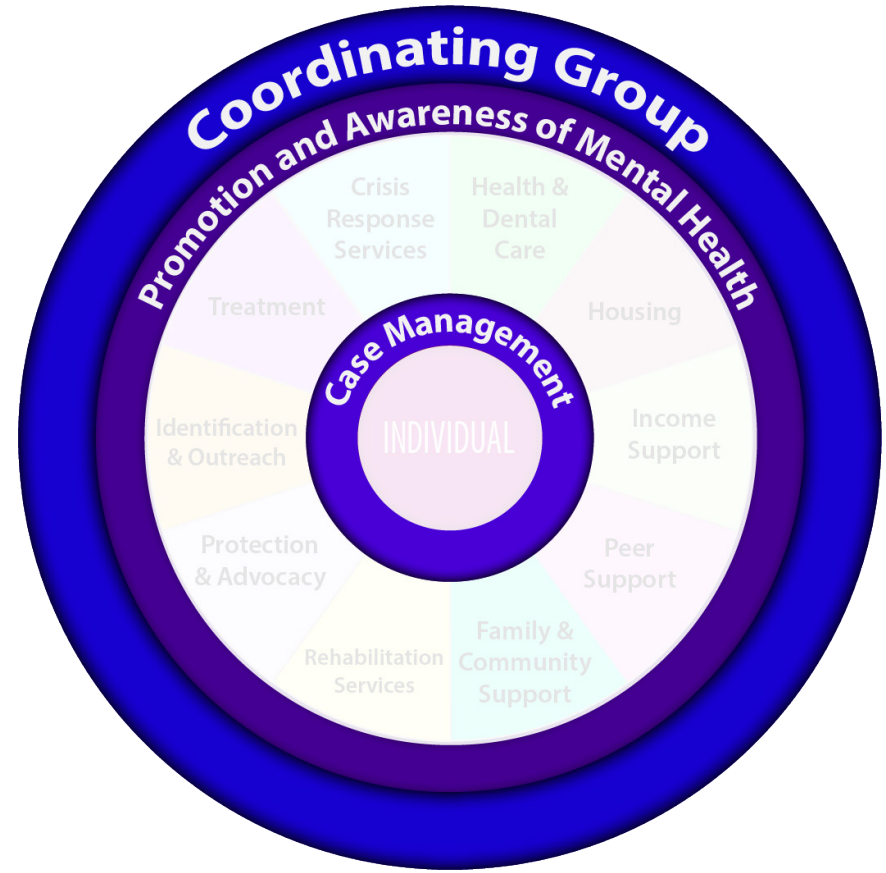
Substance Abuse Services

Detoxification and other interventions to address alcohol and drug abuse problems.

Priority 2: Case Management

Case Management

Providing a single person or team to assume responsibility for maintaining a long-term, caring, supportive relationship with the client on a continuing basis.



Priority 3: Crisis Response Services

Crisis Telephone Services

24-hour crisis telephone hotlines.

Walk-In Crisis Services

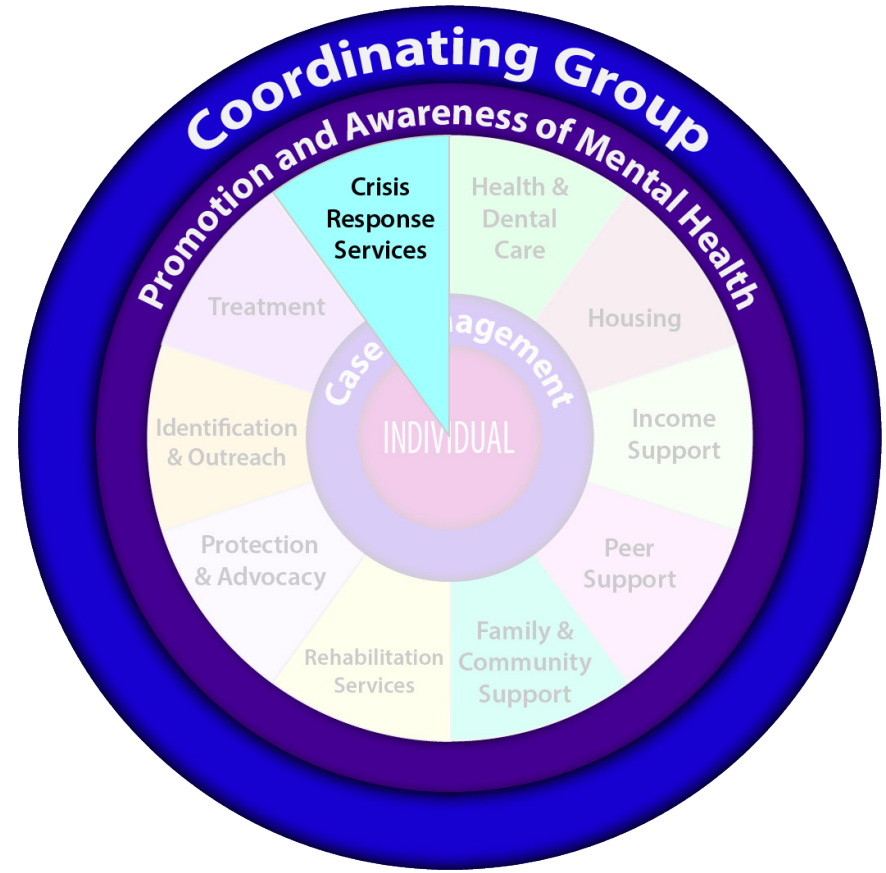
Walk-in crisis intervention services at mental health agencies.

Crisis Outreach Services

Going to the client and providing services in the setting in which the crisis is occurring.

Crisis Residential Services

Providing crisis intervention in the context of a residential, non-hospital setting on a short-term basis.



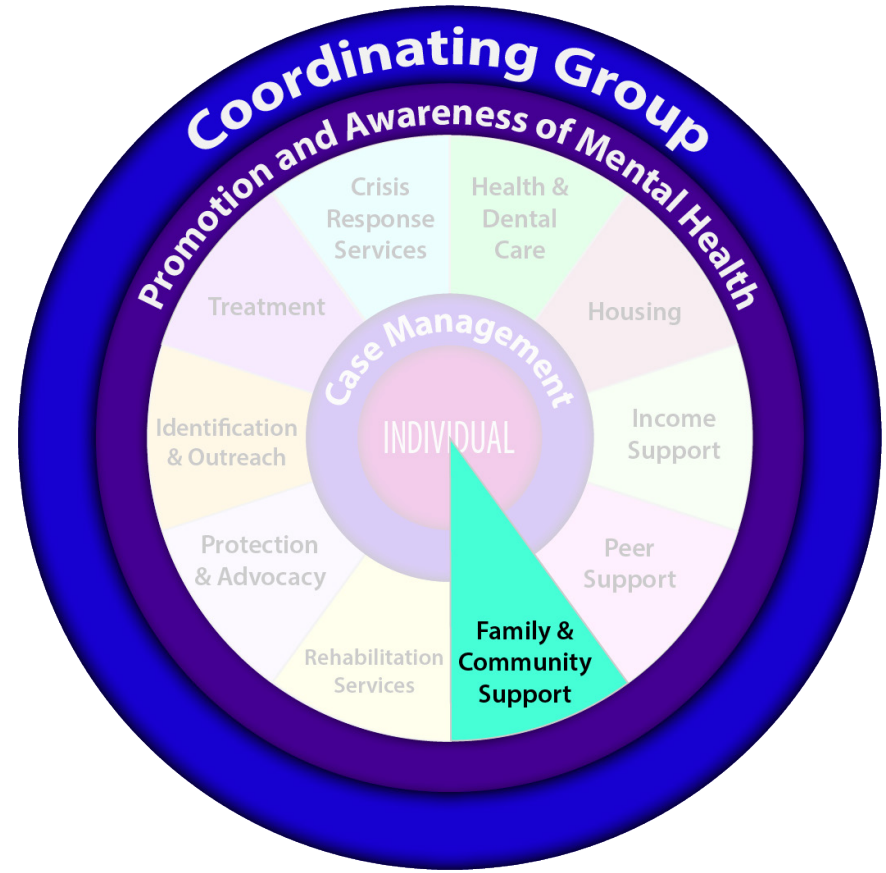
Priority 4: Family & Community Support

Support and Assistance to Families

Families being involved in treatment planning and service delivery, being educated about the nature of mental illness, being offered consultation and supportive counseling, or respite care.

Support and Education for the Community

Educating key individuals and agencies in the community who come in frequent contact with mentally ill individuals as well as educating the general public about mental illness to reduce stigma and promote community acceptance.



Priority 5: Client Identification & Outreach

Client Identification

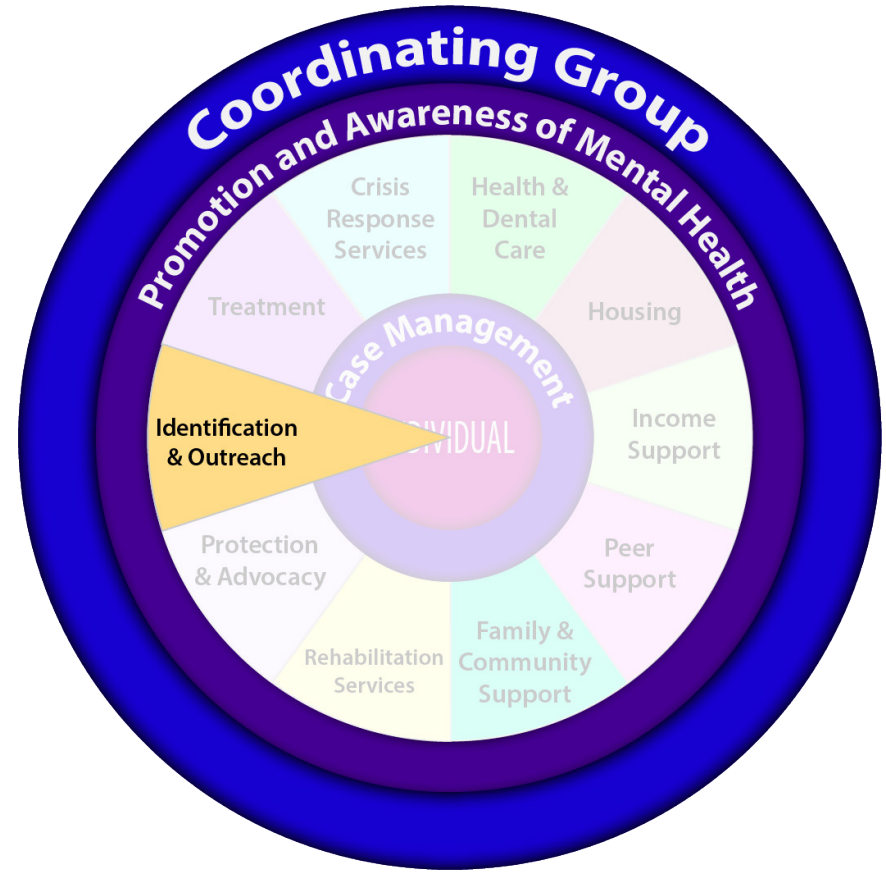
Locating potential clients, regardless of where they reside, and informing them of available services.

Outreach

Linking other agencies for the purpose of informing potential clients about other available services, agencies, and organizations.

Transportation Assistance

Providing clients with means of transportation to access needed services and community resources such as public transit, vans, buses, personal owned vehicles, or volunteers.



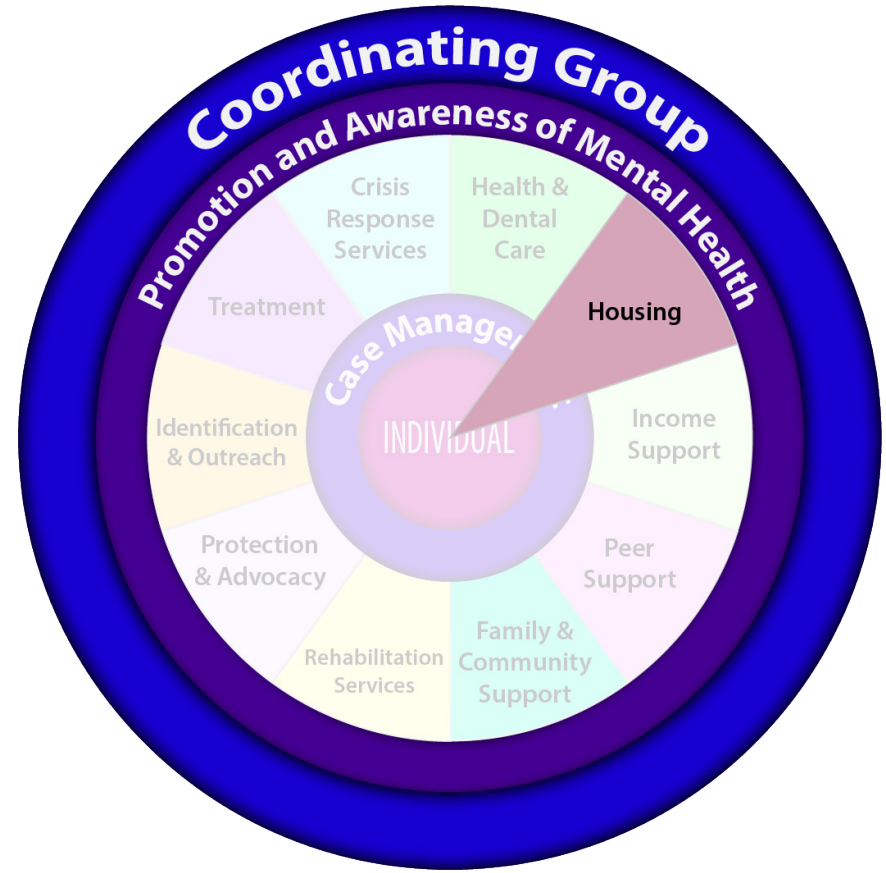
Priority 6: Housing

Supportive Housing

Array of residential alternatives that provide varying levels of support and supervision.

Residential Assistance for Homeless

A range of additional living situations with varying degrees of supervision and support, including emergency shelters, drop-in centers, and transitional housing.



Target Populations

For all priorities and service areas, the focus is on residents of Winnebago County who cannot function at age-appropriate levels due to mental illness or substance abuse disorders. This general definition falls into four different diagnostic categories outlined below.

Serious Mental Illness (18+)

Serious Mental Illness (SMI) is defined as a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities (NIMH, 2020). Diagnosing an individual with a Serious Mental Illness requires multiple observations and assessments by a trained mental health professional. Certain disorders fall into the category of Serious Mental Illnesses, and these disorders are often ones that severely impact everyday life. The prevalence of SMI is still being studied, but reports have been published estimating that over 5% of the population lives with a SMI and will require ongoing services, treatment, and support.

Trauma is a unique subset of mental illness as it can be difficult to diagnose and may present as a variety of other disorders. The differences and difficulty diagnosing acute stress disorder and post-traumatic stress disorder can lead to gaps in service and treatment. Although there are many different types of trauma such as: historical trauma, community trauma, complex trauma, early childhood trauma, intimate partner violence, medical trauma, and more, this target population includes recognizable trauma that significantly impacts functioning and does not include risk factors alone.

IL Department of Human Services provides a list of diagnoses that qualify as Serious Mental Illness. 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 Disturbances (3-21)

Serious Emotional Disturbances are diagnosable, mental, behavioral, or emotional disorders in children and youth that have been experienced in the past year and resulted in functional impairment that substantially interfered with or limited the child's or youth's role or functioning in the family, school, or community activities (SAMHSA, 2020). Serious Emotional Disturbances are most commonly found in children and young adults between the ages of 3 and 21. From the years of 18 to 21, there is an overlap with Serious Mental Illness. It is not uncommon for individuals to be reassessed and re-diagnosed during these years. Additionally, there is another overlap between the third and fifth years between Infant and Early Childhood Mental Health and Serious Emotional Disturbances. 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.

Serious Emotional Disturbances have characteristics and diagnoses such as: hyperactivity, a short attention span and impulsivity, aggression or self-injurious behavior with others or avoid social interactions through fear or anxiety, immaturity characterized by inappropriate tantrums and poor coping skills, and learning difficulties exhibited by academic performance below grade level (The Arc, 2020). Within Serious Emotional Disturbances, significant impairments within the behavioral and social-emotional learning domains are most common. These impairments cause difficulty in performing day-to-day tasks. Serious Emotional Disturbances have a prevalence rate of 10%, or roughly 6 million individuals will have a Serious Emotional Disturbance at some point in their lifetime (Brauner & Stephens, 2006). After being diagnosed with a serious emotional disturbance, individuals will require services and support.

According to the National Survey of Children's Health (NSCH), nearly 35 million children in the U.S. have experienced one or more types of trauma. For this reason, the Winnebago County Community Mental Health Board is including trauma as a sub-population under Serious Emotional Disturbances. Traumatic reactions can include a variety of responses, such as intense and ongoing emotional response, depressive symptoms or anxiety, behavioral changes, difficulties with self-regulation, problems relating to others or forming attachments, regression, loss of previously acquired skills, attention and academic difficulties, nightmares, difficulty sleeping and eating, and physical symptoms, such as aches and pains. Older children may use drugs or alcohol, behave in risky ways, or engage in risky sexual activity (NCTSN). Accurately diagnosing children and adolescents with trauma can be extremely challenging, and Post-Traumatic Stress Disorder (PTSD) does not cover the array of trauma experiences and is not always developmentally appropriate. For this reason, children with trauma and adverse childhood experiences are often misdiagnosed or over-diagnosed. Developmental Trauma disorder or Complex Trauma have been suggested by some researchers as alternative diagnoses that characterizes multiple trauma exposures that impair certain domains of human development, including attachment, cognition, behavior regulation, affect regulation, self-concept, or dissociation.

IL Department of Human Services provides a list of diagnoses that qualify as Serious Mental Illness (beginning page 2). 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)

Childhood experiences dictate the trajectory of our lives, and those experiences begin as early as infancy. Including Infant and Early Childhood Mental Health as a target will mark Winnebago County as an innovator for community mental health and serve a vulnerable and often overlooked population of community members.

Research has shown that Early Intervention (EI) and advocacy in the field of Infant and Early Childhood Mental Health (IECMH) has long-lasting, community-wide benefits. For example, when there are high-quality, well-designed early childhood intervention programs in a community, the return on investment can reach up to $17.07 for each dollar spent on the program. Early Intervention programs have been proven to show exponential benefits across academic, behavioral, educational, achievement, and attachment domains, as well as a decrease in delinquency and criminality. Combating issues of attachment, depression, anxiety, separation, behavioral challenges, trauma treatment, attention & hyperactivity problems, grief & loss, obsessive or compulsive behaviors in childhood have proven to be essential in today's society.

The first five years of a child's life are a particularly sensitive period of development where the brain is formed and strengthened by positive early experiences. When a child is living in a constant state of toxic stress, caused by extreme poverty, abuse or neglect, severe maternal depression, or other parental mental health/substance abuse illnesses, their cortisol levels are continually in a peaked state, which has neurodevelopmental consequences that have the ability to cause lifelong damage. High-quality Early Intervention services have the ability to change a child's developmental trajectory, influencing a wave of positive change in their lives.

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. Functional impairment of these domains can be shown through a child's inability to form attached relationships and failure to develop coordination of focus with another person. Delays in behavioral and social-emotional functional domains may also lead to Serious Emotional Disturbances and Serious Mental Illness later in life. 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 (Ab)use Disorders (all ages)

Substance use disorders or sometimes called substance abuse disorders span the lifetime. No individual is too young or too old to have a substance use disorder. It is estimated that every fifteen minutes a baby is born suffering from opioid withdrawal (NIH, 2019). Substance use disorders occur 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 (SAMHSA, 2020).

The DSM-5 finds ten classes of drugs to be the stem of substance-related disorders. Those drugs are: alcohol, caffeine, cannabis, hallucinogens, inhalants, opioids, sedatives, hypnotics, stimulants, tobacco, and other unknown substances. 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." (pg. 484)." 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.

Client Unit

While it is individuals who are diagnosed with mental illness and substance abuse disorders, families, providers, and communities share in experiencing its effects. All program and project proposals should be developed in accordance with evidence-based practices or best practices and include the appropriate client unit demonstrated in the research for that practice. The client unit is not necessarily limited to an individual, but the impact should benefit individuals within the target population.

Evidence-Based, Best Practice, and Promising Practice

The WCCMHB strives to implement an evidence-based framework in all decisions, including grant funding. Evidence-based practice is defined as, "any practice that has been established as effective through scientific research according to a set of explicit criteria," by the National Association of Social Workers (NASW). Evidence-based practices can be difficult to establish due to the lengthy process to replicate all results and conduct thorough peer reviews. In many cases, best practice frameworks can be established as a subsequent opportunity.

According to research from James Mold and Mark Gregory (2003), best-practice research refers to, "a systematic process used to identify, describe, combine and disseminate effective and efficient clinical and/or management strategies developed and refined by practicing clinicians," (pg. 131). The WCCMHB requires all funded programs and organizations to implement evidence-based or best practice frameworks in order to ensure the residents of Winnebago County are receiving the best care available.

Promising practice is defined as, "programs and strategies that have some scientific research or data showing positive outcomes in delaying an untoward [unwanted] outcome, but do not have enough evidence to support generalizable conclusions," (Thurston County Public Health and Social Services, 2009). WCCMHB aims to fund evidence-based and best-practice frameworks, however still takes into consideration the importance of organizations and agencies utilizing promising practice.

Intended Outcomes

Outcomes can be divided into three integrated categories: system-capacity outcomes, individual and family outcomes, and community outcomes. By improving the system capacity through the development and maintenance of a community support system in Winnebago County, the lives of individuals and families will be improved, which will in turn impact community health outcomes. Outcomes were developed from referencing local, and national research on mental health and substance abuse, including the Substance Abuse Mental Health Association's National Outcome Measures Domains (NOMS).

It is recommended that applicants for funding reference the intended outcomes definitions below and see *Appendix A* when selecting appropriate intended outcomes in their program proposals. Targets for each outcome that is selected in a program proposal should be detailed in the program proposal and should be based upon empirical research and evidence-based practices. Benchmarks can be determined by referencing current numbers at an agency for existing programming, the WCCMHB Environmental Scan Survey Results, or a model program in a peer community. Community outcomes benchmarks and targets will be developed in collaboration with community partners through the development of a learning network council that funded programs are required to participate in.

System-Capacity Outcomes

Providers

With more people seeking services, increasing the number of providers was consistently rated the highest by all perspectives and across each priority service area (see *Appendix A)*. Write-in answers provided more contextual information to specific goals within this broad category, including: more psychiatric crisis beds; more substance abuse providers and detox beds; more mental health providers for children, especially child psychiatrists; more specialized training for providers (including primary care physicians, first-responders, and police); and more diversity among providers including racial/ethnic and LGBTQ diversity.

Payment Options

The Environmental Scan Survey results demonstrated a large discrepancy between providers who accept Medicaid/Medicare versus private insurance and those who accept uninsured clients versus those who provide low-cost options. While case management and income support services should seek to connect individuals with appropriate medical benefits to mitigate the need for low-cost options, write-in answers from the community survey suggest that this alone will not solve the problem due to donut-hole coverage and managed-care limits. Efforts should be made to incorporate low-cost or no-cost options in all program proposals as appropriate.

Wait Times

Write-in responses showed that decreasing wait times—the time between assessment and the initiation of treatment—were particularly important for substance abuse treatment, medication management, and children's mental health services. Decreased wait times were generally clustered together as being equally rated with payment options, accessibility, hours of services, and mobile services.

Accessibility

Increasing accessibility of services is critical to ensuring equal access for all groups in Winnebago County. The Environmental Scan Survey results demonstrated that not all service areas are equally accessible to individuals with disabilities. Program proposals should ensure every effort is made to remove barriers that limit access to disabled individuals in the target population. Write-in answers from the community survey also demonstrated the interconnectedness of accessibility with hours of service and location of services.

System-Capacity Outcomes Continued

Hours of Service

As noted above, hours of service are critical for ensuring access to services for all community members. Write-in options demonstrate the need for more services outside of traditional 9-5 office hours.

Mobile Services

Mobile Services are services provided outside of any office setting. Increasing mobile services can be motivated by clinical reasons, for community-based programming, or to improve access of those who have difficulty going to the location where services are offered. Write-in answers demonstrated a desire for more telehealth options and for mental health providers to accompany police officers in responding to mental health crisis situations in the community.

Translation Services

It was clearly demonstrated in the Environmental Scan Survey the need for increasing the number of providers who provide translation services. Furthermore, it is referenced frequently in community survey write-in responses.

Housing Supports

The need for more supported housing options was demonstrated by responses from the Environmental Scan Survey and Community Survey, with specific needs demonstrated for increasing options for families and transitions.

Coordination

Increased coordination of services was consistently written across multiple service areas, with specific suggestions to see more services working together. This outcome is consistent with WCCMHB's value of collaboration and should be addressed by all program proposals, and should also be a key outcome for proposals focused on Case Management.

Awareness

The need for awareness about services and mental health was also consistently demonstrated in write-in answers across multiple priority service areas. This is a key outcome for proposals focused on Family & Community Support.

Individual & Family Outcomes

Persons & Families Served

Increasing the total number of persons served demonstrates an improvement in access to services and is measured by the number of persons served by age, gender, and race/ethnicity. This measure should be addressed by all program proposals.

Symptom Improvement

Decreasing symptoms for individuals receiving services demonstrate the effectiveness of services and is measured by the frequency of mental illness symptoms and/or the frequency of substance use. Increased client resilience might be used in lieu of symptoms measuring with clinically appropriate tools.

Education/Employment

Increased employment obtainment/retainment and school enrollment demonstrates improvement in occupational functioning and are measured by the number employed or in school at the last date of service compared to the first date of service for adults and school attendance rates for children.

Criminal Justice Involvement

Decreasing criminal justice involvement demonstrates improved functioning and support for individuals in the target population, and is measured by a reduction in the number of arrests in the past 30 days from the date of the first service to the date of the last service.

Housing Stability

Increased housing stability demonstrates improved housing outcomes for individuals and families in the target population and is measured by a change in living situation (including homeless status) from the date of the first service to the date of the last service.

Perception of Care

Client perception is one of the most critical outcomes to ensure the quality of care from the client's perspective and is measured by client satisfaction reporting and client self-report about outcomes. This measure should be addressed by all program proposals.

Community Outcomes

Suicide

Suicide is one of the most pervasive results of serious mental illness. Decreasing the suicide rate is critical for community health and is measured by the number of suicides divided by the total population.

Incarceration

Mental illness and substance abuse place a burden on the criminal justice system, driving up operational costs. An effective community support system will see the number of incarcerated individuals in the target population decrease.

Opioid Death

Opioid deaths are on the rise and place a burden on family and community systems. Reversing the trend and decreasing the opioid death rate is a critical measure of success and is measured by the number of opioid deaths divided by the total population.

Homelessness

In a community that has made its goal to end homelessness, individuals and families in the target population should be no exception. Ending homeless for those who cannot function appropriately due to mental illness or substance abuse disorders is a critical goal and measure of success.

Priority 1: Mental Health Treatment (Program 2022-2024)				Community Outcomes (Across All Priorities)
Service Areas	**Target Populations**	**System-Capacity Outcomes**	**Individual/Family Outcomes**	• Decrease Suicide Rate • Decrease Opioid Death Rate • Decreased Incarcerations • Decreased Homelessness
• Diagnostic Evaluation • Support Counseling • Medication Management • Substance Abuse Services	• Serious Mental Illness • Serious Emotional Disturbances • Early Childhood & Infant Mental Health • Substance Use Disorder	• More Providers • Decreased Wait Times • Better Payment Options • Improve Accessibility • Increased Hours of Service • Increased Mobile Services • Increased Translation Services	• Persons/Families Served • Symptom Improvement • Education/Employment • Criminal Justice Involvement • Housing Stability • Perception of Care	
Priority 2: Client Identification & Outreach (Program 2022-2024)				
Service Areas	**Target Populations**	**System-Capacity Outcomes**	**Individual/Family Outcomes**	
• Case Management	• Serious Mental Illness • Serious Emotional Disturbances • Early Childhood & Infant Mental Health • Substance Use Disorder	• Improve Coordination • More Providers • Better Payment Options • Improved Accessibility • Increased Translation Services	• Persons/Families Served • Symptom Improvement • Education/Employment • Criminal Justice Involvement • Housing Stability • Perception of Care	
Priority 3: Crisis Response Services (Program 2022-2024)				
Service Areas	**Target Populations**	**System-Capacity Outcomes**	**Individual/Family Outcomes**	
• Crisis Telephone Services • Walk-In Crisis Services • Crisis Outreach Services • Crisis Residential Services	• Serious Mental Illness • Serious Emotional Disturbances • Substance Use Disorder	• More Providers • Increased Payment Options • Improved Accessibility • More Mobile Services • Increased Translation Services	• Persons/Families Served • Symptom Improvement • Education/Employment • Criminal Justice Involvement • Housing Stability • Perception of Care	

Priority 4: Family & Community Support (Program 2022-2024)				Community Outcomes (Across All Priorities)
Service Areas	**Target Populations**	**System-Capacity Outcomes**	**Individual/Family Outcomes**	• Decrease Suicide Rate • Decrease Opioid Death Rate • Decreased Incarcerations • Decreased Homelessness
• Support and Assistance to Families • Support and Eduction for Community	• Serious Mental Illness • Serious Emotional Disturbances • Early Childhood & Infant Mental Health • Substance Use Disorder	• More Providers • Better Payment Options • Improve Accessibility • Increased Awareness • Increased Translation Services	• Persons/Families Served • Symptom Improvement • Education/Employment • Criminal Justice Involvement • Housing Stability • Perception of Care	
Priority 5: Client Identification & Outreach (Program 2023-2024)				
Service Areas	**Target Populations**	**System-Capacity Outcomes**	**Individual/Family Outcomes**	
• Client Identification • Client Outreach • Transportation	• Serious Mental Illness • Serious Emotional Disturbances • Early Childhood & Infant Mental Health • Substance Use Disorder	• More Providers • Improved Accessibility • More Mobile Services • Increased Translation Services • Increased Awareness	• Persons/Families Served • Symptom Improvement • Education/Employment • Criminal Justice Involvement • Housing Stability • Perception of Care	
Priority 6: Housing (Program 2023-2024)				
Service Areas	**Target Populations**	**System-Capacity Outcomes**	**Individual/Family Outcomes**	
• Supportive Housing • Residential Assistance for Homeless	• Serious Mental Illness • Serious Emotional Disturbances • Substance Use Disorder	• More Providers • More Housing Options • Improved Accessibility • Increased Translation Services	• Persons/Families Served • Symptom Improvement • Education/Employment • Criminal Justice Involvement • Housing Stability • Perception of Care	

Appendix A: Community Survey Service Improvement Responses

Appendix A Visuals

References

American Counseling Association. (2011). Fact sheet# 9: Vicarious trauma. [Fact Sheet Counseling.org. *https://www.counseling.org/docs/trauma-disaster/fact-sheet-9---vicarious-trauma.pdf?sfvrsn=f0f03a27_2*

The Arc of Western Wayne County. (2019). *What is Serious Emotional Disturbance?*. *https://thearcww.org/helpline/topic/what-is-serious-emotional-disturbance/*

Association of Community Mental Health Authorities of Illinois. (2020). *Who We Are*. *http://acmhai.org/who-we-are/*

Brauner, C. B., & Stephens, C. B. (2006). Estimating the prevalence of early childhood serious emotional/behavioral disorders: challenges and recommendations. *Public Health Reports*, *121*(3), 303-310. *https://doi.org/10.1177/003335490612100314*

Joshi, G., & Sharma, G. (2020). Burnout: A risk factor amongst mental health professionals during COVID-19. *Asian journal of psychiatry*, *54*, 102300. *https://doi.org/10.1016/j.ajp.2020.102300*

Mold, J. W., & Gregory, M. E. (2003). Best practices research - .NET framework. Retrieved October 21, 2021, from *https://fammedarchives.blob.core.windows.net/imagesandpdfs/fmhub/fm2003/feb03/pm.pdf*

National Association of Social Workers (NASW). NASW - National Association of Social Workers (n.d.). Retrieved October 21, 2021, from *https://www.socialworkers.org/News/Research-Data/Social-Work-Policy-Research/Evidence-Based-Practice*

References Continued

National Institute of Mental Health. (2020, November 2). *Mental Illness*. https://www.nimh.nih.gov/health/statistics/mental-illness

Peterson, S. (2018, November 5). *About child trauma*. The National Child Traumatic Stress Network. Retrieved October 13, 2021, from https://www.nctsn.org/what-is-child-trauma/about-child-trauma

Sasangohar, F., Jones, S. L., Masud, F. N., Vahidy, F. S., & Kash, B. A. (2020). Provider Burnout and Fatigue During the COVID-19 Pandemic: Lessons Learned From a High Volume Intensive Care Unit. *Anesthesia and analgesia*, *131*(1), 106–111. https://doi.org/10.1213/ANE.0000000000004866

Stevens, J. E. (2017, April 25). *Nearly 35 million U.S. children have experienced one or more types of childhood trauma*. ACEs Too High. Retrieved October 13, 2021, from https://acestoohigh.com/2013/05/13/nearly-35-million-u-s-children-have-experienced-one-or-more-types-of-childhood-trauma/

Substance Abuse and Mental Health Services Administration. (2020). *Mental Health and Substance Use Disorders*. SAMHSA. https://www.samhsa.gov/find-help/disorders

Thurston County Public Health & Social Services Department. (2009). *"evidence-based" and "promising ... - co.thurston.wa.us*. Retrieved October 21, 2021, from http://wwwco.thurston.wa.us/treatment-tax/docs/EvidenceBasedSummary.pdf

WCCMHB

Winnebago County
Community Mental
Health Board