



**WCCMHB**

Winnebago County  
Community Mental  
Health Board

**Strategic Plan 3.0  
Program Years 7-9  
Draft Report**



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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



# WCCMHB

Winnebago County  
Community Mental  
Health Board



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**DRAFT**



# Introduction



ABOUT  
WCCMHB

# About the Winnebago County Community Mental Health Board (WCCMHB)

## History of Community Mental Health Boards

Increased awareness surrounding the conditions of state hospitals led to the deinstitutionalization movement of the 1950s and 1960s. Ultimately, it culminated in the approval of the Community Mental Health Act of 1963, authorizing the closure of state and national hospitals for people with mental illness and the creation of local mental health boards. In turn, a new approach to mental healthcare was needed, and mental health boards envisioned creating local systems of care that could provide all the services individuals need to live and recover within their own communities, rather than in institutions. Unfortunately, funding issues and varied programming across states did not translate into the community-centered, comprehensive healthcare model originally imagined.

Community Mental Health Boards (also known as 708 Boards) now exist more universally across the nation, providing a range of services and funding opportunities to improve the quality and availability of care for people with mental health or substance use issues, helping them recover and live as independently as possible. Shortly after the Community Mental Health Act of 1963, the State of Illinois passed the Community Mental Health Act (405 ILCS 20), which allows counties, municipalities, and townships to establish Community Mental Health Boards and outlines a Board's responsibilities. As of March 2026, 95 counties, municipalities, and townships in Illinois have established a Community Mental Health Board.

## Purpose of the 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 care for mental health and substance use services for Winnebago County residents suffering from Serious Mental Illness (SMI) or Substance Use Disorder (SUD). WCCMHB distributes sales tax proceeds to provide services to County residents whose illness prevents functioning in developmentally appropriate social roles. The use of clinical, evidence-based practices allows individuals with mental health or substance use issues to remain in their community while meeting their care needs.

## Half-Cent Sales Tax

WCCMHB receives funding through a half-cent sales tax, which Winnebago County voters originally approved in March 2020 with 61.7% voter support, and renewed in November 2024 for an additional five years. Before the half-cent sales tax, Winnebago County was the largest county in Illinois with no local public funding for mental health care. The sales tax currently extends through June 30, 2031 and generates approximately \$20 million annually for mental health and substance use services across the county. WCCMHB oversees the sales tax fund and administers funding in accordance with its Strategic Plan to develop, maintain, and improve critical mental health and substance use services and its system of care around the county.



## BOARD MEMBERS BIOGRAPHIES

# Board Member Biographies

## Mary Ann Abate, President

Mary Ann Abate, currently Board President, 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 Board Vice-President. 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.

## Dr. Bill Gorski, Secretary

Dr. Bill Gorski is currently the Board Secretary. 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 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 the community.

## Dr. Terry Giardini, Treasurer

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 led group therapy and performed forensic fieldwork.

## Andrell Bragg-Shaw

Andrell Bragg-Shaw, LPC, M.S., is a licensed professional counselor with over a decade of experience in private practice settings. She holds a Master of Science in Counseling from National Louis University. Mrs. Bragg-Shaw specializes in evidence-based therapies and working with diverse populations. She has worked with individuals with intellectual and developmental disabilities, raising awareness of their rights in the classroom as a part of the Individuals with Disabilities Education Act (IDEA). Mrs. Bragg-Shaw also works with survivors of sexual assault, facilitating impactful recovery through methods such as trauma-informed therapy. She also practices cognitive behavioral therapy, emotion-focused therapy, and interpersonal psychotherapy. Outside of her counseling work and role on the Winnebago County Community Mental Health Board, Mrs. Bragg-Shaw leads community support groups on grief topics and steers youth social-emotional learning sessions.

## Rev. Dr. 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.



## BOARD MEMBERS BIOGRAPHIES

### **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.

### **Jeff Nielsen**

Jeff Nielsen was appointed to the WCCMHB in July 2024. He is a retired Chief of the Rockford Police Department, having served 34 years with the Department in various positions, including his last five as Chief. He graduated from Northwestern University's School of Police Staff and Command. Currently, he serves as President of the Rockford Police Pension Fund Board. Previously, he served on the Janet Wattles Mental Health Center Board and the Rosecrance Board after the merger of the two organizations. Jeff has a strong interest in mental health, especially concerning public safety and first responders.

### **Dr. Amanda Penney**

Dr. Amanda June Penney, DSW, LCSW, is a licensed clinical social worker with over a decade of experience in community-based mental healthcare. Dr. Penney graduated from Aurora University. She has spent her entire career working with children and adults who struggle with mental health concerns. Outside of her current role of helping homeless Veterans get housed, Dr. Penney is on an editorial board for the Journal of Social Service Research.

### **Dr. Collene Taylor**

Dr. Collene Taylor is a Certified Life Coach, author, and speaker who owns and operates WithU Counseling Group, PLLC, a private practice based in Rockford, Illinois. She is dedicated to serving adults, families, and couples, with a strong commitment to fostering growth and resilience. Dr. Taylor is licensed to practice psychotherapy in Alabama, Arizona, Florida, Illinois, and Texas. Dr. Taylor provides clinical supervision for license and license-eligible clinicians in Florida, Illinois and Texas, guiding professionals with compassion, mentorship and leadership, shaping the next generation of mental health professionals.

She holds a Doctorate in Organizational Leadership from Argosy University and a Master of Science in Community Counseling from the University of Wisconsin-Whitewater. With 30 years of professional experience, Dr. Taylor has provided psychotherapy services in both public and private sectors. Her diverse background includes work in hospitals, community agencies, mental health centers, residential and community-based settings, substance abuse treatment facilities, facilities for individuals with developmental disabilities, senior living communities, and various roles at the university level.

### **Mohammad Yunus**

Mohammad Yunus was appointed to serve on the 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, 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 use 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 use services in Winnebago County and coordinate them through planning, funding, evaluation, and communication.

## Values

*Why we do what we do*

**Wellness** – We support the Certified Community Behavioral Health Clinics (CCBHC) countywide system of care because it focuses on providing an array of services that bring people from illness to health.

**Awareness** – We believe mental illness and substance use 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 use 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 use 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 use services, so we promote trauma-informed care in all areas of service delivery.

**Accessibility** – We believe mental health and substance use 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.



VISION, MISSION,  
VALUES AND  
PRINCIPLES

COMMUNITY  
SUPPORT SYSTEM

## 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

In 1977, the National Institute of Mental Health hosted a participatory planning process with consumer groups, researchers, and mental health advocates, among others, for the Community Support Program (CSP). As a result of this process, a new comprehensive framework was created for the planning and execution of services for adults with serious mental health concerns. This framework, known as the Community Support System (CSS) Framework, identified several key components for effective, productive mental health treatment within the community, rather than state-run facilities.

These components describe the variety of services and supports that individuals living with severe mental illness might need to function and recover in their community. The 11 components are: Client Identification & Outreach, Mental Health Treatment, Crisis Response Services, Health and Dental Care, Housing, Income Support, Peer Support, Family and Community Support, Rehabilitation Services, Protection & Advocacy, and Case Management.

For its first two strategic plans, the WCCMHB utilized the CSS Framework to guide mental health and substance use programming priorities for Winnebago County. However, research into this framework has been stagnant since the 1980s, prompting the WCCMHB to seek a new framework to guide programming. For more information on the transition from the CSS wheel to the new framework, please see the [Looking Back](#) and [Where We Are Now](#) sections.

**Figure 1: Community Support System**





## PURPOSE AND PLANNING

### CERTIFIED COMMUNITY BEHAVIORAL HEALTH CENTERS

# The Purpose and Planning of a Strategic Plan

Strategic planning is the “ongoing organizational process of using available knowledge to document an organization’s intended direction”.<sup>1</sup> This process is used to prioritize efforts, effectively allocate resources, align shareholders and employees on the organization’s goals, and ensure those goals are backed by data and sound reasoning”.<sup>2</sup> Within the context of Community Mental Health Boards, the strategic planning process is a statutory requirement and evaluates the current behavioral health system in the Board’s service area through the identification of gaps, areas for improvement, and other needs the Board can address. The Association of Community Mental Health Authorities of Illinois (ACMHA) outlines community mental health as “the people of a community take responsibility for the design and organization of a local system of care”.<sup>3</sup> The individuals appointed to a Community Mental Health Board utilize the Strategic Plan to guide funding opportunities and decisions, and to identify measures of success.

## Environmental Scan

An environmental scan surveys and interprets data to identify strengths, weaknesses, opportunities, and threats within the current mental health service delivery system. 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.

## Key Informant Interviews

New to this iteration of strategic planning, Key informant interviews were conducted with 18 organizations spanning a wide array of service areas to gauge their ability and capacity for participating in the implementation of a county-wide Certified Community Behavioral Health Center (CCBHC) model. Interviews were conducted with organizations across sectors and specialties to accurately assess the feasibility of the CCBHC model in Winnebago County, IL.

## Data Synthesis

Qualitative and quantitative data were analyzed from WCCMHB and other community surveys, studies, reports, etc. The results of the Environmental Scan and Public Participation Survey were evaluated against past ES and PPS results. The results of the scan, survey, and key informant interviews were used to inform this plan.

# Certified Community Behavioral Health Clinics (CCBHCs)

A Certified Community Behavioral Health Center (CCBHC) is a designation awarded by the State of Illinois, through a federal demonstration project, to organizations equipped to improve access to comprehensive and coordinated mental health and substance use care. One designation is granted per county, and in October 2024, Rosecrance achieved this designation for Winnebago County, IL. As the CCBHC for Winnebago County, Rosecrance serves as the ‘safety net’ for individuals who are likely to fall through the cracks of the mental health system. They are required to serve any individual who seeks services, regardless of diagnosis or insurance status.

The CCBHC model is a joint effort led federally by U.S Department of Health and Human Services (HHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), Centers for Medicare and Medicaid (CMS), and Office of the Assistant Secretary for Planning and Evaluation (ASPE), which all play a role in the implementation, monitoring, and evaluation of the CCBHC model.<sup>4</sup> CCBHCs can bill



Medicaid and be reimbursed under a prospective payment system (PPS), selected by the state in which the CCBHC resides. Rates are calculated on a per-clinic basis, rather than a blanket rate for all CCBHCs in a state. Reimbursement can be at either a daily or monthly rate and may include other financial incentives and rates, depending on the state's chosen methodology.

There are four methodologies states can choose from:<sup>5</sup>

- PPS-1: Pays the expected costs on a daily basis with optional Quality Bonus Payments (QBPs)
- PPS-2: Pays expected costs on a monthly basis, with outlier payments and QBP, and the option for special population rates
- PPS-3: Pays the expected costs on a daily basis with Special Crisis Service (SCS) rates and optional QBPs
- PPS-4: Pays expected costs on a monthly basis, with required SCS rates, outlier payments, QBP's, and optional special population rates

Illinois chose to opt into the PPS-1 methodology.<sup>6</sup>

CCBHCs are required to have the following services available, either through the agency itself or through agreements with other organizations, also known as CCBHC Designated Collaborating Organizations (DCOs).<sup>7</sup> 51% of service encounters must be operated directly through the CCBHC organization, while DCO's may make up the other 49% (not including crisis services).

- Crisis Services
- Outpatient Mental Health and Substance Use Services
- Person- and Family-Centered Treatment Planning
- Community-Based Mental Health Care for Veterans
- Peer Family Support and Counselor Services
- Targeted Case Management
- Outpatient Primary Care Screening and Monitoring
- Psychiatric Rehabilitation Services
- Screening, Diagnosis, and Risk Assessment

These nine required services fall under the 'Scope of Services' CCBHC certification criterion. 'Scope of Services' is one of six criteria agencies must meet before obtaining a CCBHC designation. The other five criteria are: Staffing, Availability and Accessibility of Services, Care Coordination, Quality and Other Reporting, and Organizational Authority and Governance.<sup>8</sup>

For additional information regarding the CCBHC's, please visit the [SAMHSA](#) or [HFS](#) websites.



**WCCMHB Research**



## ENVIRONMENTAL SCAN

# Environmental Scan

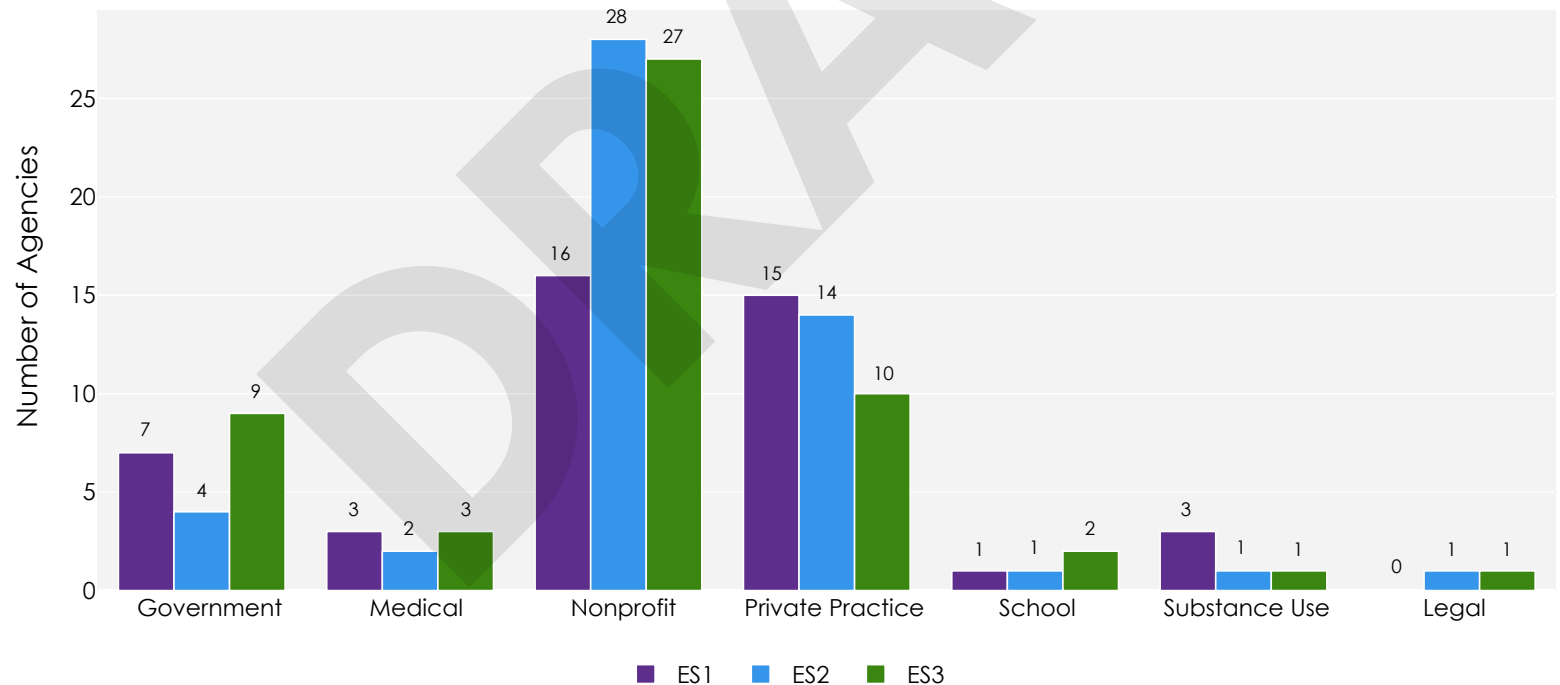
The WCCMHB Environmental Scan (ES) was created in order to better understand the community from the perspective of service providers in Winnebago County, IL. The survey asks service providers various questions about the types of services provided, annual client volumes, funding sources, service accessibility, populations served, among other topics. 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 2023. “ES3” is the most recent Environmental Scan, completed in early 2026.

ES3 resulted in 53 completed surveys. Eighteen respondents previously completed ES1-3, and 10 agencies participated in ES2-3, resulting in a total number of 28 respondents who completed one or both of the previous Environmental Scans.

## Types of Agencies

The Environmental Scan provides a longitudinal overview of the mental health and/or substance use disorder services available throughout Winnebago County. Agencies that completed the Environmental Scans were categorized into one of the following organizational types specified in the bar chart (Figure 2). Over the history of the survey, the most common categories are nonprofit agencies and private practices. Starting with ES2, there has been a notable decrease in private practices taking the survey and a corresponding increase in nonprofits and government agencies. This shift can be attributed in part to the growth in the number of WCCMHB-Funded Programs since ES1 and the WCCMHB encouraging its Funded Programs to complete the Environmental Scan.

**Figure 2: Types of Agencies**





## ENVIRONMENTAL SCAN

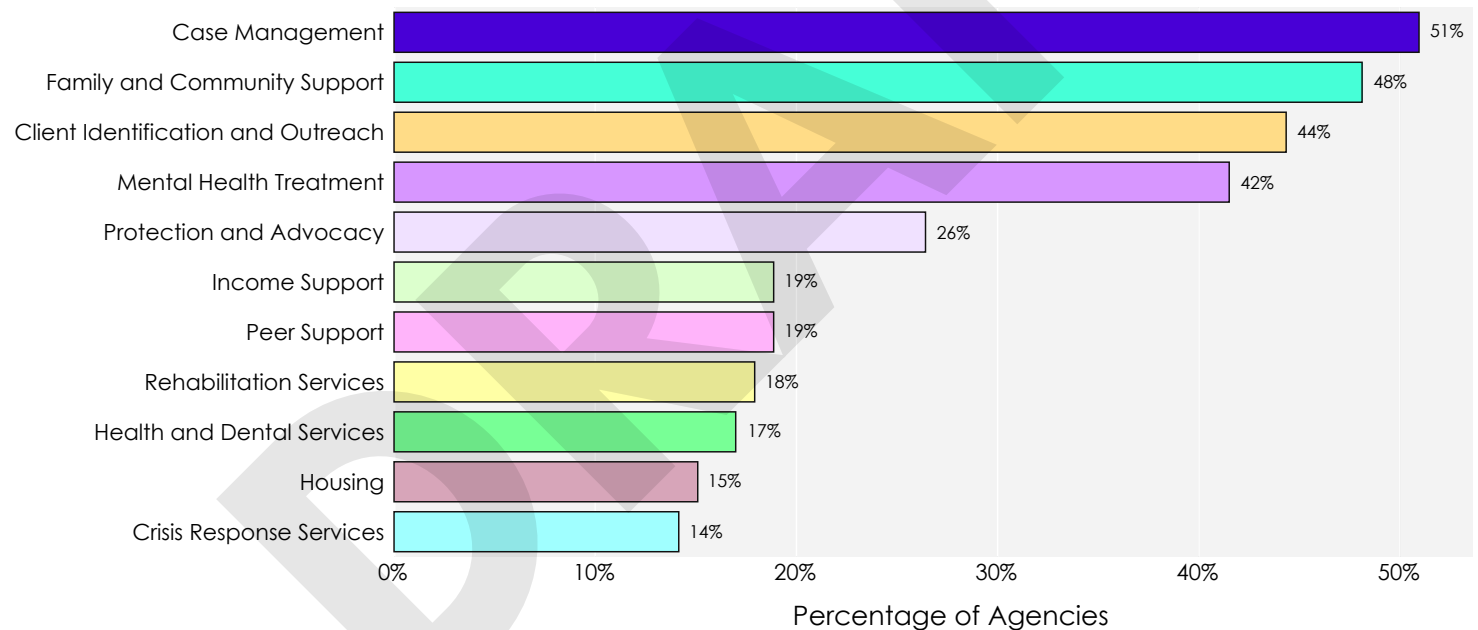
### CSS Component and Service Areas

The third Environmental Scan (ES3) maintained consistency with previous iterations by assessing services through the Community Support System (CSS) framework—a foundational model for the WCCMHB since its inception. Although the Board is currently transitioning to the [CCBHC model](#), ES3 utilized the CSS framework to allow for direct comparative analysis.

To summarize the CSS framework and provide context for the rest of the Environmental Scan results, services provided by agencies were categorized under the 11 component areas defined in the CSS framework. These component areas represent the array of services that an adequate mental health support system should provide to its community. The component areas are also identified in the bar chart (Figure 3). Several component areas are further subdivided into a few primary service areas, as shown in the “Services Offered in Each Primary Service Area” visualization. Specific definitions of these component and service areas are provided in the Environmental Scan section of the [Appendix](#).

Figure 3 shows the percentage of agencies offering services that fall under each of the 11 CSS components. The most common services fall under the Case Management, Family and Community Support, Client Identification and Outreach, and Mental Health Treatment components.

**Figure 3: Services Offered in Each Component Area**

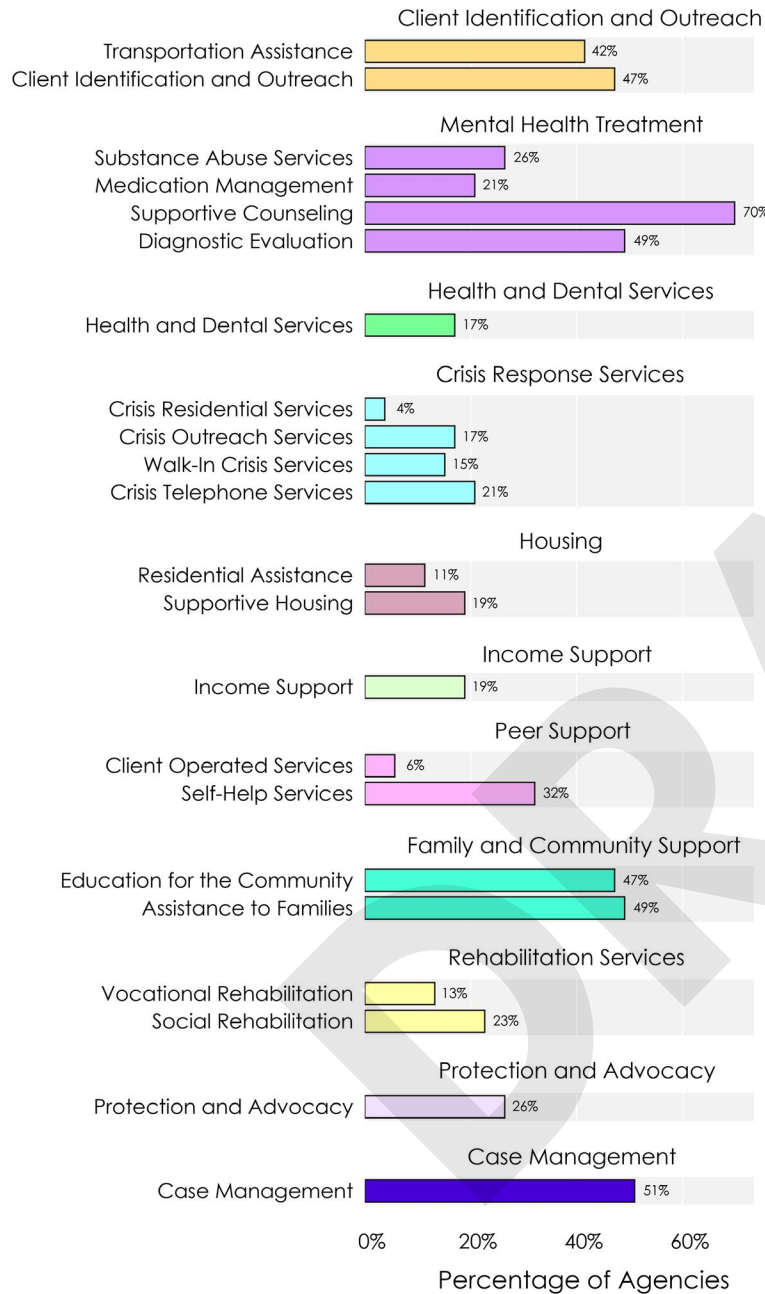


As mentioned, the components can also be broken out into their respective primary service areas. Figure 4 titled, “Services Offered in Each Primary Service Area,” shows the percentage of agencies offering expertise within these service areas. Within components that have multiple service areas, the percentage of agencies offering services in these areas can vary. For example, Supportive Counseling is the most common service area within the broader Mental Health Treatment component, with 70% of providers reporting it as a core service area. Within the same component, Diagnostic Evaluation remains a prevalent service area. Conversely, Substance Use Services and Medication Management are significantly less common; this disparity results in an overall fourth-place ranking for the Mental Health Treatment component.



ENVIRONMENTAL  
SCAN

**Figure 4: Services Offered in Each Primary Service Area**



Service prevalence is largely determined by the balance between community demand and operational feasibility. ES3 data indicates that services within Case Management, Family and Community Support, Client Identification and Outreach, and Mental Health Treatment are the most widely available. These foundational services—such as counseling, diagnosis, and case management—are characterized by high community demand and lower operational barriers, allowing agencies of all sizes to offer them as core components of the system of care.

In contrast, the least common services fall under the components of Crisis Response, Housing, and Health and Dental Services. These service areas are often highly specialized and carry higher clinical or financial risk, requiring specific staff credentials and robust organizational infrastructure. While housing support and crisis response services typically serve a lower volume of community members compared to counseling and case management, they are critical components of the community safety net.

A recurring theme throughout the ES3 results is the tension between the community demand for a service and the provider capacity. This imbalance is often most visible when certain services have waitlists, indicating the collective agency capacity is not meeting the overall demand. One of the major community improvements since ES2 is a reduction in the frequency of reported waitlists across a few key services. This trend is analyzed further in the [Agencies and Services with Waitlists](#) section, following a review of the service distribution and client volume results.

### Service Area Changes from ES2

Another primary success outcome identified from the ES3 data is significant growth in historically uncommon services. Table 1 shows the three service areas with the greatest increase in the percentage of agencies offering these services since ES2: Supportive Housing, Medication Management, and Substance Abuse Services. The fourth column tracks changes specifically among “repeat respondents” (agencies that participated in both surveys), further supporting that these increases represent an actual expansion of capacity within existing organizations, not just a shift in the survey sample.

In ES2, Medication Management was among the least commonly provided services. Under the same component of Mental Health Treatment, Substance Abuse Services were also less frequently offered compared to Supportive Counseling and Diagnostic Evaluation Services. The Mental Health Treatment component was previously identified in Strategic Plan 1.0 as the top priority area.



Therefore, the long-term growth in these two service areas represents success for both WCCMHB planning and the community.

Similarly, the growth of Supportive Housing—previously the second-least offered service—is a successful outcome. Given that supportive housing demand continues to exceed available resources (as detailed in the [Agencies and Services with Waitlists](#) section), maintaining this upward trajectory will likely assist in addressing this imbalance.

**Table 1: Service Areas with the Greatest Growth in Percentage of Agencies Offering these Services**

Service	ES2 Percentage	ES3 Percentage	Change	ES2-ES3 Repeats Change
Supportive Housing	7.8%	18.9%	+11.1%	+9.9%
Medication Management	11.8%	20.8%	+9%	+9.4%
Substance Abuse Services	17.6%	26.4%	+8.8%	+23%

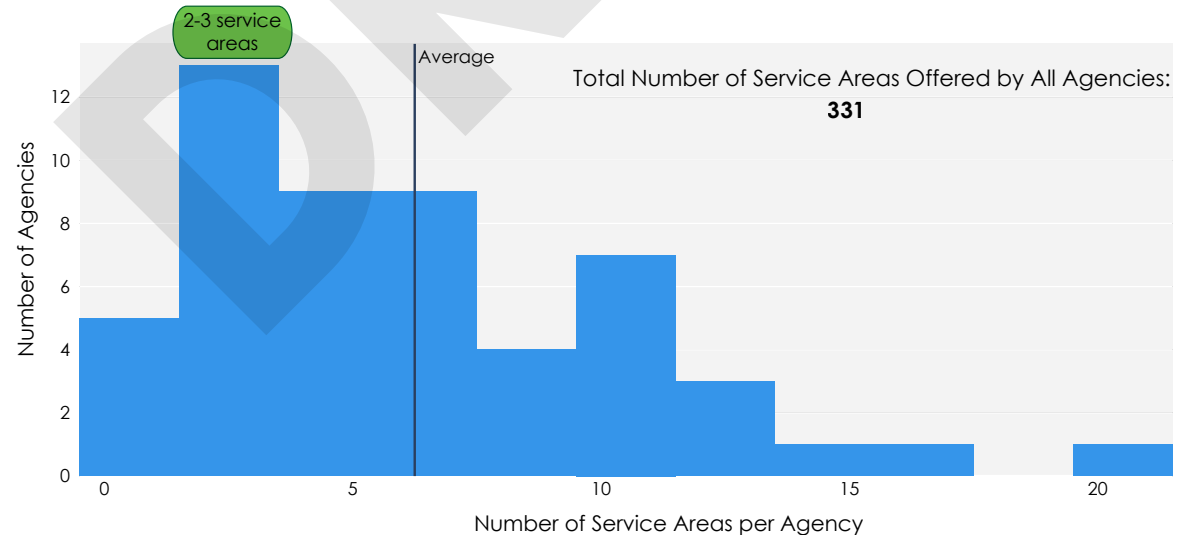
Conversely, service areas with the greatest decline in the percentage of agencies offering those services include Protection and Advocacy (-10.9%), Education for the Community (-8.8%), and Client Operated Services (-8.3%). These shifts likely reflect two factors:

1. Protection and Advocacy and Education for the Community remain very commonly offered service areas. A small decline likely reflects a slightly different group of agencies responding to ES2 versus ES3.
2. The decrease in Client-Operated Services may stem from varying respondent interpretations of the service definition rather than a true reduction in available support.

## Number of Service Areas and Agency Resources

The 53 agencies participating in ES3 collectively provide a total of 331 service areas across Winnebago County. While the average agency offers six service areas, the majority are specialized, typically providing two to three targeted service areas. A small group of “anchor” organizations—large agencies with robust infrastructure and diverse funding—serve as outliers, offering between 15 and 20 distinct services.

**Figure 5: Number of Service Areas and Agency Resources**





# ENVIRONMENTAL SCAN

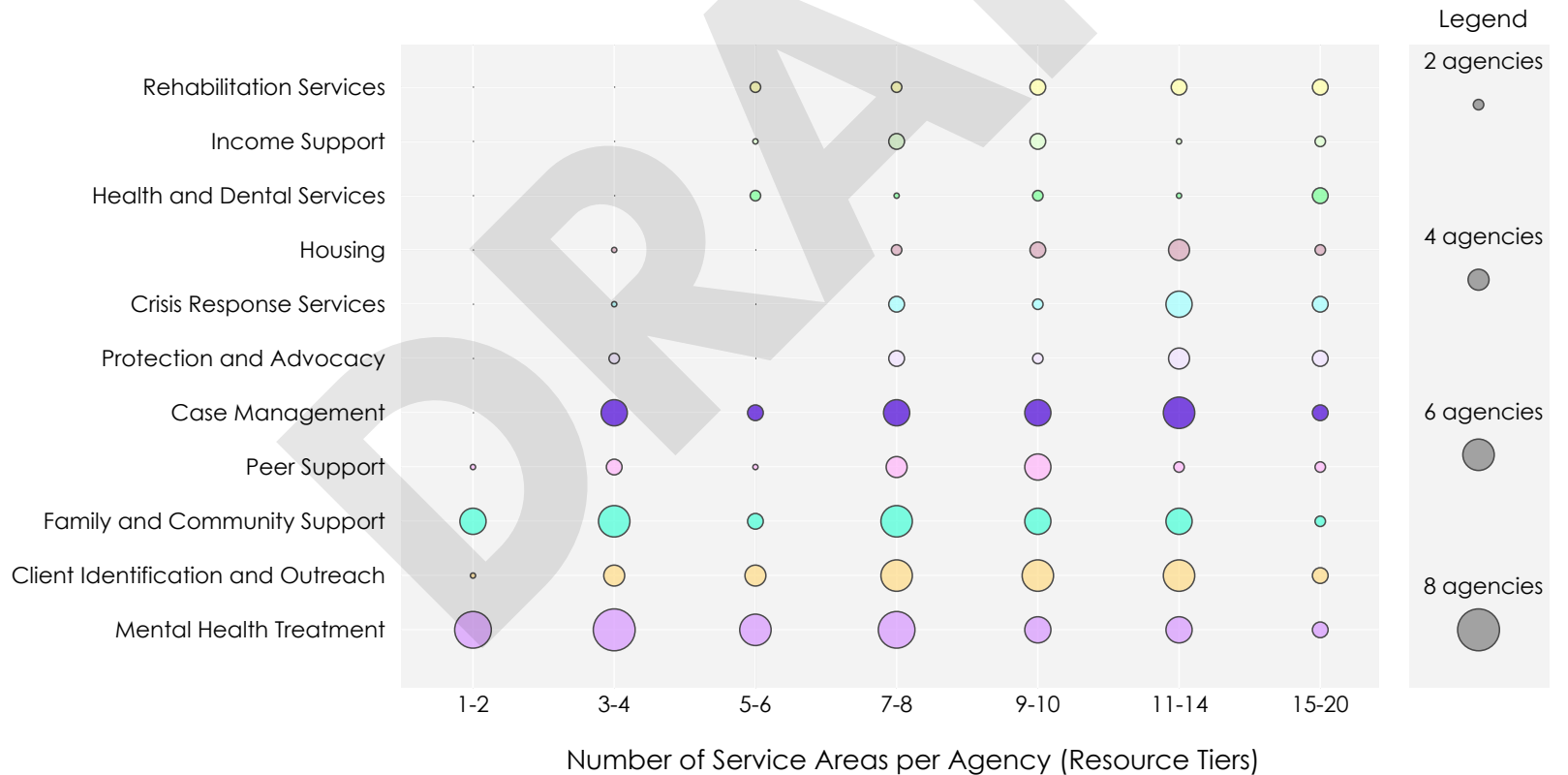
To better understand community capacity, agencies are categorized into “Resource Tiers” based on the volume of services they provide. This serves as a proxy for organizational scale. For example, agencies offering 1-5 service areas would fall into the lowest tiers, while those offering 15-20 service areas would fall into the highest.

Agencies within the lower tiers (1-5 services) often focus on specific niches within the “universal” component areas like Mental Health Treatment, Client Identification and Outreach, and Family and Community Support. The strength that lies within these smaller but more numerous agencies is their ability to offer a particular expertise to targeted clients. In contrast, agencies within the highest tiers (10+ services) possess the infrastructure necessary to sustain “specialized” services—such as Crisis Response, Housing, and Health and Dental care—which involve higher operational costs and clinical risk.

These trends are represented visually in Figure 6, titled, “Relationship between Components and Number of Service Areas per Agency.” The sizes of the bubbles occurring at each intersection represents the number of agencies at that resource tier offering services within that component area. Larger bubbles indicate that services under that component area are more common at that resource tier.

The distribution of services across these tiers reveals a clear pattern in the community’s system of care. Services within Mental Health Treatment, Outreach, and Family Support are provided by agencies of all sizes. Conversely, as mentioned, Crisis Response and Housing Support services are concentrated among the higher resource tiers (specifically those offering 11-14 services). These complex service areas require significant staff credentials and organizational resources that are more commonly found in larger, multi-service agencies.

**Figure 6: Relationship between Components and Number of Service Areas per Agency**



\* Bubble sizes (see legend) indicate the number of agencies at the agency resource tier providing services within the respective component.

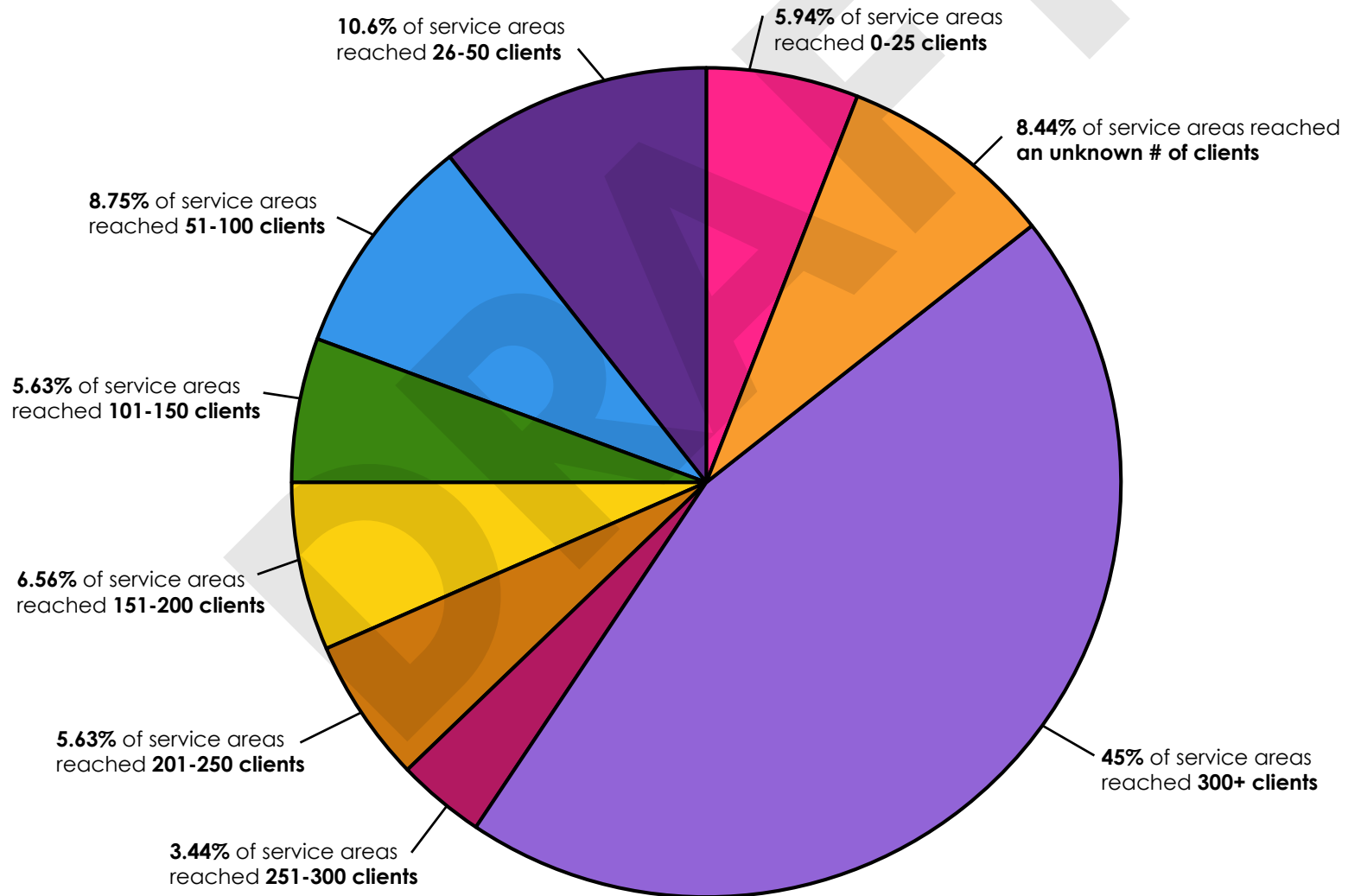


## Annual Client Volumes

The annual client volume for a specific service reflects a complex combination of community demand, agency capacity, and the nature of the service itself. For example, there is a notable distinction between rapid-access services (such as Crisis Response and therapeutic services) and long-term services (such as Supportive Housing), where the complexity of the process limits the total number of clients served at any given time.

The pie chart, Figure 7: Number of Clients per Service Areas, shows the overall distribution of client volumes across the approximately 300 collective service areas offered by agencies. The most frequent client volume reported was 300+ clients, representing 45% of the collective number of service areas offered. Conversely, on the small end of the client volume spectrum, respondents collectively indicated that 5.94% of services are used by 0-25 clients annually.

**Figure 7: Number of Clients per Service Area**



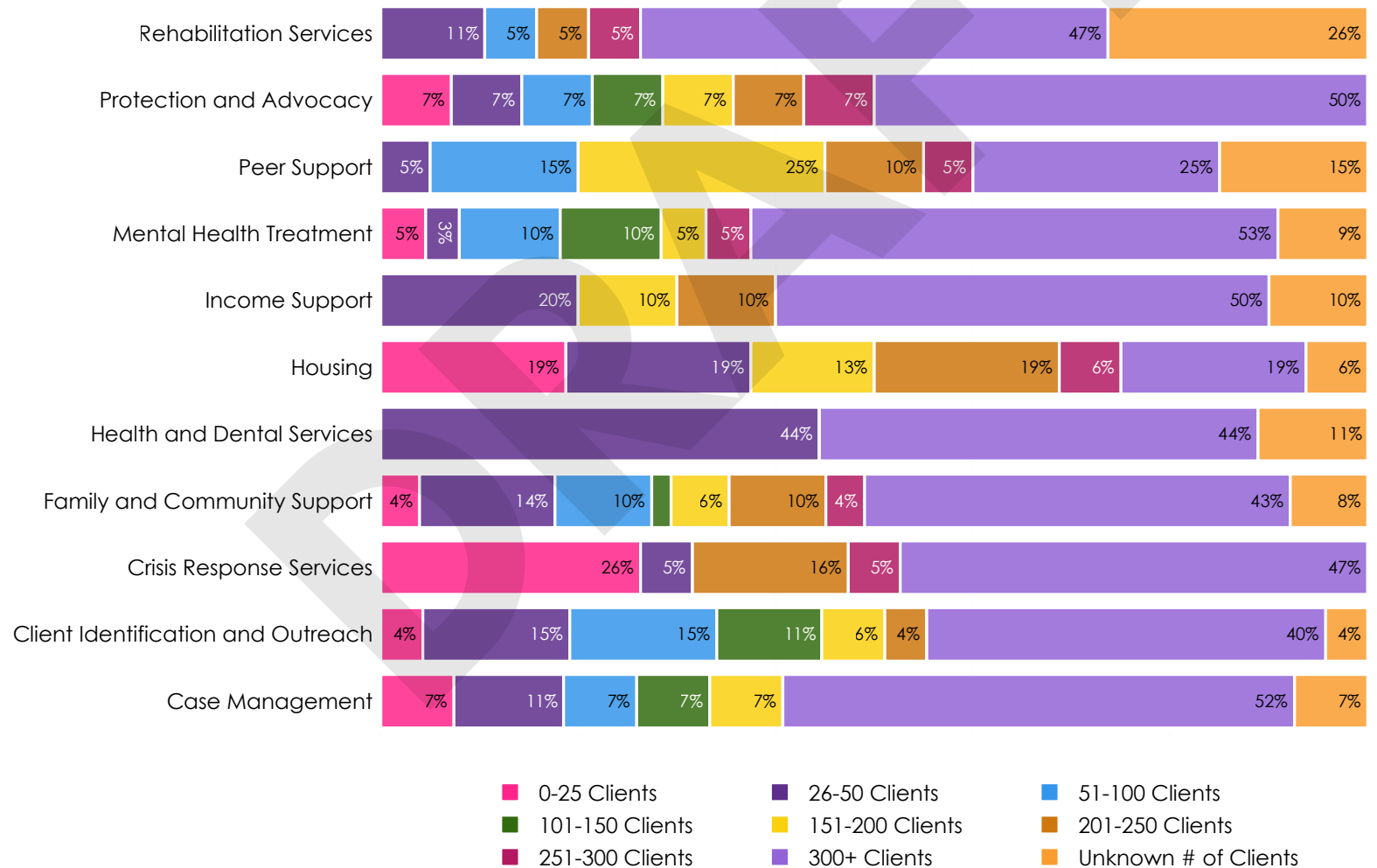


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The distribution of client volumes, broken out by each component area, is shown in the chart (Figure 8), titled “Number of Clients per Service by Component Area.” The components that contain general services such as Mental Health Treatment, Client Identification and Outreach, Case Management and Family and Community Support, mirror the overall community distribution, with high volumes reported across most agencies. However, the more specialized components such as Housing, Health and Dental Services, Crisis Response Services, and Rehabilitation Services differ significantly from the overall distribution, in part reflected by the smaller numbers of agencies offering these services.

Components such as Housing, Crisis Response, and Health and Dental show more fragmented distributions. For example, in the Health and Dental component, a clear divide exists between large-scale government or medical organizations serving 300+ clients, and smaller nonprofit or school-based programs serving 26-50 clients. The main observation from the annual client volume analysis is that providers across almost all components maintain substantial reach. High client volumes are not restricted to the largest organizations; even agencies with a narrow, specialized focus frequently report serving a high number of individuals.

**Figure 8: Number of Clients per Service by Component Area**





## Agencies and Services with Waitlists

The presence of waitlists is a natural consequence of the demand for a service exceeding an agency's capacity to provide that service. Waitlist times have been a longstanding, historical issue within the mental health and substance use treatment systems. Waitlists may occur for services across the spectrum of client volumes, from 300+ clients annually to as few as 0-25 clients, depending on the operational challenges of the service and agency capacity.

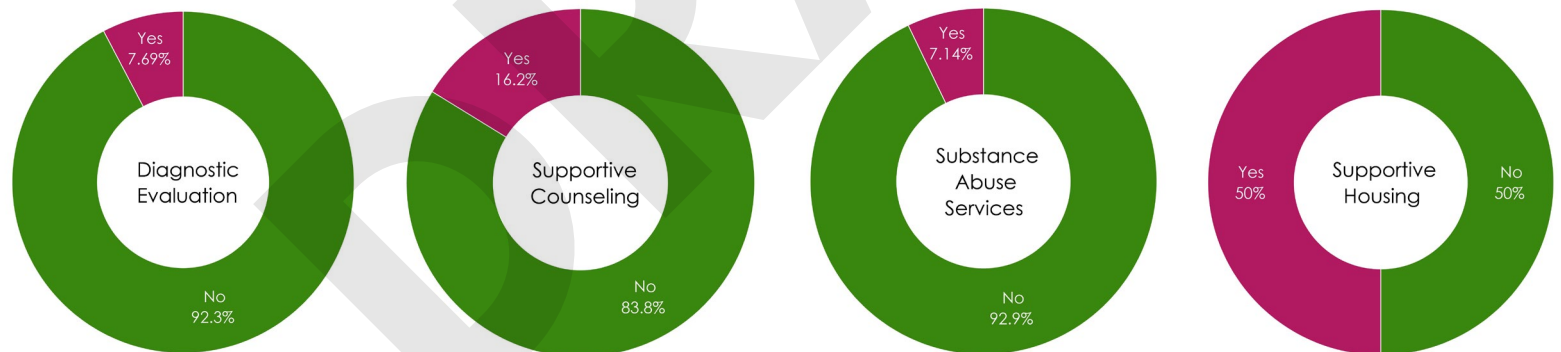
A major community success identified in ES3 is a decline in waitlist frequency for diagnostic and therapeutic services. This shift suggests increased operational efficiency and expanded capacity among local providers. The service area of Diagnostic Evaluation showed the largest improvement, from 41.7% of agencies reporting a waitlist for this service in ES2, dropping to only 7.7% agencies reporting a waitlist in ES3. Waitlists for Supportive Counseling also showed a large decrease, from 43.3% of agencies in ES2 to 16.2% in ES3. A smaller decrease was observed in the Substance Abuse service area, from 12.5% of agencies reporting a waitlist to 7.14%. Collectively, these results indicate increased efficiency by agencies to serve clients in these areas.

Additional questions added to ES3 addressed Supportive Housing and Medication Management waitlists. Of the agencies that said they handle medication management, none of them reported a waitlist for that service.

However, in contrast to the gains made in clinical services, Supportive Housing remains a critical area for further improvement. Half of all agencies offering this service (50%) maintain a waitlist, with 60% of those waitlists exceeding 50 individuals. Agencies offering Supportive Housing services reported that clients stay an average of 22 months in their housing, with a maximum reported length of 60 months, and these long stays limit availability and extend wait times.

Housing is a service type that has previously been emphasized in this report and within the community as a complex system to navigate and costly for agencies to operate. For further analysis of the intersection between Serious Mental Illness (SMI), Substance Use Disorders (SUD), and housing, please refer to the [Region 1 Planning Council Winnebago and Boone Counties Housing and Mental Health Community Needs Assessment](#) in the Other Community Research section of the Strategic Plan.

**Figure 9: Service Areas with Waitlists**





## ENVIRONMENTAL SCAN

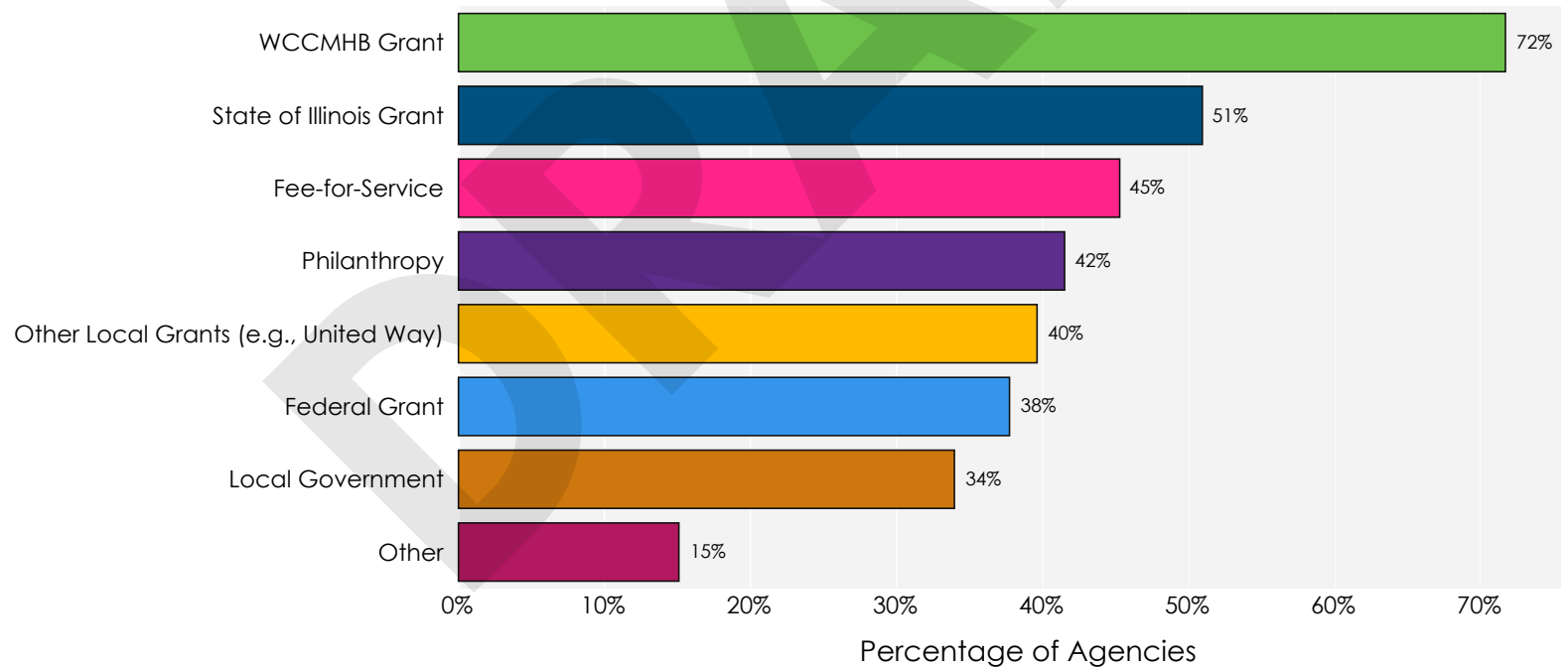
In total, 11 agencies reported waitlists among these four service areas. Interestingly, the data shows no direct correlation between waitlists and an agency's total client volume or a lack of diverse funding. For example, six of the 11 agencies with waitlists report having at least four distinct funding sources, suggesting that waitlists are driven by capacity shortages or specialized service needs rather than a simple lack of budget.

When subsetting by service area, data from the ES3 survey concerning waitlists is limited by a small number of responses. However, the presence of waitlists appears to depend on both the agency and the service type. For example, many agencies that have Supportive Counseling waitlists were categorized as nonprofits, and waitlists may be associated with more specialized counseling services, such as couples therapy, family therapy, or group counseling. Nonetheless, there has been a positive change: agencies are reporting lower frequencies of waitlists in ES3 compared to ES2.

### Funding Sources

To better understand how agencies pay for their operations, past Environmental Scans have asked organizations about their principal funding sources. Since ES2, organizations have increased and diversified their funding sources across multiple categories. For example, 72% of agencies reported utilizing WCCMHB grant funding, as shown in the "Funding Sources for Services" bar chart (Figure 10), compared to 48% in ES2. Reasons for this increase include the WCCMHB offering Accelerator Awards for one-time capital projects between ES2 and ES3, and fewer private practices and non-WCCMHB-Funded Organizations among respondents in ES3. Other notable increases were in philanthropy and other local grants, rising from 18% to 42% and from 20% to 40%, respectively.

**Figure 10: Funding Sources for Services**



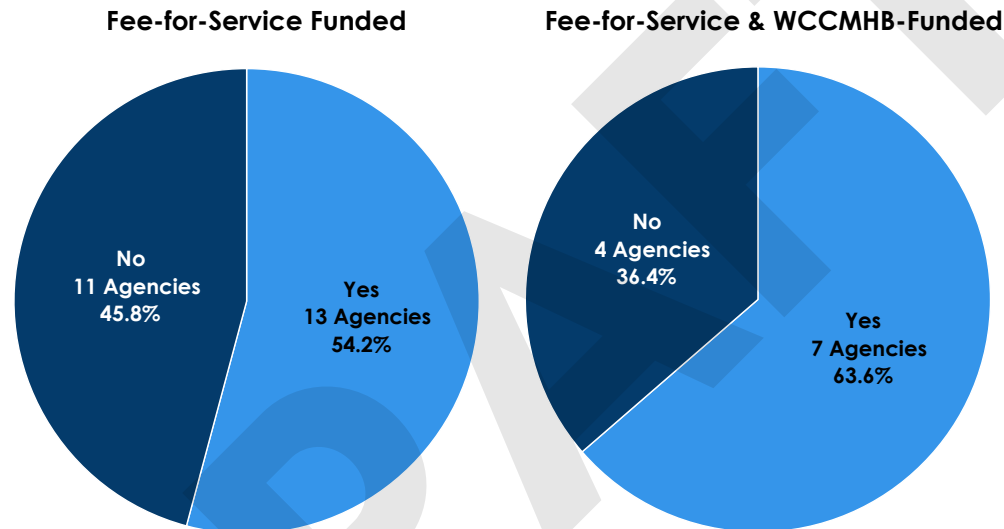


## ENVIRONMENTAL SCAN

Of the agencies that reported funding their operations through at least some fee-for-service avenues, 13 (54.2%) also offer sliding-scale payments. A sliding-scale payment model charges individuals for services based on their ability to pay, rather than a universal set rate for all. This reduces the financial barrier for individuals and families who may otherwise be unable to afford services. Eleven respondents said they do not have a sliding-scale payment option.

With additional external funding sources, particularly the WCCMHB grant, agencies are better equipped to offer sliding scale payments. In fact, after subsetting the fee-for-service agencies to only include WCCMHB-Funded Respondents, the percentage of agencies that offer sliding-scale payments increased from 54.2% to 63.6%. Notably, WCCMHB agencies may have still responded “No” to offering sliding-scale payment options due to their services being free of charge, making a sliding-scale model unnecessary. Finally, the agencies may also bill an insurance company and the WCCMHB grant will cover the portion that the insurance company does not.

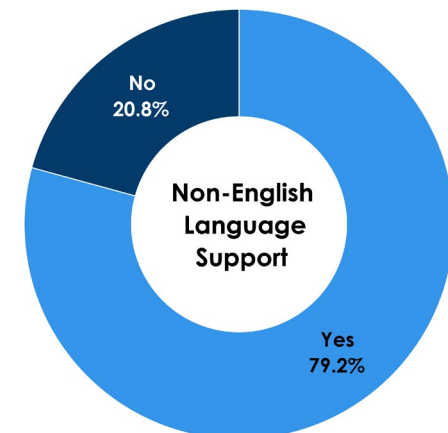
**Figure 11: Agencies Offering Sliding-Scale Payments**



## Non-English Language Support for Services

In ES3, 79.2% of respondents indicated they offer language support for non-English speakers, compared to 62.7% in ES2, which is a notable positive impact on the community. 26.4% of agencies reported offering a language line service as well, which is an especially notable development as they indicated this through the “Other” option category in the survey form. A language line service is an on-demand interpretation service that offers a robust portfolio of languages for translation via artificial intelligence. Advances in this new technology have also likely contributed to the increased amount of non-English language support services. Many WCCMHB-Funded Programs also employ bilingual staff to reduce language barriers. The top non-English languages offered in agency services were Spanish (66% of agencies), Arabic (18.9%), and Swahili (18.9%).

**Figure 12: Non-English Language Support**



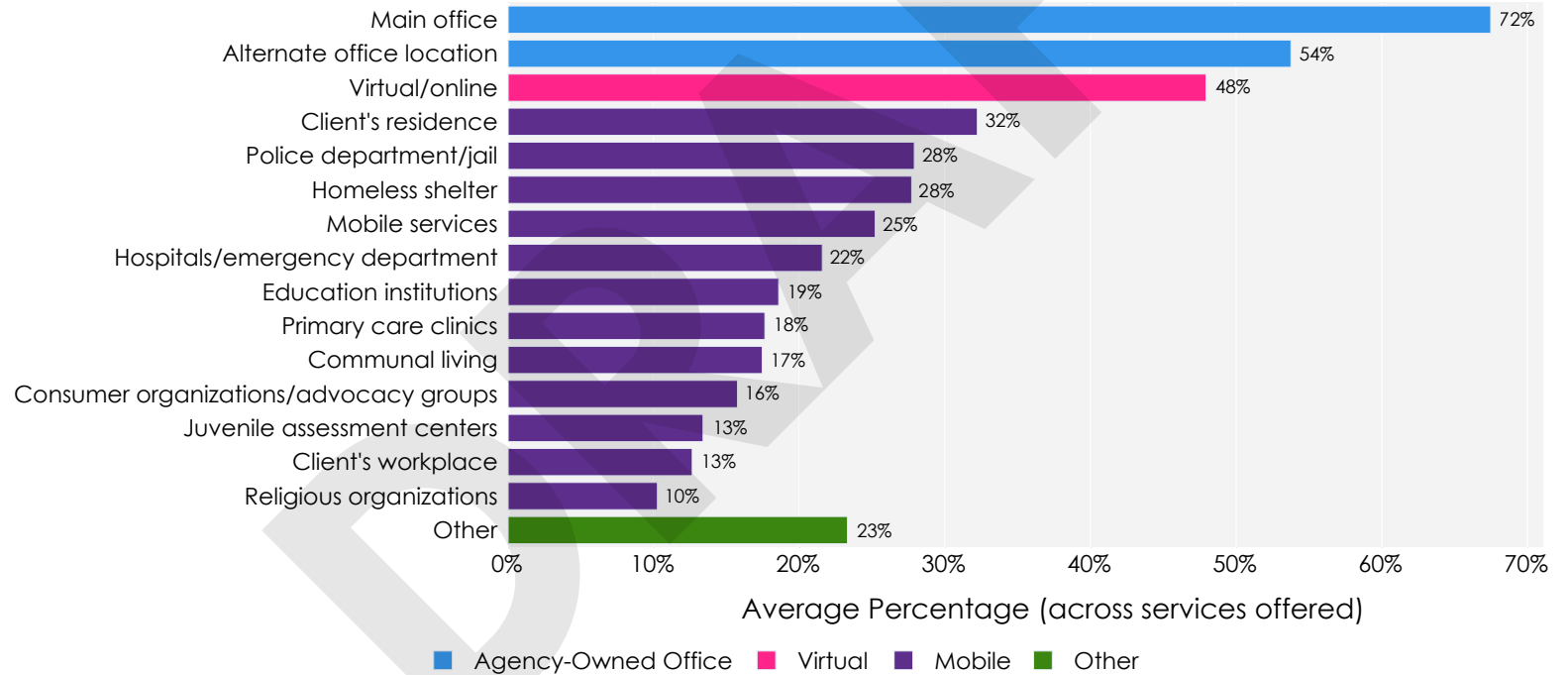


## Service Locations

Mental health and substance use sectors typically embrace a “meet them where they are” philosophy, which is a person-centered approach that accounts for each individual’s unique mobility and environmental circumstances. Building on trends identified in ES2, the current data shows a continued shift toward diversified service delivery, moving beyond traditional office settings to include both virtual and mobile options. For the ES3 analysis, “virtual” and “mobile” services were categorized as distinct delivery methods to better track how agencies are overcoming potential geographic barriers. Mobile services are defined as any in-person interaction occurring in non-agency settings, such as a client’s residence, workplace, or a community center.

The vast majority of agencies continue to utilize main office locations as their primary hubs, with many leveraging satellite offices to maintain a physical presence in specific neighborhoods. Telehealth has emerged as the second-most frequent option. Its high adoption rate reflects the growing community demand for the convenience and immediate access provided by virtual platforms. In contrast, mobile services remain a less common service delivery option. This delivery mode is often reserved for specific types of services that require “in-the-field” intervention, and they may have higher infrastructure, transportation, and operational costs associated with them.

**Figure 13: Service Locations**

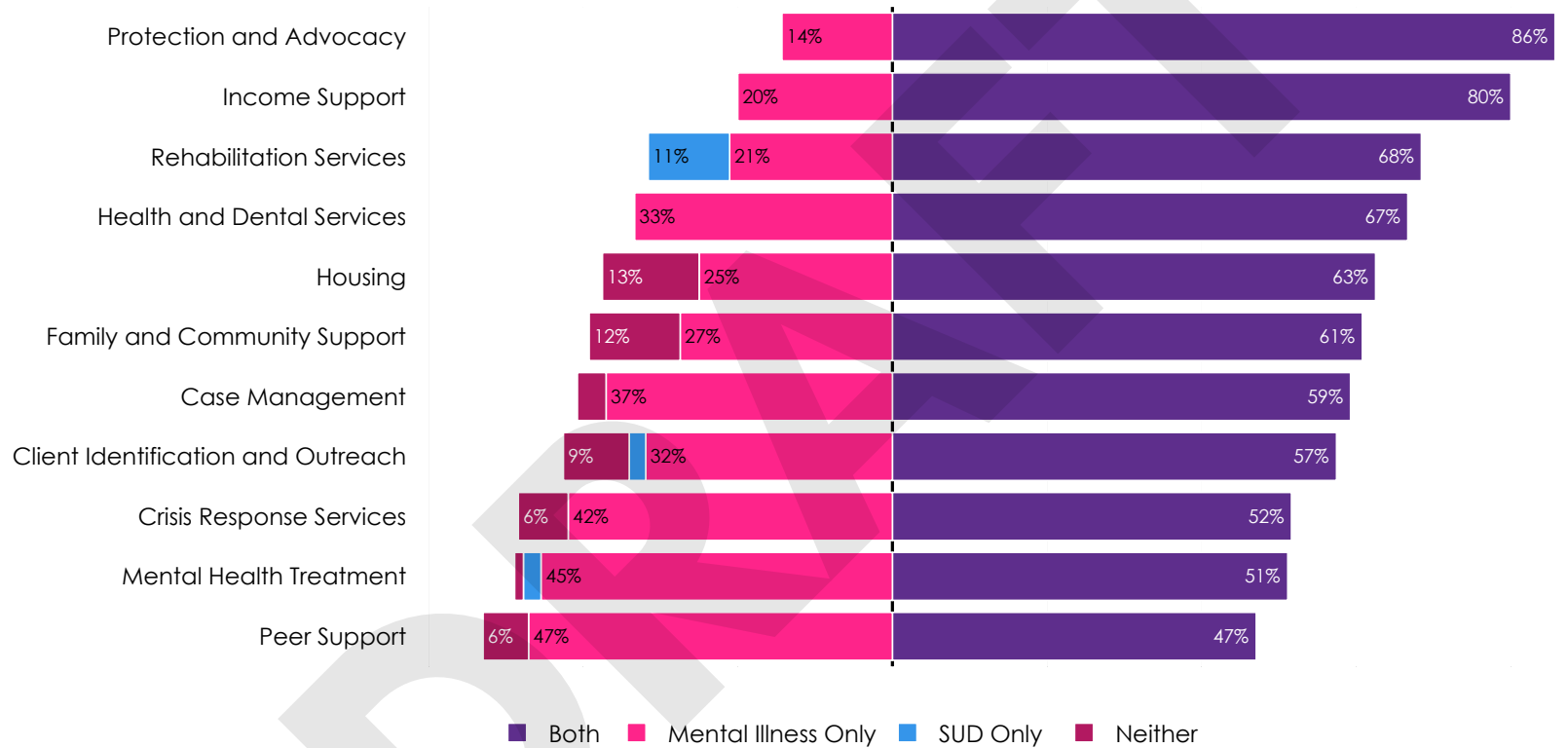




## Services for Mental Illness and SUD

Mental illness and substance use disorder are oftentimes intertwined, so providers should acknowledge the need to treat both illnesses rather than focusing on one or the other. Agencies in ES3 generally offer services to both the mentally ill population and those suffering from substance use disorder. The diverging bar graph (Figure 14) shows for each component area, a comparison of the percentage of services offered to “Both” SMI and SUD populations, versus the percentage of services offered to only one of the populations—generally those with mental illness—and/or neither of the populations. Most components have above 50% in the “Both” category, with the highest components in the 80%-86% range, and even the lowest component has close to 50%.

**Figure 14: Services for Mental Illness and/or Substance Use Disorder by Component Area**





## Populations Served

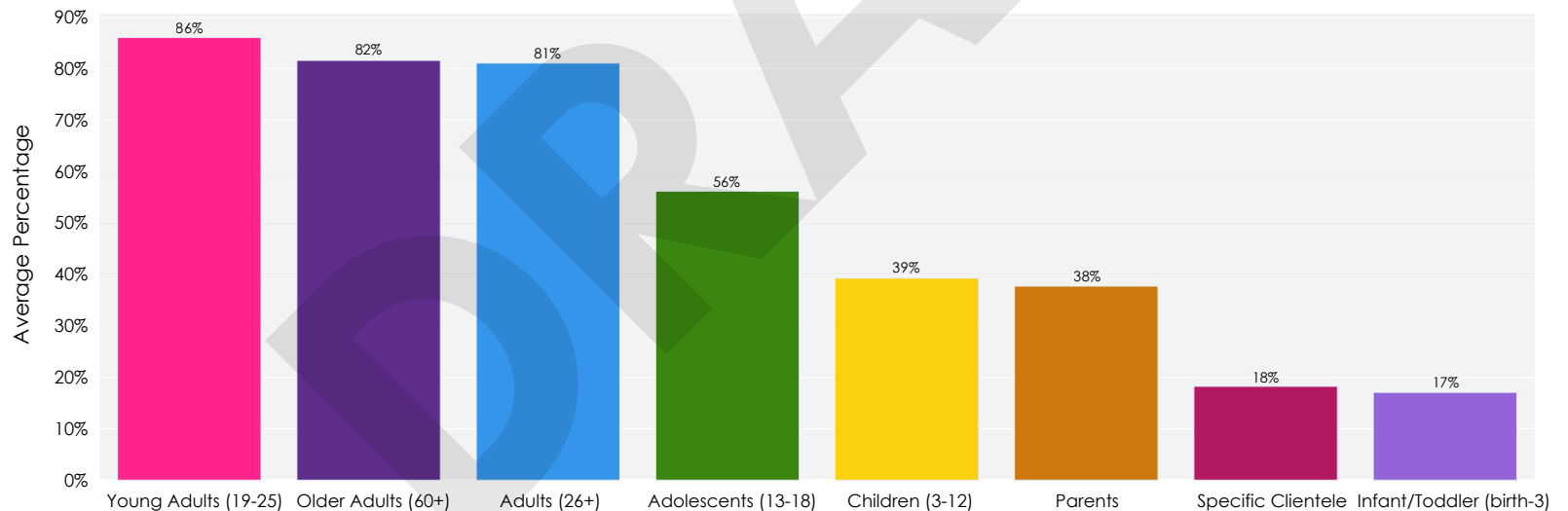
The onset of Serious Mental Illness (SMI) and Substance Use Disorders (SUD) typically occurs during adolescence or young adulthood, making these populations a focal point of targeted service delivery. The bar chart (Figure 15), titled, “Populations Served Across All Service Areas,” compares the frequency of service offerings to various age populations, including adolescents and young adults.

While the sheer volume of service offerings appears high for adults and older adults, this is attributable to the broader age ranges these categories encompass. The data actually reveals a concentrated focus on younger populations after accounting for the varying age ranges (see the [WCCMHB Data Dashboard](#)). Children and adolescents remain the most frequently served age groups across WCCMHB-Funded Programs, followed closely by young adults.

Beyond age-based demographics, agencies reported serving specialized populations based on their organizational missions (“Specific Clientele”). These include populations such as students and youth at risk, survivors of domestic violence and sexual assault, individuals with disabilities, and high-risk probationers. With regards to serving specialized populations, a critical need identified in WCCMHB Notice of Funding Opportunities (NOFOs) is clinical services targeting eating disorder treatment. As such, it remains an unmet community need, representing an opportunity for future service development.

Compared to ES2, the percentage of populations served across all age groups has increased, with the largest increase seen in the older adult age category, rising from 71% in ES2 to 82% in ES3. Increases across all age categories likely point to the successes of the WCCMHB NOFOs. These initiatives have prioritized specialty populations, ranging from infant and early childhood mental health to youth crisis and older adult services.

**Figure 15: Populations Served Across All Service Areas**





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Beyond increased access, the ES3 data highlights a clear transition in the types of support required as clients age. This data is summarized in the table titled “Top Component Areas for Each Population” and demonstrates how the most common types of services provided varies by age category:

- Children and Adolescents (Under 18): Service needs are primarily concentrated in Protection and Advocacy, Peer Support, and Family and Community Support. These foundational services often emphasize awareness, development, and the strengthening of the family unit.
- Young Adults (19-25): This key developmental phase marks a shift in the types of services required for these populations. While Protection and Advocacy is still a major type of service provided for these populations, they show an increasing need for Rehabilitation Services, Income Support, and Housing, which reflects the unique challenges individuals with SMI and SUD encounter when transitioning into adulthood.
- Adults and Older Adults (26+): For these adult populations, Rehabilitation Services emerges as the top component, and there is a sustained need for Income Support, reflecting the long-term needs of these populations. Housing also emerges as a top priority for older adults, highlighting an increasing need for specialized residential supports as they age. Finally, services tailored specifically for parents are concentrated within Protection and Advocacy, Family and Community Support, and Client Identification and Outreach. This focus ensures that caregivers have the necessary advocacy and community-based resources to maintain a stable environment for the family unit.

**Table 2: Top Component Areas for Each Population**

Population	Number 1 Component Area	Number 2 Component Area	Number 3 Component Area
Infant/Toddler (birth-3)	Protection and Advocacy	Income Support	Family and Community Support
Children (3-12)	Protection and Advocacy	Peer Support	Family and Community Support
Adolescents (13-18)	Protection and Advocacy	Peer Support	Mental Health Treatment
Young Adults (19-25)	Protection and Advocacy	Rehabilitation Services	Income Support Housing
Adults (26+)	Rehabilitation	Income Support	Protection and Advocacy
Older Adults (60+)	Rehabilitation Services	Housing Income Support	N/A
Parents	Protection and Advocacy	Family and Community Support	Client Identification and Outreach



## ENVIRONMENTAL SCAN

### Conclusions

Environmental Scan 3.0 provides a data-rich analysis of the mental health and substance use services offered in Winnebago County. While the full report offers detailed insights, the following findings represent the most critical trends for WCCMHB's strategic planning.

### Improvements in the Community

Compared to the previous scans, the Winnebago County agencies that responded to ES3 demonstrated significant improvements in several key areas:

- The community has seen significant growth in the percentage of providers offering Supportive Housing, Medication Management, and Substance Use services.
- The occurrence of waitlists have decreased in these clinical service areas: Diagnostic Evaluation, Supportive Counseling, and Substance Use services.
- Agencies have increased and diversified their funding sources, and the WCCMHB has become a more common funding source supporting their programming and operations.
- WCCMHB funding has allowed agencies to more frequently offer sliding-scale payment options, directly reducing the financial cost to individuals with SMI and SUD.
- Services have expanded to include a broader age range, from infants to older adults, underscoring the success of WCCMHB NOFOs targeting specific populations.

### Realities and Gaps

The ES3 results also highlight the constraints and realities service providers face, as well as the potential gaps in services within the community.

- Service providers often serve a large volume of clients. Across all service areas, agencies collectively indicated that 45% of their services reach over 300 clients annually.
- 50% of agencies offering Supportive Housing Services reported having a waitlist. The complexity and high cost of housing resources makes this a difficult service area for agencies to offer. Moreover, for those that do offer this service, the fact that many clients require long stays—sometimes lasting months or even years—limits the number of available supportive housing units. Promisingly, the growth in the number of agencies providing Supportive Housing may help address this gap.
- A service gap for specific clientele that has yet to be met from earlier funding opportunities is treatment for eating disorders.
- Many agencies focus on providing a few different services concentrated under component areas such as Mental Health Treatment, Client Identification and Outreach, and Family and Community Support. This often allows them to find success through fitting into a specific service niche. However, importantly, the more specialized and resource-intensive component areas such as Housing and Crisis Response are typically provided at agencies with a broad offering of service areas. These agencies tend to already possess the existing infrastructure and capacity to provide these intensive services. It is critical that agencies work together to serve clients with different needs, creating a robust care coordination system.

The WCCMHB is committed to assisting providers and funded agencies in working within these realities and filling service gaps.



## PUBLIC PARTICIPATION SURVEY

# Public Participation Survey

Designed to engage Winnebago County community members on perspectives related to mental illness and/or substance use services and gaps, the Public Participation Survey (PPS) is developed and released once every three years to align with the WCCMHB strategic planning process. The PPS 2 and PPS 3 versions have the same base question structure to allow for comparison of change-over-time data.

The PPS focuses on the barriers individuals encounter in their daily lives when seeking mental health or substance use services, and takes into account three different perspectives: mental health workers, lived experience, and community members. The PPS 2 version allowed only one perspective selection; however, since individuals can have more than one perspective, the PPS 3 version of the survey allowed participants to report on multiple viewpoints.

“Lived experience” encompasses both individuals living with a mental illness or substance use disorder, as well as family or caretakers of said individuals. This perspective was asked about their experience utilizing services within the past year, services needed but could not receive, and what could have helped them receive those services.

The mental health worker section reflects both agency administrators and direct service staff working directly with clients. Administrators and direct service staff were asked which services are easy for clients to access and how overall service access can be improved for individuals seeking services.

Community members represent the population of individuals who may not be receiving mental health services or are not involved with anyone’s mental health or substance use care. While these individuals may not currently have a need for mental health or substance use services, knowledge of the various services offered throughout the county reflects the WCCMHB’s promotion to the broader community.

In this PPS 3 iteration of the Public Participation Survey, four additional questions were included in a section named ‘Residential Awareness’. This section was optional, gauging general awareness of the WCCMHB, how long respondents have been aware of WCCMHB, whether their awareness has changed over the past year, and their knowledge of the WCCMHB Funded Programs.

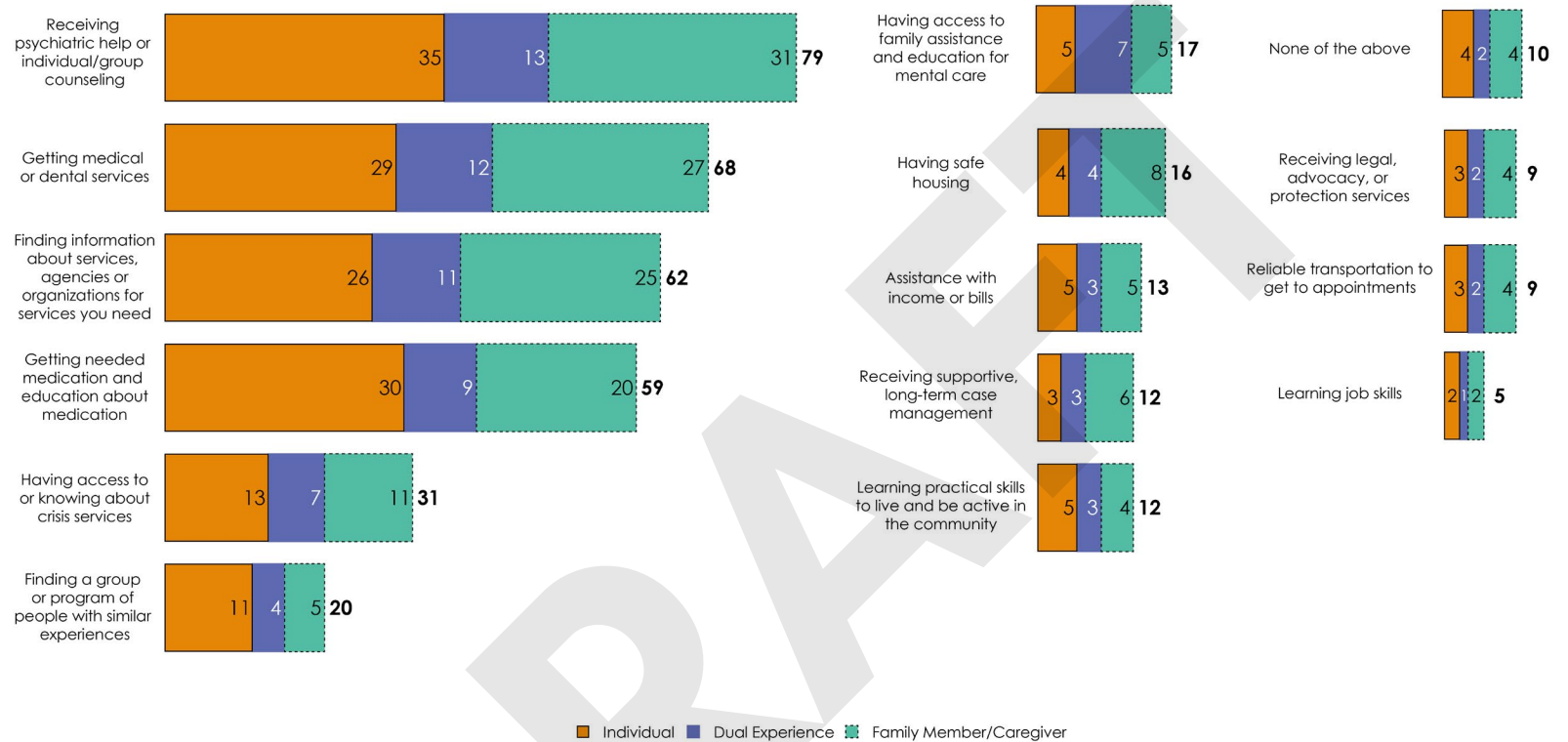
After the perspective and resident awareness sections, free-response feedback was offered so respondents could share their additional thoughts on anything that may or may not have been covered in the survey.



## PPS Quantitative Data

### Lived Experience

Figure 16: In the past 12 months, which of the following services did you, or someone in your household, use?



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 (68.7%)
- Getting medical or dental services (59.1%)
- Finding information about services, agencies, or organizations for services you need (53.9%)
- Getting needed medication and education about medication (51.3%)
- Having access to or knowing about crisis services (27.0%)

The top response for the most utilized service was consistent across iterations of the PPS: 'receiving psychiatric help or individual/group counseling' remains the number one most used service. In the PPS 2, 58.8% of respondents indicated they had used this service, and in PPS 3, that percentage rose by an additional 9.9 percentage points.



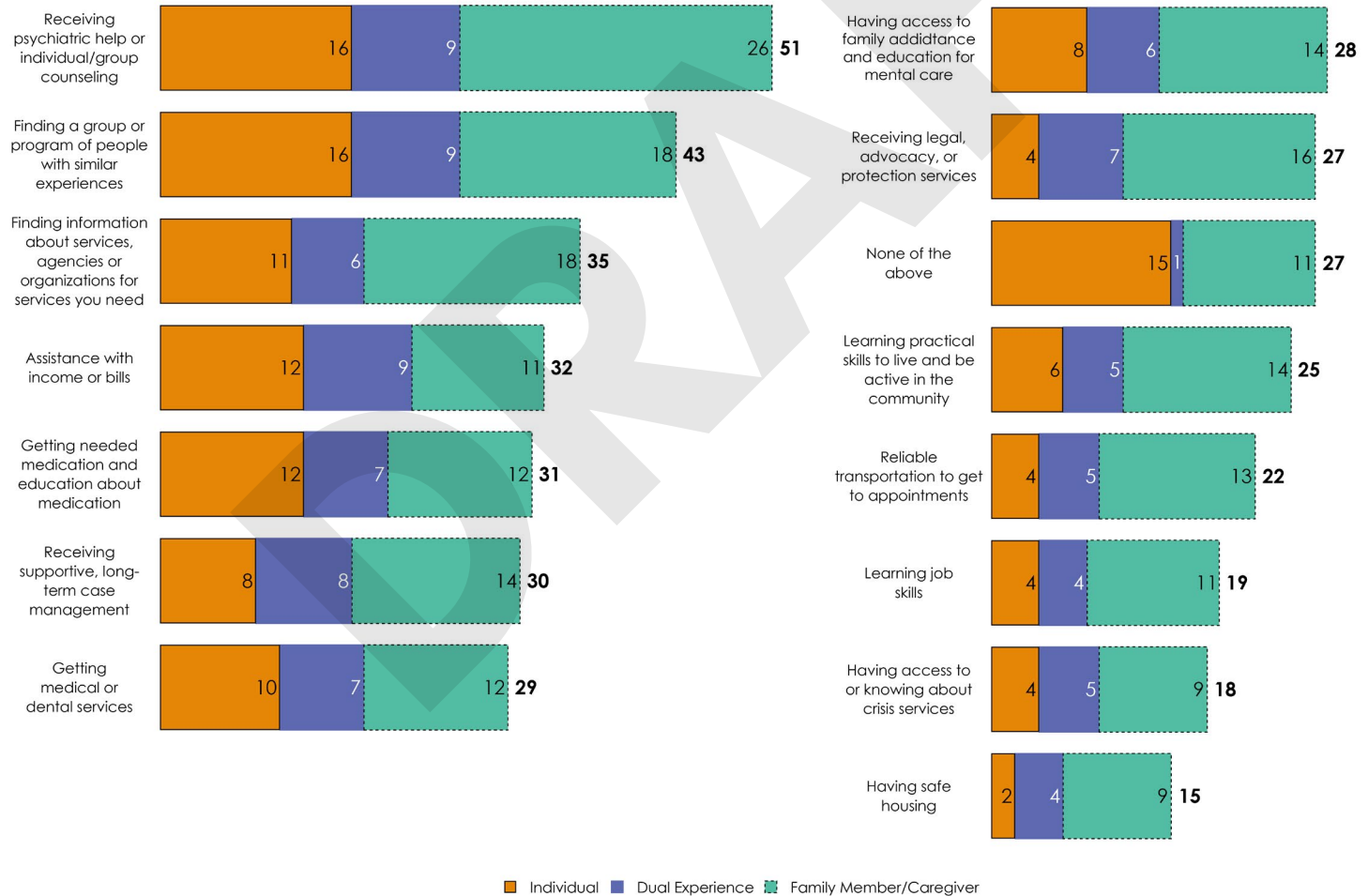
PUBLIC PARTICIPATION SURVEY

The new second most popular response was medical or dental services, consistent with common medical practices that emphasize physical health as “primary” and models that integrate physical and mental health. Finding information about mental health services, including the various agencies and organizations that offer them, was the new third-most-used response option. This is related to the increase in receiving psychiatric help or counseling, as people will seek out information about their options before choosing an agency.

The previously ranked 2nd, which is getting needed medication and education about medication, increased by 4.2 percentage points but is now fourth ranked. So, this is still a need, but not as high a priority after the new 2nd- and 3rd-ranked responses.

The responses out of the top 4 had response rates under 50%. The responses ranked 5-7 were the same rank in PPS 2 to 3. The other responses may have shifted in rank, but their response rates were less than 7 percentage points of change. Interestingly, awareness of crisis services increased by 7 percentage points, which could be due to increased awareness and utilization of crisis response services such as the Crisis Co-Response Team (CCRT) and Mobile Integrated Health (MIH), both of which receive funding through the 1/2 cent sales tax for mental health.

**Figure 17: In the past 12 months, which of the following services did you, or someone in your household, need but could not receive?**





## PUBLIC PARTICIPATION SURVEY

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 (44.3%)
- Finding a group or program of people with similar experiences (37.4%)
- Finding information about services, agencies, or organizations for services you need (30.4%)
- Assistance with income or bills (27.8%)
- Getting needed medication and education about medication (27.0%)

While receiving psychiatric help or counseling was the most utilized service reported by respondents, the service individuals cited as needed, but could not access, was psychiatric help and/or counseling. This is a reflection of a common issue; when the need is higher than the current amount of resources offered, there are more individuals seeking psychiatric help than the current workforce can address. Approximately 44.3% of PPS 3 respondents indicated that they, or someone in their household, needed but could not obtain these services, a 7.3 percentage point increase from PPS 2.

Finding groups or programs with individuals of similar experiences remained a consistently needed service across iterations of the PPS. 37.4% of PPS 3 respondents indicated that they, or someone in their household, needed the service but could not obtain it, a 19.2 percentage point increase. This significant increase could be due to a decreasing stigma that encouraged clients to attempt to seek out others who understood their experience.

Much like the previous section, finding information about services, agencies, and organizations increased between PPS 2 and PPS 3. This is consistent with the increase in utilizing psychiatric help and/or counseling, as individuals need to gather information about agencies and services before making an informed decision on their care.

While assistance with income or bills dropped in rank between PPS 2 and PPS 3, the response selection increased by 7.8 percentage points, from 20% to 27.8%. When considered within the context of the tension the social services sector faces and uncertainties in federal assistance programs, individuals who experience functional impairments due to mental illness are likely to be seeking assistance with income or bills.

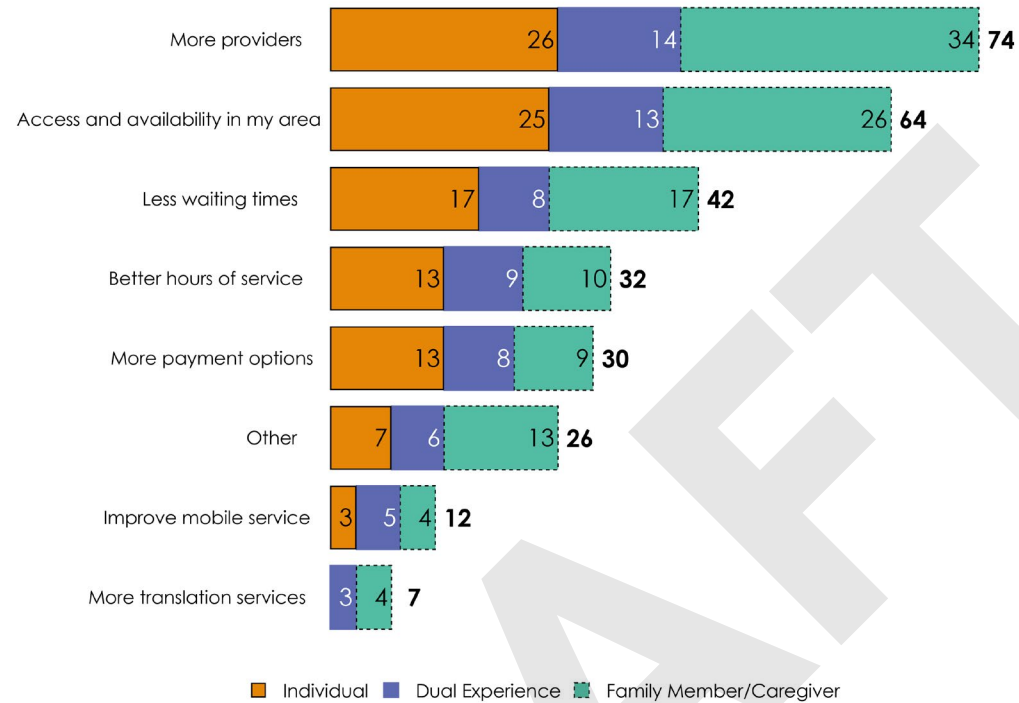
Finally, receiving needed medications and education about medicines showed a 7.8 percentage point increase between PPS 2 and PPS 3. With additional utilization of mental health and substance use services, more individuals are likely to get assessed and diagnosed, and may be put on medication for their conditions. This, in turn, increases the number of people needing medication and puts strain on the local pharmacy supply, especially when taking preexisting medication shortages into account, such as ADHD medications.

All other responses increased from PPS 2 to PPS 3, indicating that more residents are recognizing they may need mental health or substance use services. In turn, they are using the community's services and resources and may continually strain an already burdened workforce.



PUBLIC PARTICIPATION SURVEY

Figure 18: What would have helped you, or someone in your household, receive these services?



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 (64.3%)
- Access and availability in my area (55.7%)
- Less waiting times (36.5%)
- Better hours of service (27.5%)
- More payment options (26.1%)

The need for more providers remains consistent across both PPS 2 and PPS 3. Respondents in both surveys indicated that more providers would have helped them, or someone in their household, receive services. There was a 2 percentage point increase between PPS 2 and PPS 3, from 62.4% to 64.3%. Many individuals seeking these services have Medicaid insurance, therefore access to care could be increased by more providers, particularly prescribers, accepting Medicaid.

A substantial increase was observed between PPS 2 and PPS 3 when respondents were asked about accessibility to services in their area. In PPS 2, 28.8% reported that access in their area would have helped them receive services. However, in PPS 3, the percentage increased to 55.7% of respondents indicating that access and availability would have helped them receive services. This could be for many reasons, including variations in an individual’s perception of ‘in my area’. For some individuals, ‘in my area’ may mean a 20-minute drive, while others, especially those with transportation barriers, may consider that same distance to be outside their area.



PUBLIC PARTICIPATION SURVEY

Waitlists and wait times have slightly decreased between PPS 2 and PPS3. In PPS 2, 40.6% of respondents expressed that reducing waitlists and wait times would have helped them receive services. In contrast, 36.5% of respondents indicated the same in PPS 3, a 4.1 percentage point decrease. These results are consistent with those from the third iteration of the Environmental Scan, which found that fewer organizations have waitlists than in the previous Environmental Scan survey.

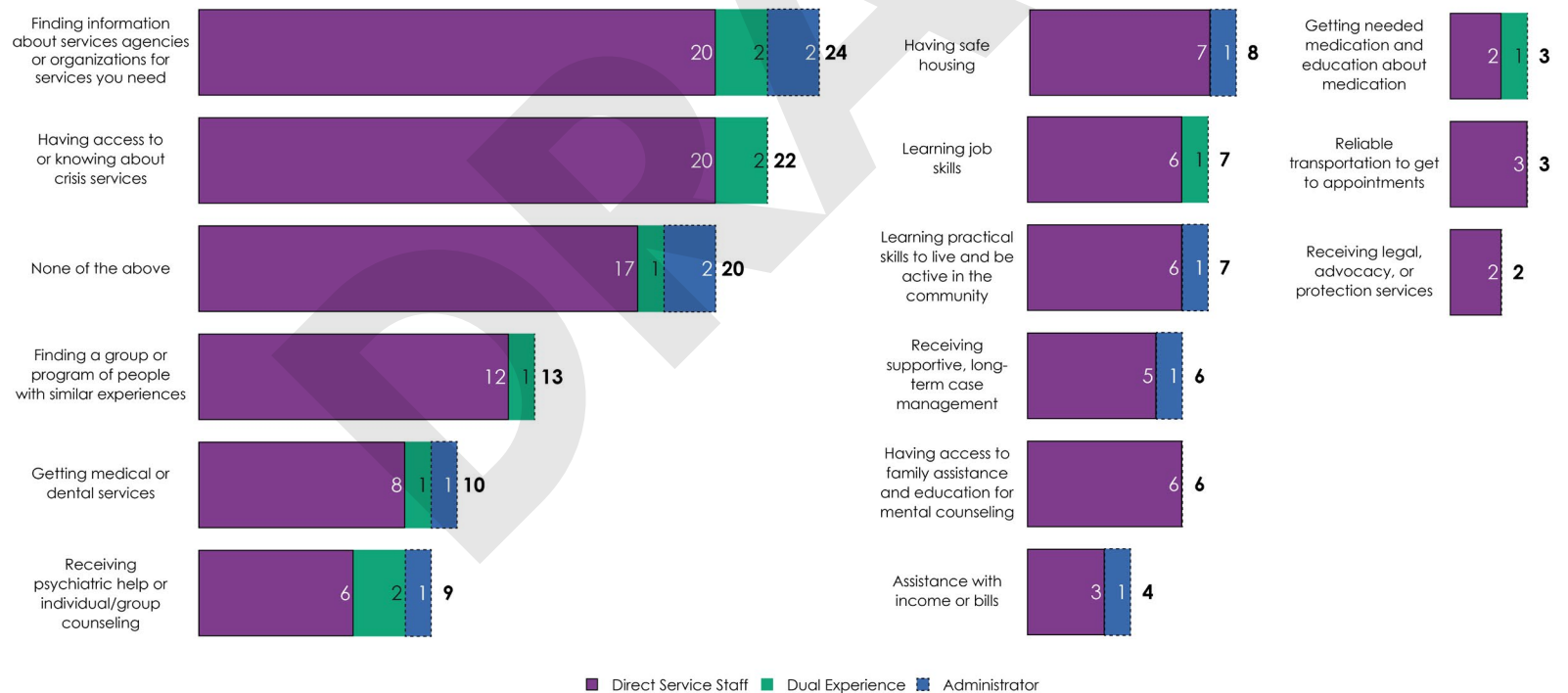
Winnebago County residents reported that hours of service remain an area for improvement. In PPS 2, 25.3% of respondents selected that better hours of service would have helped them receive services, and this increased to 27.8% in PPS 3. Many individuals work in a typical shift-like setting, where taking time off can be a barrier to care. Agencies may want to explore expanding their hours past 5:00 PM, and into the weekend in order to best serve individuals and their schedules. However, agencies may find sourcing staff for these shifts difficult.

Diverse payment options remain a need within the county. In PPS 3, 26.1% responded that more payment options would help them receive services. While this is a 1.5 percentage point decrease from the previous PPS, payment type diversity remains a persistent barrier to services. Results from the Environmental Scan indicate that organizations are using sliding-scale options; however, public perception of the accessibility of those options remains unchanged. Organizations may want to consider promoting the various payment options they accept.

While both mobile services and translation options increased across both Public Participation Services, they remain the least selected options for what would help an individual receive services. Fourteen percent of respondents selected the 'other' short-answer option, and described the specific barriers they've experienced when attempting to access services.

Mental Health Workers

Figure 19: As a mental health worker, what services are easy for clients to access in Winnebago County?





## PUBLIC PARTICIPATION SURVEY

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 (38.7%)
- Having access to or knowing about crisis services (35.5%)
- None of the above (32.3%)
- Finding a group or program of people with similar experiences (21.0%)
- Getting medical or dental services (16.1%)

Obtaining different perspectives from both users of mental health and substance use services in Winnebago County, as well as from the workforce that administers services, is critical to understanding the full landscape and context. Mental health workers were asked what services they felt were easiest to access for clients. Approximately 40% of mental health workers indicated that finding information about services or agencies is easily accessible. This remains consistent with results from PPS 2. However, 30% of utilizers of services said that a barrier to care is finding information about services. Therefore, there may be a disconnect between the information disseminated to providers and the information provided to the community.

Additionally, mental health workers indicated that access to, or knowledge of, crisis services was easy to obtain. This is a substantial increase when compared to PPS 2. In PPS 2, 15.6% of respondents indicated that crisis services were easy to access. In PPS 3, this response increased to 35.5%. This increase of 19.9 percentage points demonstrates a positive change in the perceptions and access to crisis services in the community. Drivers of this change could include new local programs like the Crisis Co-Response Team (CCRT) Mobile Integrated Health (MIH) response teams, state-level policy changes, such as the Community Emergency Services and Supports Act (CESSA), and at a national-level the expansion and promotion of the crisis-line number "988".

A subset of mental health worker respondents felt that there are no services that are easy for clients to access. Thirty-two percent of workers responded that none of the listed services are easy for clients to access and receive, an increase from 15.1 percentage points in the previous PPS. This may indicate unidentified access issues within the community, necessitating further analysis of the barriers that restrict people from accessing services.

PPS 3 found that 21% of respondents reported that finding a group or program of people with similar experiences was easily accessible. This is a 10 percentage point increase since PPS 2, indicating that this has become less of an issue within the community over time. This is in contrast to those with lived experience, as they reported that finding a group or program with people of similar experiences was the second-most difficult service to access. While providers may be obtaining the knowledge about these services or programs, the discrepancy between the lived experience and mental health workers' perspectives may be attributed to how the information is disseminated to clients.

Approximately 16.1% of mental health workers in Winnebago County believe that medical and dental services were easy to obtain. Fourteen percent of workers expressed this same sentiment in PPS 2. In contrast, while almost 60% of those with lived experience reported receiving medical or dental care within the last year, that still leaves 40% of respondents who did not receive physical healthcare. This gap could have similar barriers to receiving mental healthcare: hours of operation, payment options, and available workforce, as just some examples. Annual check-ups with a Primary Care Physician (PCP) are a critical access point for individuals who may need to be screened for mental health issues, but do not want to seek mental health-specific providers. PCPs have a unique understanding of the clients due to seeing them on a regular basis. PCPs can act as early detection if an individual starts showing subtle signs of mental health or substance use issues. Ultimately, physical health is greatly intertwined with one's mental health; therefore, the importance of regular medical treatment must be emphasized.

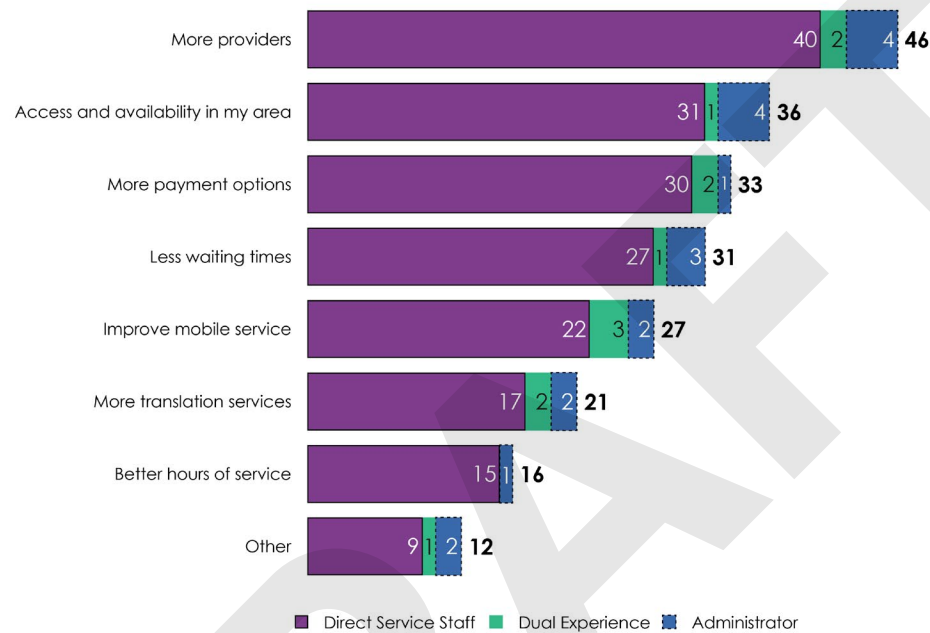
Overall, the least available service for clients was legal, advocacy, or protection services. Only 3.2% of respondents indicated that this service was easy to obtain, a 10.9 percentage point decrease when compared to PPS 2. Similar to how prescribing providers need many



PUBLIC PARTICIPATION SURVEY

years of specialized education, these services, particularly legal services, also require extensive education and licensure. As such, there are only a limited number of providers in the community who can provide these services, and the need may be surpassing the current system capacity. Additionally, arrests, evictions, and other activities needing legal intervention disproportionately affect those with mental health or substance use issues.<sup>9</sup>

**Figure 20: As a mental health worker, what do you think would increase access to mental health treatment in Winnebago County?**



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

- More providers (74.2%)
- Access and availability in my area (58.1%)
- More payment options (53.2%)
- Less waiting times (50.0%)
- Improve mobile services (43.5%)

Consistent with the lived experience perspective, mental health workers overwhelmingly believe that more community providers will improve access. In PPS 2, 56.3% of workers cited a need for more providers, and in PPS 3, this jumped to 74.2% of respondents. The need for additional providers in the community is a common theme that has appeared throughout WCCMHB research for this Strategic Plan, as both the Environmental Scan and Key Informant Interviews resulted in the same conclusions.

Similar to the perspectives of those with lived experience, mental health workers believe that access and availability will improve overall service access. Fifty-eight percent of mental health worker respondents indicated this as a key area for improvement within the mental health and substance use system of care. This perception has increased since PPS 2, where only 29.7% of respondents cited access and



PUBLIC PARTICIPATION SURVEY

availability as a solution to service accessibility, a 28.3 percentage point increase. This change could be attributed to a multitude of factors, from increasing overall awareness to the subjectivity of what ‘accessibility’ means.

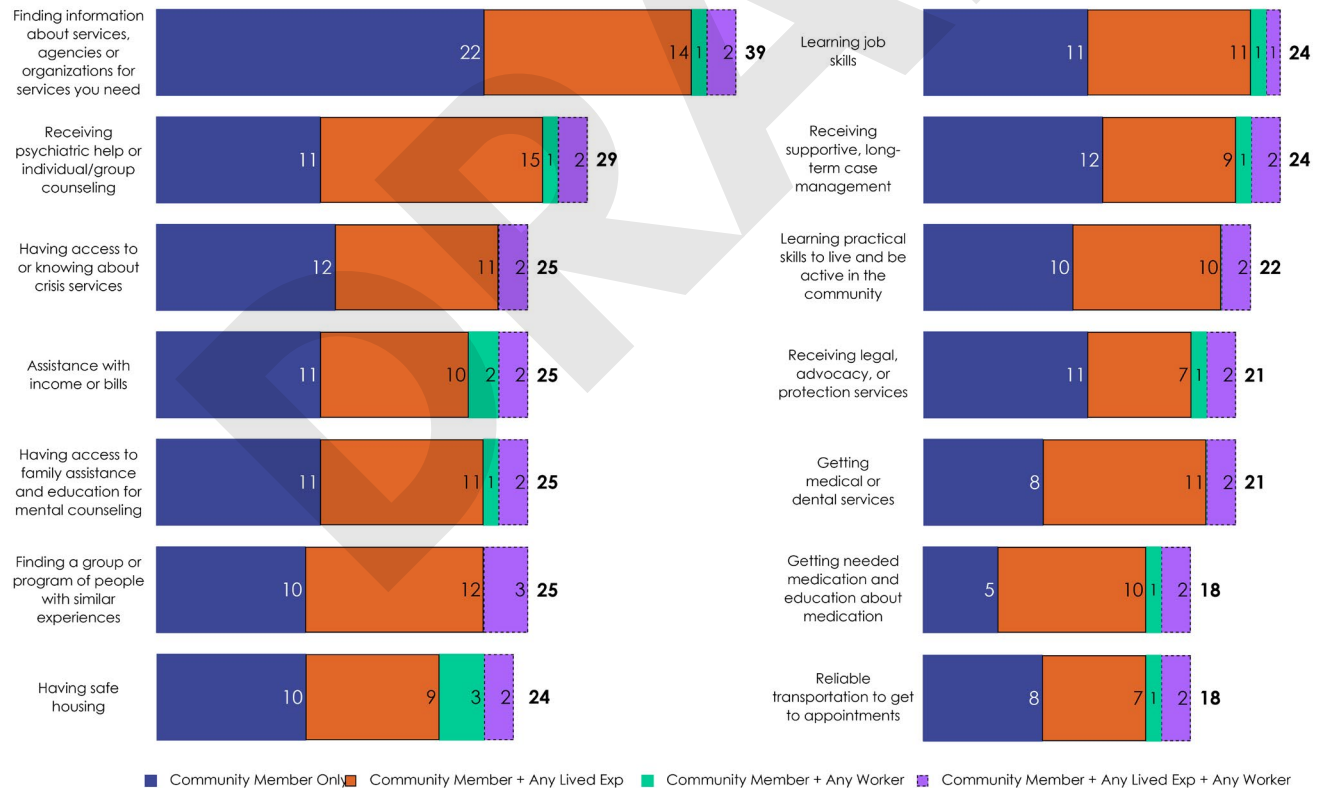
Mental health workers also believe that additional payment options would increase access to services within the county. Over 50% of PPS 3 respondents cited that diverse payment options would expand access, an increase of 28.1 percentage points compared to PPS 2. Alternatives such as sliding-scale payments and acceptance of public insurance may make mental health and substance use services more accessible for various income levels.

Wait times and wait lists are critical when assessing service access. Fifty percent of PPS 3 mental health worker respondents identified shorter wait times and waitlists as a possible solution to access issues, a slight decrease of 1.6 percentage points compared to PPS 2. Despite Environmental Scan 3 survey results revealing fewer waitlists in the community, the public perception of this barrier remains largely unchanged, as people may believe there are always significant wait times for services in the community. Shortened wait times ensure that individuals receive services when they need them, not after their needs have worsened or a crisis has occurred.

Mobile services are critical to implementing a ‘meet them where they are at’ mentality. Forty-four percent of mental health workers indicated improvement in mobile health services as an area where the community can grow, a significant increase from 23.4% in PPS 2. In general, mobile health services have become more commonplace nationwide, and the increase in awareness of these services could be due to designed mobile services such as Mobile Integrated Health (MIH) or UIC’s Addiction and Street Medicine programs.

Community Members

Figure 21: Would you like to learn more about any of the following types of services?





## PUBLIC PARTICIPATION SURVEY

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 (37.1%)
- Receiving psychiatric help or individual/ group counseling (27.6%)
- Having access to or knowing about crisis services (23.8%)
- Assistance with income or bills (23.8%)
- Having access to family assistance and education for mental counseling (23.8%)

The third perspective in the Public Participation Survey gauged community members' awareness of different services by asking respondents which services they would like to learn more about. The service community members were most interested in was finding information about services or agencies, which coincides with the fact that many community members may not ever need to interact with mental health or substance use services, resulting in a knowledge gap.

This overarching knowledge gap about agencies and their services trickles down to the other common responses to this question. Psychiatric help, individual counseling, and crisis response are all specific types of mental health or substance use services. Agencies may consider broadly advertising their services to the community or collaborating together to provide a comprehensive list of agencies and their specializations, so that community members can easily access information without extensive searches.

### PPS Comments Analysis

Additional themes and insights were identified through a qualitative analysis of optional comments added by respondents.

#### Access to Services

Access to services was the most common theme throughout the free response section, and can be broken down into four sub-themes: location, affordability, waitlist, and information.

Respondents indicated that service locations are too concentrated in the metro Rockford area, leaving the rural parts of the county without critical mental health or substance use services. Additionally, inpatient beds for those suffering from mental health or substance use issues are limited within the county, often resulting in individuals traveling out of their county of residence for an available bed.

Many respondents also noted in the free-response section that the affordability of services is also a barrier to care. A limited number of providers in the county accept Medicaid, Medicare, or other public health insurance, and the rates charged by private providers make it inaccessible to those with low incomes. Many individuals and families who are middle-income experience a gray area in medical services where they make enough to not qualify for most assistance programs, yet make too little to comfortably afford mental health or substance use services.

Waitlists and wait times have been longstanding barriers to care within the community. While results from the Environmental Scan and Public Participation Survey indicate that these times have improved, there are still additional areas for improvement, especially within residential services. Furthermore, the frequency with which an individual can see a provider can be limited by either the provider or the insurance.

Information dissemination is another topic of interest identified in the PPS and then solidified in the free-response answers. The PPS identified, overarchingly, that providers should consider different avenues for advertising their services, while the additional feedback provided insight into the different niches people are searching for. This can include LGBTQ or Domestic Violence support groups, or services specifically designed for older adults or court-ordered treatments.



## PUBLIC PARTICIPATION SURVEY

### Provider-Focused

Free-response answers taken from provider perspectives can be broken into two sub-themes: psychiatric care and workforce. These themes work in conjunction with one another; without a robust psychiatric workforce, the community's psychiatric care needs cannot be met. Particularly, respondents cited a need for psychiatrists who are able and willing to treat those with Schizophrenia, Bipolar Disorder, or other mental illnesses that need consistent psychiatric supervision. This need is further emphasized when considering that many psychiatrists do not accept Medicaid. In addition to the shortages of other types of mental health and substance use providers, like social workers, this leaves many without the critical care they need to remain functional.

### Care-coordination

Care coordination is a significant function of the mental health and substance use system of care. Without care coordination, agencies operate in silos rather than working together to provide the best outcomes for their clients. An existing perception is that many services are available to the community but coordination among them is not well integrated. The themes identified from the Key Informant Interviews – trust in systems, client access, and collaboration – connect back to this perception.

Three key responses from the free-response section were chosen, each representing one of the three perspectives: lived experience, mental health worker, and community member. A common thread throughout all of them is the topic of coordination in the system of care. There are numerous services available in the community, both private and nonprofit, funded by WCCMHB and not funded by WCCMHB. However, respondents indicate that the system of care requires significant reform to function as effectively as possible.

## Resident Awareness Survey

**Table 3: Are you aware of the Winnebago County Community Mental Health Board (WCCMHB)?**

Perspective	"Yes" Percentage	"No" Percentage
Total	63.8%	36.2%
Community Member Only	67.6%	32.4%
Lived Experience - Individual	51.2%	48.8%
Lived Experience - Both (Individual and "Family or Caregiver")	52.9%	47.1%
Lived Experience - Family or Caregiver	44.4%	55.6%
Any Lived + Any Worker (Admin or Direct Staff)	70.0%	30.0%
Worker Only (Admin or Direct Staff)	88.5%	11.5%

In this iteration of the Public Participation Survey, all perspectives were asked if they were aware of the WCCMHB. 63.8% of respondents, across all perspectives, indicated that they were aware of the WCCMHB. When broken down by perspective, 88.5% of mental health worker respondents knew about the WCCMHB. It should be expected that mental health workers are aware of the WCCMHB, particularly mental health staff who handle the indirect, or administrative, work of an agency. Seventy percent of mental health worker respondents with lived experience are aware of the WCCMHB, and just 67.6% of those with just a community member perspective were aware of the WCCMHB. Only one perspective did not reach a 50% awareness level, which was family or caregivers of an individual with mental health or substance use issues.



PUBLIC  
PARTICIPATION  
SURVEY

**Table 4: When were you first aware?**

Perspective	"Within the last year" Percentage	"Within the past 3 years" Percentage	"Over 3 years" Percentage
Total	17.4%	31.5%	51.0%
Community Member Only	13.0%	30.4%	56.5%
Lived Experience - Individual	31.8%	27.3%	36.4%
Lived Experience - Both (Individual and "Family or Caregiver")	33.3%	33.3%	33.3%
Lived Experience - Family or Caregiver	10.0%	25.0%	65.0%
Any Lived + Any Worker (Admin or Direct Staff)	28.6%	28.6%	42.9%
Worker Only (Admin or Direct Staff)	13.0%	37.0%	50.0%

Respondents were also asked when they were first made aware of WCCMHB. Many of the respondents were made aware of WCCMHB over three years ago, particularly within any combination of community member, family, or caregiver lived experience, or mental health worker perspectives. However, there were significant increases in awareness of the WCCMHB over the last year for those in the individual lived experience perspective, the individual and family/caregiver lived experience perspective, and the lived experience and mental health worker perspective. The WCCMHB's awareness efforts have been successful in achieving increased awareness of the Board among those with lived experience.

**Table 5: Did your awareness change over the past year?**

Perspective	"Yes I am more knowledgeable now" Percentage	"No my awareness stayed the same" Percentage	"No I know less now" Percentage	"Not sure" Percentage
Total	37.3%	51.3%	6.0%	5.3%
Community Member Only	36.1%	60.9%	8.7%	4.3%
Lived Experience - Individual	40.9%	31.8%	13.6%	13.6%
Lived Experience - Both (Individual and "Family or Caregiver")	33.3%	66.7%	0.0%	0.0%
Lived Experience - Family or Caregiver	40.0%	50.0%	0.0%	10.0%
Any Lived + Any Worker (Admin or Direct Staff)	71.4%	28.6%	0.0%	0.0%
Worker Only (Admin or Direct Staff)	41.3%	52.2%	4.3%	2.2%

Respondents from all perspectives were asked whether their awareness of the WCCMHB changed in the last year, however, as stated previously, this table only includes the responses of individuals who said 'Yes' they were aware of WCCMHB, in Question 1. Approximately seventy-one percent of mental health worker respondents with lived experience reported becoming more aware in the last year. Almost sixty-seven percent of respondents who are both a caregiver/family member and someone with mental health or substance use issues themselves, indicated that their awareness has stayed the same over the past year. This is followed closely by the community member perspective, at 60.9%, indicating that their awareness changed in the past year.



PUBLIC  
PARTICIPATION  
SURVEY

**Table 6: Are you aware of WCCMHB Funded Programs?**

Perspective	"Yes" Percentage	"No" Percentage
Total	46.8%	51.1%
Community Member Only	47.1%	51.5%
Lived Experience - Individual	30.2%	65.1%
Lived Experience - Both (Individual and "Family or Caregiver")	29.4%	70.6%
Lived Experience - Family or Caregiver	35.6%	62.2%
Any Lived + Any Worker (Admin or Direct Staff)	60.0%	40.0%
Worker Only (Admin or Direct Staff)	73.1%	25.0%

The final question on the Resident Awareness survey asked participants if they were aware of any WCCMHB Funded Programs. In this instance, all responses are in the table. A majority (over 50%) of perspectives indicated they were not aware of any Funded Programs, with the exception of mental health workers. This is not surprising, as clients who use services often do not know the name of the specific grant to which their services are billed. Mental health workers, on the other hand, have unique backend knowledge that causes them to be aware of specific WCCMHB-Funded programs, as well as other funding streams.

DRAFT



## SEQUENTIAL INTERCEPT MODEL (SIM)

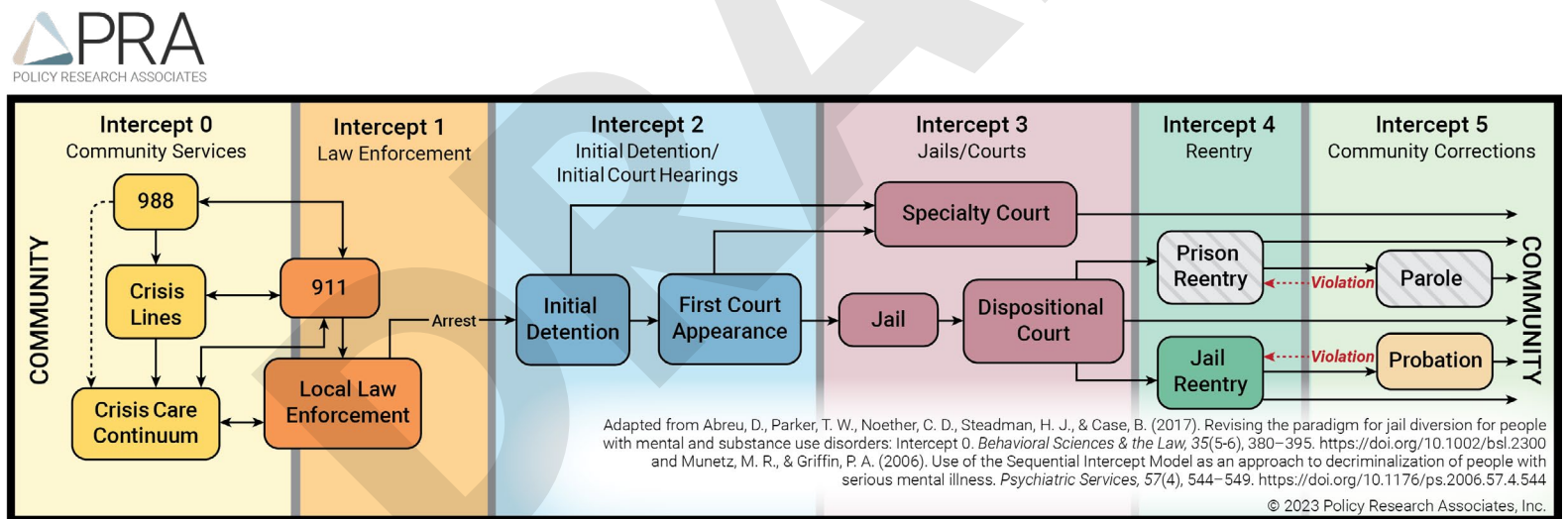
# Sequential Intercept Model (SIM)

The Sequential Intercept Model (SIM) is a conceptual framework used to detail how an individual with mental health or substance use disorders interacts with the justice system. More importantly, it identifies points within the justice system where an individual could be diverted for treatment rather than continuing through the system. The SIM mapping process convenes key stakeholders within the community, ensuring each SIM is uniquely tailored to the community.

Each step of interacting with the justice system is referred to as an 'intercept', and SIM Maps are split into 6 intercepts:

- Intercept 0: Community Services
- Intercept 1: Law Enforcement
- Intercept 2: Initial Court Hearinging & Initial Detention
- Intercept 3: Jails & Courts
- Intercept 4: Reentry
- Intercept 5: Community Corrections

**Figure 22: Policy Research Associates (PRA) graphic**



Each intercept is intended to represent a point in time at which an individual will interact with the justice system; intercepts include the various resources and services that can assist in diverting them from the justice system into treatment. Essentially, it is a roadmap of services and resources for an individual suffering from SMI and/or SUD who is involved with the justice system. For more information about Sequential Intercept Modeling, please go to the [SAMHSA](#) or [Policy Research Associates](#) website.



## SEQUENTIAL INTERCEPT MODEL (SIM)

In 2021, Winnebago County conducted its first Sequential Intercept Model Mapping Report, and some of the recommendations that emerged were: improving warm handoffs, introducing a co-responder model into 911 dispatch, and conducting an overall systems and service review. Four years later, in February 2025, WCCMHB and Region 1 Planning Council Staff partnered with Winnebago County's Criminal Justice Coordinating Council and invited Scott Block, the State Court Behavioral Health Administrator, to a Learning Network Collaborative (LNC) to assist in updating the SIM Map. The following are the recommended resources and strategies for consideration for each intercept:

### **Intercept 0, Community Services:**

- Explore Public Act 101-0574: Psychiatric Collaborative Care Model
- Explore Public Health and Prevention Programs

### **Intercept 1, Law Enforcement:**

- Explore flagging possible diversion candidates at arrest
- Explore Community Emergency Services and Supports Act impact
- Implement Mental Health First Aid for Public Safety

### **Intercept 2, Initial Court Hearings & Initial Detention:**

- Explore Pre-Arrest Diversion for Emerging Adults

### **Intercept 3, Jails & Courts:**

- Implement Competency to Stand Trial System Assessment Tool
- Explore Dismiss Upon Civil Commitment with AOT
- Develop Civil Outpatient Commitment FAQ
- Explore Emerging/Young Adult Court

### **Intercept 4, Reentry:**

- Explore 1115 Medicaid Demonstration Waiver Reentry Services
- Explore Increased Peer Recovery Support Services in the Corrections setting
- Implement Improved Discharge Planning and Warm Handoff Practices

### **Intercept 5, Community Corrections & Supports:**

- Explore Cognitive Behavioral Health Programs for Emerging Adults
- Explore Online Brain Injury Screening and Support System (OBISSS)

Five recommendations did not fall into one particular intercept, but are still important to diversion and overall treatment of individuals with SMI/SUD within the justice system:

- Enhancing peer support roles
- Enhancing Trauma-Informed Approaches
- Increase information and the utilization of Advanced Directives
- Attendance at Decriminalizing Mental Illness: The Miami Model 2-day Workshop
- Host an annual community empowerment and resource fair

Two of these recommendations have already been implemented. WCCMHB co-hosts the annual NAMI Building Bridges event, and in April of 2026, key administrators and stakeholders in and around the Winnebago County justice system attended the Miami Model 2-Day Workshop.

Please see [Appendix E](#) for the full SIM Map updates.

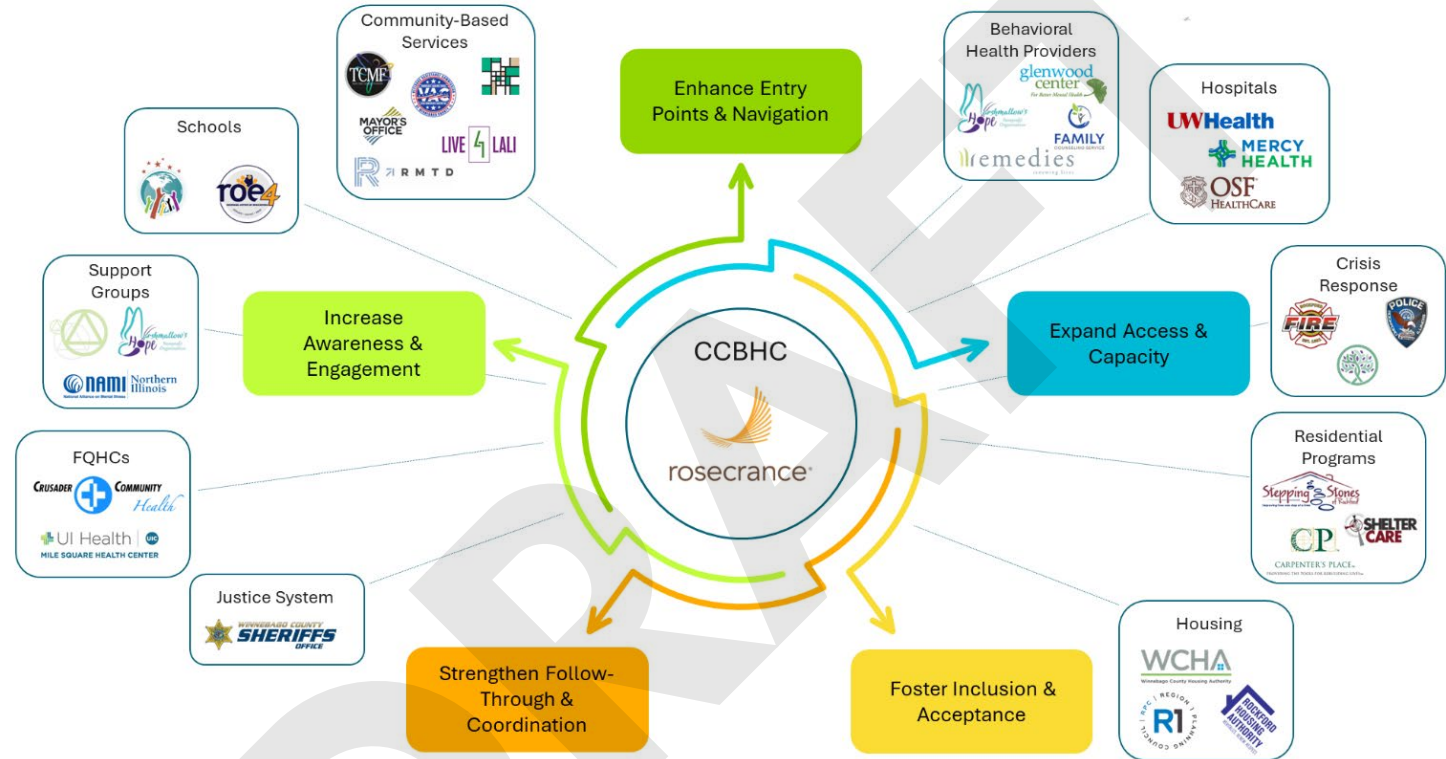


## KEY INFORMANT INTERVIEWS

# Key Informant Interviews

Region 1 Planning Council staff identified 20 potential interviewees by utilizing the Guidehouse Report's initial visual (Figure 23). One potential interviewee declined, and another organization was contacted in their place. One potential interviewee did not respond to the invitation.

**Figure 23: Guidehouse Report Initial Visual**



Between December 2025 and January 2026, Key Informant Interviews were conducted in-person at Region 1 Planning Council offices with 18 unique organizations, including the CCBHC hub of the 'hub-and-spoke model'. The interview guide with pre-determined questions is located in the [Appendix](#). Interviewers could ask follow-up questions if they needed additional information or clarification about an interviewee's answer. Interviews were approximately 45 minutes long.

Two to three note takers transcribed the interviews live during the sessions. Notes were cleaned for clarification, combined together to make a single transcript, and any identifying information about the organization, county, or other agencies was removed. Five staff members identified between six and eight themes that stood out from the transcripts. ChatGPT served as an additional reviewer of de-identified information.

The following five themes were agreed upon as the central topics from the Key Informant Interviews.



## KEY INFORMANT INTERVIEWS

### Information and Data Sharing

Mental health and substance use service agencies in Winnebago County can use referral platforms, such as the Integrated Referral and Intake System (IRIS) and Julota, to stay connected and collaborate to provide a well-rounded continuum of care to clients. However, utilizing referral platforms like these raises legal and ethical concerns among organizations. Thus, while IRIS and Julota help streamline the referral mechanisms between organizations, the referral systems are only as strong as the number of agencies that utilize them.

Data sharing is important to organizations so they can understand which treatments or services a client is receiving at other organizations or what the client's history has looked like. Additionally, data sharing allows clients to share their story only once, instead of repeating it at each organization they are referred to for services. In turn, this can help an agency serve a client more proactively and ensure their care is cohesive and trauma-informed. Platforms like IRIS and Julota, while useful for those participating, are still subject to human error.

While most key informants expressed interest in data sharing as a way to better serve their clients and swiftly connect them to additional services, several acknowledged the ethical and legal issues of a shared data platform. Different industries, such as domestic violence service agencies and health care organizations, have varying legal and regulatory requirements and restrictions regarding information sharing. These barriers, intended to protect clients and patients, make whole system information sharing close to impossible. However, others in the community indicated that a more complete system for information and data sharing would be a significant incentive to participate in the CCBHC model.

### Organizational Reputation and Trust in Systems

The hub organization has been established in Winnebago County for many years, allowing for organic partnerships and programs to develop. Several WCCMHB-Funded Organizations have close ties with the hub, and many of the interviewee organizations either have partnered with them in the past, or are currently partnering and collaborating with the hub organization.

"Getting everyone to trust the model. We've all heard it: there are organizations that don't trust other organizations. It's not that they don't all want to help, but maybe there's history there, or they feel like they're losing their autonomy (which is scary for a lot of organizations)."

- Quote from Interviewee

However, clients often cite concerns about the hub organization due to historical preconceptions or recent issues they may have had. Consequently, clients turn to other organizations, relaying these concerns, resulting in complex public perceptions and reputation. In general, potential clients and current clients might feel distrustful of mental health and substance use systems of care as a whole. The closure of Singer Hospital, for example, has had lasting ramifications on mental health and substance use care in the region. Other conceptions, such as the belief that holders of private insurance are prioritized within the community, complicates the relationships between provider and client.

Trust among the different mental health and substance use providers within the community can also be fragile. A common sentiment expressed amongst Key Informants is the long-held belief of eliminating 'silos' of care, so that organizations can work together effectively. While many silos have been broken down over the years in the mental health and substance use sector, there are still existing barriers. Key Informants were also concerned that the hub may hold onto intakes rather than referring them to other agencies. An incentive of the CCBHC model is that opportunities for collaboration are available in a structured, sustainable way.

"Laws about sharing records amongst each other – substance abuse has its own laws, mental health has laws, HRSA has its own laws for FOHCs. [In a CCBHC] Patients are going to have to sign releases, things like universal laws – that could be a hard sell."

- Quote from Interviewee



## KEY INFORMANT INTERVIEWS

### Funding, Capacity, and Resources

It is common knowledge that the behavioral health field faces a workforce shortage, regardless of setting. Several Key Informants noted that Winnebago County is missing Peer Recovery Support Specialists and professionals who can prescribe medications. Another gap mentioned in interviews was the lack of inpatient beds. There is one inpatient care center within a 30-mile radius, with a limited number of beds, and the interviewees indicate that the current supply of inpatient beds is far lower than the demand. Agencies would benefit from more, especially when the systems of care are expanded in the new CCBHC model. Additionally, the nature of mental health work leads to high turnover and can demoralize the workforce. As such, it is critical to either attract workers to the area and retain them, or build local career pipelines that incentivize residents to stay in the area.

“The job market has never made it to the full staffing level we want to get to—we can find qualified candidates but there’s more attractive places for them to work. Compensation wise, it’s hard to match what private practice or government offers.”

- Quote from Interviewee

Due to current workforce stressors and levels, Key Informants were concerned about their capacity to implement the changes required of a CCBHC model. It is important to note that they also expressed questions about the hub’s ability to operate with its current capacity. Staffing increases might be needed on both the back-end (accounting, management, etc.) and the patient-facing, front-end side (case management, social workers). Several Key Informants noted that while they are operating fine right now, there is always a need for more staffing.

Many Funded Organizations and Key Informants receive some type of Medicaid reimbursement from some of their services, though most are at a loss, such as psychiatry services. With recent uncertainty around Medicaid, Key Informants are worried another funding stream might be lost or reduced. One incentive Key Informants mentioned to encourage them to participate in the CCBHC model is increased funding to address workforce shortages. Additional funding could be used to prepare for a potential influx of clients and referrals with positions such as case managers or intake specialists.

### Client Access to Services

Key Informants were very interested in the idea of a one-stop shop, where services are located in a single building and assigned offices. An example of a one-stop shop in the domestic violence sector is the Family Justice Center model, which brings law enforcement, medical teams, advocates, and other types of professionals under one roof. This convergence of services would enable a physical, formal warm hand-off of a client from provider to provider. Similar models already exist in the community and can serve as examples when developing a new center. The appeal of a one-stop shop would be increased referral follow-through, ensuring clients are actually served, and reduced barriers for both clients and organizations. Alternative ideas presented include dedicating more space for resource offices in larger organizations, rather than an entire neutral host space.

It is important to Key Informants that a CCBHC model follows a “No Wrong Door” approach rather than a “Single Point of Entry” approach. No Wrong Door ensures that a client can enter the system at any referral location and still get access to services, whereas a Single Point of Entry approach requires each client to come through the same starting spot in order to get services in the system. A single point of entry approach, while useful in some situations, limits client access and creates a power imbalance between the hub and spoke organizations. The Guidehouse report recommended a No Wrong Door approach; however, the original visual was misleading to reviewers, and as a result, a new visual was created. More information on the new CCBHC visual is located on [Page 66](#). No Wrong Door is critical to meeting clients where they are at, ensuring potential clients can access services that are beneficial to them.



## KEY INFORMANT INTERVIEWS

Another important consideration to Key Informants when moving to the CCBHC model is the maintenance of client choice and autonomy. Should clients be referred to services that they did not initially consent to, or referred to an agency that did not provide adequate care, Key Informants expressed that the relationships, trust, and reputations they have with their clients would be harmed. In mental health and substance use care, respecting a client's autonomy and control over their own care is essential. In a CCBHC model where organizations are often interconnected and constantly completing referrals, client choice should remain a top priority.

"In a perfect world I'd like for each of these entities to have an office in our building so I can knock on their doors. I like events like the resource fair — everybody was there, and it helps me look outside of my four corners, of [services] that are out there and the other people doing [the work] too. If you don't have that kind of buy-in, nobody's going to do it."

- Quote from Interviewee

## Collaboration and Defined Roles

There is some uncertainty about what the CCBHC model means for spoke organizations. They are unsure where they fit in, or it is unclear what their responsibilities would be. This uncertainty has been attributed to a fear of losing organizational autonomy within the CCBHC hub-and-spoke system. Prior to the final implementation of the CCBHC system, organizations need additional clarity on what the system requires of them and what benefits it provides to themselves and the community. They would also like additional guidance on how much proprietary or sensitive information they need to provide to other organizations, such as financial information.

"A lot of fear amongst boards of organizations, how much do you want another organization to know about who you are, what your finances look like?"

- Quote from Interviewee

Several Key Informants emphasize the need for collaboration between organizations, so issues like service duplication do not occur. However, additional collaborations introduce different, complex challenges that would need to be managed and resolved. Some Key Informants mentioned misalignments of missions and visions between organizations. Others shared that 'silos' continue to exist in the community, and agencies may be resistant to collaborations. One Key Informant highlighted that lived experience should be incorporated into every aspect of the behavioral health systems of care that 'collaboration' has become a buzzword in recent years, and has somewhat lost its meaning in its current stage.

A more formal collaboration system might help organizations better understand what each is doing in the community and how they can work together seamlessly. Some Key Informants expressed interest in identifying the current gaps in mental health and substance use services, and wish to fill them accordingly.



**Community Health Needs  
Assessment & Community Research**

# Community Health Needs Assessment



COMMUNITY  
HEALTH NEEDS  
ASSESSMENT

## Community Profile

Winnebago County, Illinois, is located in the Northern region of the state. As of 2024, there were 283,790 residents of the county, making it the most populous county outside of the Chicagoland region. The City of Rockford, located in Winnebago County, is the fifth-largest city in Illinois, and is the largest city in Winnebago County.

In 2024, there were 65,994 individuals under age 18, 163,488 individuals between 18 and 64, and 54,308 individuals 65 and older (Table 7). The median age in Winnebago County is 39.4, which is equivalent to the median age of the State of Illinois. There are approximately 95 males per 100 females in Winnebago County, which is less than the state ratio of 98 males per 100 females.

The largest Race/Ethnicity group in Winnebago County is White (approximately 62.5% of the total population). The second-largest group, accounting for 16.6% of the population, is Hispanic/Latino. Black/African American residents compose 10.26% of the population, Asian residents compose 2.78%, American Indian/Alaska Native residents compose 0.09%, and Pacific Islander/Native Hawaiian residents are 0.07% of the population. Approximately seven percent of residents in Winnebago County identify as two or more races (Table 8).

**Table 7: Population Age Distribution in Winnebago County, IL (2024)<sup>10</sup>**

Population by Age	Number of Residents
Total Population	283,790
0-4	16,760
5-17	49,234
18-39	78,070
40-64	85,418
65 and Older	54,308

**Table 8: Population Race/Ethnicity Distribution in Winnebago County, IL (2024)<sup>11</sup>**

Race/Ethnicity	Total Percentage of Winnebago County Residents (%)
American Indian / Alaska Native	0.09
Asian	2.78
Black / African American	10.26
Hispanic or Latino	16.60
Pacific Islander / Native Hawaiian	0.07
White	62.54
Two or more races	7.26

The median household income in Winnebago County is \$66,702, which is almost \$20,000 less than the Illinois median household income of \$83,211. Black/African American Winnebago County residents have the lowest median household income at \$35,255, while Hispanic or Latino residents have a median household income of \$65,358 and White residents have a median household income of \$72,856. Notably, consistent with Illinois averages, Asian households have the highest median household income at over \$90,000. Native American households have an income closest to Hispanic or Latino households. All race/ethnicity groups have lower median household incomes compared to their total Illinois counterparts; however, the largest disparity exists for White and Asian residents, with a difference of \$18,245 and \$20,826, respectively (Table 9).



COMMUNITY  
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**Table 9: Median Household Income Distribution by Race/Ethnicity in Winnebago County, IL (2024)<sup>12</sup>**

Population by Race/Ethnicity	Median Household Income for Winnebago County	Median Household Income for Illinois
Total Population	\$66,702	\$83,211
Asian	\$93,273	\$114,099
Black/African American	\$35,255	\$51,174
Hispanic or Latino	\$65,358	\$77,413
Native American	\$69,798	\$81,487
Pacific Islander/Native Hawaiian	No data available	No data available
White	\$72,856	\$91,101
Two or more races	\$66,775	\$83,174

The percentage of individuals living under the Federal Poverty Line (FPL) is higher in Winnebago County (15.42%) than in Illinois (11.58%) (Table 10). Notably, over 35% of Black/African American individuals and a quarter of children aged 0–4 in Winnebago County are living in poverty. Winnebago County’s older adult population (65+) is the only demographic that has a lower poverty rate than the state rate, with 9.90% of County residents 65+ living in poverty compared to the state rate of 10.38% (Table 11).

In 2023, 40.59% of all households in Winnebago County were living below the Asset Limited, Income Constrained, Employed (ALICE) threshold.<sup>13</sup> The ALICE threshold is a United Way measurement that determines the minimum income level necessary to meet the Household Survival Budget in each county in the United States. The household survival budget is calculated according to family size and average cost for necessities, such as housing or food, in each county. Families who live under the ALICE threshold earn more than the Federal Poverty Level, yet earn below what is needed to afford basics like childcare, food, housing, transportation, and technology. Thirty-seven percent of all households in Illinois live under the ALICE threshold.

**Table 10: Poverty Rate by Race/Ethnicity in Winnebago County, IL (2020-2024)<sup>14</sup>**

Population by Race/Ethnicity	Individuals Living Under the Federal Poverty Line (%) for Winnebago County	Individuals Living Under the Federal Poverty Line (%) for Illinois
Total Population	15.42	11.58
Asian	11.31	10.23
Black/African American	35.49	23.72
Hispanic or Latino	24.85	14.49
Native American	15.41	13.14
Pacific Islander/Native Hawaiian	27.97	20.95
White	10.31	7.97
Two or more races	20.46	12.61



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**Table 11: Poverty Rate by Age in Winnebago County, IL (2020-2024)**

Population by Age	Individuals Living Under the Federal Poverty Line (%) for Winnebago County	Individuals Living Under the Federal Poverty Line (%) for Illinois
0 - 4	25.02	16.01
5 - 17	21.23	14.84
18 - 39	16.86	12.16
40 - 64	11.98	9.39
65 and older	9.90	10.38

A family or individual who is housing-cost burdened pays more than 30% of their income on housing costs (including utilities). As of 2024, in Winnebago County, 28.69% of all occupied housing units (both owner and renter-occupied) were considered housing-cost burdened. This is just under the Illinois percentage of 29.90%. The total population ratio of owner-occupied to renter-occupied housing is similar in Winnebago County and Illinois. However, while White and Hispanic/Latino Winnebago County residents had similar ratios to their Illinois counterparts, Black/African Americans in Winnebago County rent more and own less compared to the Black/African American population in Illinois (Table 12).

**Table 12: Housing Type by Race/Ethnicity in Winnebago County, IL (2024)<sup>15</sup>**

Owner Occupied by Race/Ethnicity	Housing Occupancy (%) for Winnebago County	Housing Occupancy (%) for Illinois	Renter Occupied by Race/Ethnicity	Housing Occupancy (%) for Winnebago County	Housing Occupancy (%) for Illinois
Total Population	66.19	24.55	Total Population	33.81	32.43
Asian	82.77	64.59	Asian	17.23	35.41
Black/African American	30.92	42.62	Black/African American	69.08	57.38
Hispanic or Latino	55.56	58.81	Hispanic or Latino	44.44	41.19
Native American	69.03	61.80	Native American	30.97	38.20
Pacific Islander / Native Hawaiian	7.32	41.65	Pacific Islander / Native Hawaiian	92.68	58.35
White	74.12	75.45	White	25.88	24.55
Two or more races	55.42	61.17	Two or more races	44.58	38.83



## Health Outcomes

The leading causes of death in Winnebago County, Illinois, are coronary heart disease and cancer. In general, Winnebago County experiences less favorable health outcomes compared to the State of Illinois. A higher percentage of Winnebago County residents experience disability, coronary heart disease, obesity, high cholesterol, and high blood pressure. Residents of Winnebago County have more negative mental health outcomes, citing a higher percentage of self-reported poor mental health and depression (Table 13).

**Table 13: Health Outcomes in Winnebago County, IL (2023)**

Health Outcomes	Residents Affected (%) for Winnebago County	Residents Affected (%) for Illinois
Disability <sup>16</sup>	15.30	12.51
Coronary Heart Disease <sup>17</sup>	5.80	3.20
Obesity <sup>18</sup>	34.7	29.5
High Cholesterol <sup>19</sup>	32.80	32.10
High Blood Pressure <sup>20</sup>	33.90	30.30
Self-Report Poor Mental Health <sup>21</sup>	18.80	16.32
Depression <sup>22</sup>	23.40	20.34

The Health Resources and Services Administration (HRSA), classifies Winnebago County as a 'medically underserved area', meaning that the county does not have sufficient access to primary care.<sup>23</sup> Despite this, in 2022, Winnebago County had a higher number of primary care providers per 100,000 residents (98.8) than Illinois (95.8). This is likely due to other areas of Illinois having a much lower ratio of providers to residents.

In addition to a lack of access to primary care, residents of Winnebago County also struggle to access mental health care. In 2025, over 80,000 people in the county had unmet mental health provider needs. Total mental health providers in Winnebago County are much lower than the ratio of providers to residents in the state of Illinois. However, Winnebago County has a better opioid treatment provider ratio than Illinois (Table 14).



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Winnebago County has a significantly lower number of psychiatrists per 100,000 residents than Illinois and a slightly lower number of child psychologists per 100,000 residents (Table 15). Psychiatrists are medical doctors with the ability to diagnose mental disorders, prescribe medication, and manage treatment for patients. Psychologists are mental health professionals with doctoral degrees who have the ability to treat mental health disorders through psychotherapy, but do not have the ability to prescribe medication.

**Table 14: Health and Substance Use Providers Per Capita in Winnebago County, IL (2025)**

Mental Health and Substance Use Providers	Providers Per 100,000 Residents for Winnebago County	Providers Per 100,000 Residents for Illinois
Mental Health Providers <sup>24</sup>	357.2	580.8
Clinical Social Workers <sup>25</sup>	97.45	121.94
Opioid Treatment Providers <sup>26</sup>	13.70	11.71

**Table 15: Psychology and Psychiatry Providers Per Capita in Winnebago County, IL (2023)**

Psychology and Psychiatry Providers	Providers Per 100,000 Residents for Winnebago County	Providers Per 100,000 Residents for Illinois
Child Psychologists <sup>27</sup>	1.75	2.48
Psychiatry Physicians <sup>28</sup>	4	12

Compared to Illinois, Winnebago County has a higher suicide mortality rate, drug overdose mortality rate, and alcohol-related mortality rate. Notably, in 2023, Winnebago County had the highest drug overdose mortality due to opioids of all counties in the State of Illinois (Table 16).

**Table 16: Mortality Rates in Winnebago County, IL (2024)**

Mortality Rates	Deaths Per 100,000 Residents for Winnebago County	Deaths Per 100,000 Residents for Illinois
Suicide Mortality <sup>29</sup>	16.60	10.80
Drug Overdose Mortality <sup>30</sup>	26.78	19.25
Alcohol-Related Mortality <sup>31</sup>	14.40	10.50

While the percentage of residents uninsured is approximately equal between Winnebago County and Illinois, Winnebago County has higher rates of public insurance coverage (Medicaid and Medicare) compared to Illinois. Conversely, Illinois has a higher percentage of residents covered by private health insurance, including employer-provided insurance, than Winnebago County (Table 17).

**Table 17: Health Insurance Coverage in Winnebago County, IL (2024)**

Health Insurance Coverage	Residents Coverage (%) for Winnebago County	Residents Coverage (%) for Illinois
Private Health Insurance <sup>32</sup>	62.97	69.46
Medicaid Coverage <sup>33</sup>	26.78	19.25
Medicare Coverage <sup>34</sup>	14.40	10.50
Uninsured Rate <sup>35</sup>	6.25	6.87



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## Community Research

### Winnebago County Health Department Illinois Project for Local Assessment of Needs (IPLAN), 2025-2030<sup>36</sup>

Once every five years, certified local health departments in Illinois must conduct an Illinois Project for Local Assessment of Needs (IPLAN). The IPLAN is a combination of a Community Health Assessment (CHA) and a Community Health Improvement Plan (CHIP) that requires input from residents, stakeholders, and other key partners in the region. This regular process identifies critical public health issues that the county should prioritize initiatives and resources to improve.

In March 2025, the Winnebago County Health Department (WCHD) released their IPLAN for 2025-2030. Mobilizing for Action through Planning and Partnerships (MAPP) is a community-centric strategic planning approach that evaluates local perspectives on public health issues. WCHD utilized the three MAPP 2.0 assessments: Community Partner Assessment, Community Status Assessment, and Community Context Assessment (CCA), to assist in identifying the three public health priorities for Winnebago County, Illinois. Similar to the 2020 and 2023 IPLANs, WCHD determined the priority improvement areas as:

- Maternal and Child Health
- Mental/Behavioral Health
- Violence

Disparities in maternal and infant health are present in Winnebago County, Illinois. Black/African American infants have a mortality rate over two times higher than White and Hispanic/Latino populations in the county, and Black/African American mothers had a higher preterm birth rate than White and Hispanic/Latino mothers. The IPLAN found Severe Maternal Morbidity (SMM) rates were high compared to other areas in the state and nearly half of all live births in Winnebago County, Illinois, occurred among mothers with obesity, diabetes, or hypertension. Between 10 and 12.9 percent of all births in the county were affected by substance use.

The Community Context Analysis (CCA) found that Winnebago County residents are still struggling to access mental health care. Residents frequently cited problems with insurance coverage and affordability. Residents reported they could not access care due to not knowing where to look, a lack of available appointments, and appointments being only available during work hours. According to the CCA, five percent of county residents describe their mental health as either 'unhealthy' or 'very unhealthy'. The most prevalent mental health disorders reported in themselves or their households were anxiety, depression, Attention Deficit/Hyperactivity Disorder (ADD/ADHD), Post-Traumatic Stress Disorder (PTSD), and Substance Use Disorder (SUD).

Despite drops in homicide rate and firearm-related mortality rate, Winnebago County's rates remained higher than both the state and national rates. Adverse childhood experiences (ACEs) are traumatic events that can have long-lasting effects across a person's life, including an increased risk of mental health and substance use challenges. WCHD specifically identified trauma and ACEs as contributing factors to community and firearm-related violence.

### Mercyhealth Community Health Needs Assessment 2023<sup>37</sup>

Mercyhealth Javon Bea Hospital in Rockford, Illinois, released their most recent Community Health Needs Assessment (CHNA) for Winnebago and Boone Counties in 2023. They utilized the Rockford Regional Health Council's 2023 Healthy Community Study and local census data to identify significant health needs in the community. Consideration of the Community Profile, Community Survey, Key Informant Interviews, and the Winnebago County IPLAN assisted the Mercyhealth Executive Council in determining the public health priority areas for the 2023 CHNA. They identified the following priorities:

- Chronic Diseases
- Nutrition, Physical Activity, and Obesity
- Maternal, Infant, and Child Health



COMMUNITY  
RESEARCH

The Community Survey revealed that older residents (65+) of the Rockford Area were more likely to report incidences of cancer, Alzheimer’s or dementia, arthritis or rheumatism, and cardiovascular disease than younger individuals. In comparison, those between 45 and 64 years typically reported kidney and liver diseases, chronic digestive disorders, hypertension, obesity, and high cholesterol.

Mercyhealth found when compared to general Illinois rates, adult residents in the Rockford area had a higher rate of obesity. Over 85% of participants in the Community Survey said they did not get 150 minutes of moderate to vigorous exercise per week, the amount recommended for adults by the American Health Association. Rockford area residents were less physically active in their free time over the past month and had more difficulty accessing recreational spaces and grocery stores than the average Illinois resident.

The rate of low birth weight infants is higher in the Rockford area compared to the Illinois rate.

### **OSF Saint Anthony Medical Center Community Health Needs Assessment 2025<sup>38</sup>**

In 2025, OSF Saint Anthony Medical Center released an updated Community Health Needs Assessment (CHNA). Their collaborative team utilized both primary and secondary data collection. Using a survey formulated according to best practices, OSF collected a primary data sample of 423 survey responses. In order to ensure inclusion of at-risk populations, physical copies of the surveys were distributed at local homeless shelters and food pantries.

From their survey and secondary data collection, the OSF team has identified two areas as health need priority areas:

- Mental health, including substance use
- Healthy behaviors – preventative health

Forty-five percent of survey respondents said they felt depressed, and 35% said they felt anxious or stressed within the past 30 days.

The 2024 Illinois Youth Survey, as cited in the CHNA, found that the percentage of 8th graders in Winnebago County, Illinois, who use alcohol, cigarettes, vaping products, inhalants, and cannabis was lower than state averages. The percentage of eighth graders who use illicit drugs other than cannabis is the same as the Illinois percentage (1%). Similarly, the percentage of 10th graders who used any of the above substances was lower than Illinois percentages. On a regular day, 23% of adults in the county drink alcohol, 11% use cannabis, 8% misuse prescription medication, and 3% use illicit substances.

For reference, the daily recommended amount of fruits and vegetables is five servings. Almost two-thirds of survey respondents indicated they eat either no servings of fruits and vegetables or only one to two servings every day. In contrast, two-thirds of respondents reported exercising between one and five times a week, while 20% reported not exercising at all.

### **UW Health SwedishAmerican & Belvidere Hospital Community Health Needs Assessment 2025<sup>39</sup>**

UW Health SwedishAmerican Hospital and UW Health Belvidere Hospital utilized census, community, and survey data from the 2023 Healthy Community Study to inform their Community Health Needs Assessment (CHNA) for Winnebago and Boone Counties. They identified the following four areas as priority areas for health improvement:

- Chronic Conditions
- Access to Healthcare
- Mental Health and Substance Use
- Social Determinants of Health

Similar to other health systems in the Rockford area, the incidence of chronic conditions increases with age. The most common chronic conditions reported by survey respondents were cancer, arthritis, spinal pain, and asthma. Heart disease, the leading cause of death in Winnebago County, can be attributed to almost 23% of deaths in the county, which is slightly higher than the almost 22% of deaths due to heart disease in Illinois.

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## COMMUNITY RESEARCH

Despite 80% of survey respondents visiting a primary care provider in the last year, they identified several barriers to healthcare, such as long wait times, difficulty finding a specialist, and affordability of care. Individuals and families without insurance were the least likely to be able to access any type of care.

Mental health care was less accessible than primary care. Over 30% of people who needed treatment and care were not always able to access it. Anxiety and depression were the most commonly reported mental health problems, and 17% of survey respondents indicated that they used cigarettes and tobacco. Mental health concerns were most prevalent between the ages of 18-44.

According to the Centers for Disease Control and Prevention (CDC), Social Determinants of Health (SDOH) are “the nonmedical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, worship, and age. These conditions include a wide set of forces and systems that shape daily life such as economic policies and systems, development agendas, social norms, social policies, and political systems.” Approximately 50% of survey respondents said they did not work full-time; although almost 30% of the individuals who did not work full-time indicated they were retired, disabled, a homemaker, a student, or unemployed. Fewer than 20% of respondents indicated that they exercise the recommended amount or eat the appropriate quantity of fruits and vegetables every day. Almost 15% of respondents depended on another individual, public transportation, or walking to get to the grocery store. One third of respondents relied on or qualified for food assistance programs.

Personal health literacy is defined by the CDC as “the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.” When asked about their health literacy, survey respondents who easily understood health information were more likely to self-report their health as good or excellent. In contrast, those who struggle to understand medical information were more likely to rate their health as fair or poor. Similarly, individuals who understood medical information well were more likely to trust their medical professional’s decision-making and advice, whereas those who had less understanding of medical information had lower levels of trust in their provider.

### **Alignment Rockford Early Development Instrument (EDI) 2025<sup>40</sup>**

The period of a child’s life from birth to five has a significant impact on their future wellness and educational outcomes. Every three years, Alignment Rockford, in partnership with UCLA’s Data Informed Futures Lab, conducts a survey of teachers in the Rockford area to gauge early childhood development across neighborhoods. Teachers assess whether their kindergarten students are “on track” on the following five domains:

- Physical health and well-being
- Emotional maturity
- Social competence
- Language and cognitive skills
- Communications skills and general knowledge

The 2025 EDI survey expanded to include additional neighborhoods and schools than were initially included in the 2022 survey. While the percent of children classified as vulnerable in the 2025 EDI increased in almost every domain (excluding language and cognitive skills and social competence skills, where the percentage decreased by three percentage points and one percentage point, respectively), Alignment Rockford and UCLA are working to collect a more representative sample of the community and this could impact the percentage of children vulnerable.



**Table 18: Percent of Children Vulnerable by EDI Iteration**

Domain	2022 % Vulnerable Community Wide	2025 % Vulnerable Community Wide
Physical Health and Well-Being	14%	17%
Emotional Maturity	12%	16%
Language and Cognitive	19%	16%
Communication Skills and General Knowledge	11%	14%
Social Competence	13%	12%

This valuable local data can be used to identify gaps in services, as well as assist community leaders and service providers identify where to allocate resources. In particular, mental health services allocated to high vulnerability areas for social competence and emotional maturity could help to improve results in those areas.

### **Birth To Five Illinois Region 4 Early Childhood Needs Assessment: Focus on Mental & Behavioral Health<sup>41</sup>**

Birth To Five Illinois Region 4, which covers Winnebago and Boone Counties, released a Mental & Behavioral Health Needs Assessment in 2024. The coalition utilized formal state and local data, focus groups, interviews, and surveys to formulate recommendations for improving mental and behavioral health care in the region.

Among the key takeaways from the report is that a shortage of mental and behavioral health providers that serve young children is leading to extreme wait times that can make accessing services close to impossible. Several parents and workers in the space are quoted, expressing personal anecdotes of children who waited over six months for services.

The report identified the following community needs for children’s mental and behavioral health:

- Increase the number of providers offering a range of services for children
- Expand services specifically designed for younger children
- Reduce wait times for services
- Address language and cultural barriers to care
- Strengthen focus on preventative mental health, rather than reactive care, and provide family wraparound services to ensure all family members receive the support they need
- Additional funding



COMMUNITY  
RESEARCH

## Region 1 Planning Council Winnebago and Boone Counties Housing and Mental Health Community Needs Assessment<sup>42</sup>

In 2025, Region 1 Planning Council (R1) utilized funds from an Environmental Protection Agency (EPA) grant to conduct research regarding the state of housing for those with mental health disorders in the region. This research was done to determine whether an open brownfield site, which is an “abandoned or under-utilized industrial and commercial [property] with actual or perceived contamination and an active potential for redevelopment”, in Southeast Rockford would be an ideal location for a mixed-use or mixed-income housing development. Through key informant interviews with relevant housing providers and mental health treatment stakeholders in the community, R1 determined that those with mental health disorders were struggling to find and maintain housing for a variety of reasons. R1 investigated why individuals with mental illness or substance use issues experience chronic homelessness, and they found that the solution is much more complex than building a single development. Targeted investment and updated zoning laws may be necessary to begin addressing the housing crisis, particularly for individuals with mental illness.

Qualitative data collection determined that Serious Mental Illness and Substance Use Disorder, as well as the cost of living and high housing costs, are the most significant barriers faced when securing and maintaining housing. Other notable barriers to housing include past rental history, work status, criminal background, and credit history. R1 found that landlords can be hesitant to accept Housing Choice Vouchers for a multitude of reasons, including the additional administrative processes that accompany government contracts. Key informants emphasized the importance of building and maintaining positive, productive relationships with local landlords to help their clients obtain housing.

Finally, most housing programs are not designed to function as residential treatment facilities for higher-risk, higher-need clients who may need that level of care. While there is interest in expanding treatment programs within housing organizations, limited funding and workforce capacity remain major barriers.

## Region 1 Planning Council Health and Transportation Study<sup>43</sup>

Region 1 Planning Council (R1) published the Health and Transportation Study in 2024. This study was formulated for the Metropolitan Planning Area (MPA) that encompasses parts of Winnebago, Boone, and Ogle Counties. The purpose of this study is to explore the current status of transportation and health in the community, as well as the relationship between the two, serve as a baseline for health-related indicators, and act as a guide to stakeholders and decision makers.

Research was done through secondary data collection from national and state sources such as the U.S. Department of Housing and Urban Development (HUD) and the Illinois Department of Public Health (IDPH). They also collected data from local organizations and stakeholders, as well as conducted their own research via a public survey.

Among the recommendations for policy, built environment, natural environment, and advocacy are:

- Improve physical access to health care services, mental health providers, and dental care.
- Collaborate with organizations providing mobile health services.
- Support ridesharing programs that connect people to jobs and essential services.
- Increase outreach efforts to underserved areas during the transportation planning and programming process.



# **Target Populations, Trauma & The Continuum of Care**



## TARGET POPULATIONS

# Target Populations

WCCMHB focuses on residents of Winnebago County, IL, who experience functional impairments in their daily lives due to mental illness or substance use. This general definition is categorized by the target populations outlined in the following text.

## Serious Mental Illness (SMI) (Ages 18+)

Serious Mental Illness (SMI) is defined by the Substance Abuse and Mental Health Services Administration (SAMHSA) as “someone over 18 having (within the past year) a diagnosable mental, behavioral, or emotional disorder that substantially interferes with a person’s life and ability to function”. According to the National Institutes of Health (NIH), an estimated 15.4 million adults ages 18+ had an SMI diagnosis in 2022, representing approximately 6% of the nation’s adult population.<sup>44</sup> SMIs are long-term illnesses that, without proper treatment, can result in the inability to maintain health, employment, housing, and social connections, with an increased likelihood of hospitalization, homelessness, and/or incarceration.

The Illinois Department of Human Services (IDHS) [provides a list of diagnoses](#) that qualify as Serious Mental Illness. SMI diagnoses include, but are not limited to: Bipolar Disorders, Major Depressive Disorder, Schizophrenia, Obsessive-Compulsive Disorder (OCD), and the various eating disorder presentations, such as Anorexia Nervosa. Other DSM-5 diagnoses may be acceptable under this target population when the symptoms of the disorder cause significant impairment in daily functioning.

## Substance Use Disorder (SUD) (All Ages)

Drug addiction is defined by SAMHSA as “a chronic disease where people compulsively seek and use drugs despite harmful consequences”. The eleven DSM-5 diagnosis criteria are characterized into four groupings - impaired control, social impairment, risky use, and pharmacologic (physical) dependence - with severity ranging from mild to moderate to severe. Drug addiction can occur at any age, and includes ten types of classes: alcohol, caffeine, cannabis, hallucinogens, inhalants, opioids, sedatives, stimulants, tobacco, and other/unknown. In 2023, Winnebago County’s fatal overdose rate was 4.69 per 10,000, and the non-fatal rate was 27.8 per 10,000. Statewide in the same year, the fatal overdose rate was 2.63, and the non-fatal rate was 23.0 per 10,000 for all drug types.<sup>45</sup> As with the other target populations, the focus is on severe SUD that inhibits developmentally-appropriate functioning.

## Serious Emotional Disturbance (SED) (Ages 3-21)

Serious Emotional Disturbance (SED) is defined by SAMHSA as “someone under the age of 18 having (within the past year) a diagnosable mental, behavioral, or emotional disorder that resulted in functional impairment that substantially interferes with or limits the child’s role or functioning in family, school, or community activities”.<sup>46</sup> While SMI focuses on maintaining independent living and employment as an adult, SED looks more closely at how a youth functions in school or family environments.

The list of diagnoses that qualify for public funding as SED can be found on the [Illinois Department of Human Services \(IDHS\) website](#). Most, if not all, SED diagnoses on this list overlap with the IDHS list of Serious Mental Illness (SMI) diagnoses, with the exception of Attention-Deficit/Hyperactivity Disorder (ADHD). Other DSM-5 diagnoses may be acceptable under this target population when the symptoms of the disorder cause significant impairment in daily functioning.

While SAMHSA defines individuals 18 and under as the SED population, WCCMHB defines the SED age range as 3 to 21 years old. Those in the 18 to 21 years old age range are typically diagnosed with SED prior to their 18th birthday and have demonstrated a continued need for services. There is an existing overlap between SED age criteria with Infant & Early Childhood’s age range. This is because diagnoses for SED are often not age-appropriate for children under the age of five, and the methods of intervention are different for these age groupings. Therefore, to avoid hard cut-offs in services and symptom regression, and to account for age-related variations in diagnosis and treatment, there is an overlap across these age groups.



TARGET  
POPULATIONS

TRAUMA

## Co-Occurring (All Ages, split into 0-17 and 18+ categories)

Co-Occurring Disorders, or dual diagnosis, is defined by SAMHSA as “the coexistence of both a mental health disorder and a substance use disorder”. A dual diagnosis can occur at any age, but WCCMHB separates Co-Occurring Disorders into two age groupings: 0-17 and 18+. Individuals with either SED or SMI are at higher risk of developing a Co-Occurring Disorder. In 2024, an estimated 21.2 million adults in the nation had a co-occurring mental health and substance use disorder.<sup>47</sup>

## Infant & Early Childhood (Ages 0-5)

An individual’s brain is 90% developed by the time they reach 5 years old, making those first five years critical to their growth.<sup>48</sup> In these early years, the brain is extremely sensitive to its environment and experiences, as its circuitry is still developing connections and associations. In turn, “early experience has a unique advantage in shaping the architecture of developing brain circuits before they are fully mature and stabilized”.<sup>49</sup> Infant and Early Childhood Mental Health can be defined as “the growing ability of infants and young children to form secure, close relationships, experience and express a wide range of emotions and engage with their surroundings”.<sup>50</sup> By identifying Infant & Early Childhood Mental Health as a vulnerable, yet overlooked, Target Population, Winnebago County cements itself as an innovator in community mental health. Including Infant & Early Childhood Mental Health as a target population marks Winnebago County as an innovator in community mental health by identifying a vulnerable, yet overlooked, population.

However, an infant’s mental health and development are connected to the parent’s health and environment. Some conditions, such as Schizophrenia or Bipolar Disorder, have strong genetic factors that make certain individuals predisposed to these illnesses.<sup>51</sup> Other mental health issues can be caused or exacerbated by experiencing various forms of trauma throughout life. Maternal health is also crucial to infant mental health and development; children who have been born to mothers experiencing poor maternal health outcomes (such as chronic stress, chronic illness, or poor nutrition) are more likely to experience negative physical and mental health outcomes.<sup>52</sup>

## Trauma

Trauma is defined by SAMHSA as “an event or circumstance resulting in: physical harm, emotional harm, and/or life-threatening harm [...] that has lasting adverse effects on an individual’s mental, physical, social or spiritual wellbeing”.<sup>53</sup> Trauma can occur at any age to any population. Some examples of trauma include: community, complex, medical, and intimate partner violence. Common diagnoses for those facing issues with functionality after a trauma include: Post-Traumatic Stress Disorder (PTSD), Acute Stress Disorder (ASD), Adjustment Disorders, and Reactive Attachment Disorder (RAD).<sup>54</sup> Although trauma is not a specific Target Population, WCCMHB acknowledges that all Target Populations can experience the effects of trauma, as it is a significant factor in behavioral health that potentially leads to or exacerbates mental health or substance use conditions.

Adverse Childhood Experiences (ACEs) are “potentially traumatic events” that occur anytime between birth and age 17.<sup>55</sup> The types of events can vary, but generally cover the categories of abuse, neglect, and household difficulties (such as domestic violence, housing instability, or food insecurity). The full [ACE Questionnaire](#) can be found on the [Rockefeller Foundation website](#). How adults in a youth’s life respond to traumatic events shapes a youth’s perspective on safety, stability, and bonding, which in turn affects their ability to function and form relationships later in life.<sup>56</sup> Youth who experience four or more ACEs have a strong association with developing problematic drug use and negative mental health outcomes.<sup>57</sup> Different age groups will express signs of trauma differently. Preschool children may have nightmares or a fear of separation, while elementary-aged children experience increased anxiety, shame, guilt, and may express aggression or social isolation. Middle and high school-aged youth may show signs of trauma through self-harm, substance use, aggression, and other risky behaviors.<sup>58</sup>



TRAUMA

THE CONTINUUM  
OF CARE

Vicarious trauma occurs in those who have not directly been impacted by a traumatic event, but spend much of their careers or time working with trauma and traumatic events. As a result, an individual's worldview may shift, and negative behaviors such as burnout, fatigue, excessive worry, and difficulty managing emotions may occur. Individuals working with victims of trauma, such as first responders, law enforcement, or victim services, are especially vulnerable to vicarious trauma.

## The Continuum of Care

### Prevention

In the behavioral health context, prevention is defined as “an approach aimed at reducing the likelihood of future disorder in the general population or for people who are identified as being at risk of a disorder”.<sup>59</sup> It can be further broken down into three types: universal, selective, and indicated. Universal prevention targets the whole population, while selective prevention focuses on high-risk subgroups or communities, and indicated prevention concentrates on individuals who show mild symptoms but have not progressed to a full, diagnosable disorder.<sup>60</sup>

The goals and methods for prevention used within each grouping also differ, with some overlap existing between universal and selective prevention. Universal prevention focuses on the general population, with no specific subgroup targeted. Universal prevention methods, such as promoting policy and program changes, work to address broader public health topics in order to increase protective factors against mental illness. Stable housing, employment, and social connections are all examples of protective factors.<sup>61</sup> Simply put, protective factors are anything that helps prevent a problem before it arises.<sup>62</sup>

Selective prevention occurs at the group or individual level and operates on a smaller, more focused scale. The focus of selective prevention is on subpopulations at higher risk of developing an illness or disorder, who are also asymptomatic.<sup>63</sup> At-risk populations can include those in poverty, those in high-crime areas, or those with a familial history of SMI or SUD. Techniques and strategies used for selective prevention can include targeted training or promotional efforts, but are carried out in conjunction with more intensive elements, such as support groups or home-visiting programs.

Indicated prevention narrows down selective prevention efforts by identifying individuals who are exhibiting early symptoms of a mental illness, but have not yet reached the diagnostic criteria. These individuals are at an especially high risk of developing SED/SMI or SUD.

It is common for prevention efforts to focus on youth because the best time to conduct prevention is before emerging issues escalate into lifelong problems. While preventive measures, such as Social-Emotional Learning (SEL) and mindfulness, are not directly tied to those diagnosed with an SED or SMI, WCCMHB recognizes that preventive measures are an important part of the continuum of care for SED or SMI. Therefore, WCCMHB may fund SEL and other preventative wellness measures when they are directly connected to a step-up, step-down continuum of care as part of indicated prevention focused on individuals presenting with early symptoms of mental illness and/or substance use disorders, particularly symptoms of SED and/or SMI.



## THE CONTINUUM OF CARE

### Treatment

Symptom identification, also known as ‘screening’, assists professionals in identifying individuals who may be suffering from the early stages of mental illness. There are a plethora of evidence-based screening tools to assist mental health professionals in identifying the signs of mental health issues. These tools, also known as assessments, are administered at the initial patient interview and are used to monitor treatment progress.<sup>64</sup> For example, professionals may use the Edinburgh Scale with mothers to screen for postpartum depression, and they may use the GAD-7 for generalized anxiety screenings. Symptom or case identification falls between prevention and clinical treatment, as it is when professionals determine whether an individual may need a diagnosis and a higher level of care.

Behavioral health treatment refers to any professional care designed to manage or reduce the symptoms of a diagnosed mental illness or substance use disorder, with a focus on restoring functionality and promoting healing. Treatment can take various forms, with varying levels of intensity, from visiting a primary care physician for mild symptoms to staying in inpatient settings for those in crisis.<sup>65</sup> Common treatment modalities include psychotherapies such as Cognitive Behavioral Therapy (CBT), Dialectical Behavior Therapy (DBT), or Eye Movement Desensitization and Reprocessing Therapy (EMDR). In severe cases, medication, intensive outpatient programs (IOP), and/or hospitalization options may be appropriate.

### Continued Care

Continued Care refers to “the stage of treatment that follows an initial episode of more intensive care, usually inpatient/residential or intensive outpatient”.<sup>66</sup> For some individuals, ongoing care needs can be met in their communities through community-based services after they achieve stabilization. In some cases, continued care may involve long-term residency in a supportive environment, with consistent assistance and supervision, until an individual reaches and maintains a level of functioning that allows them to live safely and independently. Regardless of the setting, long-term treatment involves routine activities one must engage in to maintain mental health and stability. This includes medication management, regular appointments with mental health professionals, wrap-around services from providers, and long-term permanent housing options.

Rehabilitation, or recovery, is defined by SAMHSA as “a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential”.<sup>67</sup> While mainly used when referring to substance use disorders, individuals with co-occurring or severe mental illnesses may benefit from recovery services. SAMHSA further breaks down recovery into four dimensions: health, home, purpose, and community.<sup>68</sup> Health refers to overcoming or managing a disease and its symptoms; Home is having a safe and stable place to live; Purpose is the daily activities an individual finds meaning in, such as employment, volunteerism, creative endeavors, that led to the ability to participate in society; and Community is the relationships and social networks an individual has that provide them support, friendship, and love.<sup>69</sup>



**Looking Back &  
Where We Are Now**



## LOOKING BACK

# Looking Back

## Funds Awarded

WCCMHB awarded its first round of Core Funding in May of 2021. In the first year of awards, WCCMHB funded 15 programs totaling \$8.8 million. The largest of the awards went to expanding psychiatric evaluation services at Rosecrance, ensuring rapid access to psychiatric evaluation and crisis beds. The second-largest award was allocated to the City of Rockford to establish the Crisis Co-Response Team (CCRT), using a co-responder model to pair mental health professionals with law enforcement during incidents involving mental health or substance use.

The second round of awards in Program Year 2 (PY2) doubled the number of Funded Programs, with 30 awards totaling \$14.6 million. Notable awards included a capital award that helped establish an Equine Assisted Learning (EAL) program through the Rockford Park District, as well as another award that assisted in expanding and renovating supervised housing for adults with serious mental illness.

Program Year 3 (PY3) continued to increase the number of awards and amount awarded, with \$20 million being allocated to 44 programs. Many of these awards were renewals from the previous Program Year (PY2), with some new additions to the Core programs. For example, PY3 funding established an Assistant State’s Attorney position focused solely on mental health, brought mental health services into the local Family Justice Center (referred to as the Family Peace Center), and created a transitional housing program for the County’s chronically unhoused population.

For the Program Years 4-6 (PY4-6) cycle, it was decided that, to best align with the state statute requiring a new Strategic Plan every three years, and to provide funding stability to programs, WCCMHB would move to three-year funding cycles. The PY4-6 cycle awarded nearly \$60 million (\$20 million per year) to 38 programs, to be spent over this three-year period. Program Years start on June 1st, and end on May 31st of the following calendar year.

**Table 19: Funding Opportunity History**

Program Year (PY)	Calendar Year(s)	Number of Awards	Amount
PY1	2021 - 2022	15	\$8.8 million
PY2	2022 - 2023	30	\$14.6 million
PY3	2023 - 2024	44	\$20 million
PY4-6	2024 - 2027	38	\$60 million
Accelerator Awards	Case-By-Case Basis	18	\$10 million
Grassroots Funding	2026 - 2028	9	\$1.6 million



## LOOKING BACK

## WHERE WE ARE NOW

In response to a surplus of unallocated funds, Accelerator Awards were developed to distribute a one-time capital funding call for projects that would accelerate the development of any combination of human, social, or physical capital. A total of \$10 million was awarded to 18 proposals. Notable awards included expanding the local juvenile detention facility to include mental health suites, adding new mental health access points, and providing vehicles to address the transportation barrier. All Accelerator Awards are expected to be completed by the summer of 2027.

To further address the transportation barrier many clients experience, WCCMHB established a HIPAA-Compliant Rideshare Program for its funded agencies. When clients are otherwise unable to get to and from mental health appointments, funded agencies can schedule rides for them, free of cost. The rideshare program was piloted in Program Year 5 (PY5), and agencies that have opted into the service report that they are able to serve more clients and that clients are appreciative of the service. WCCMHB plans to continue funding this service for use by funded agencies and their clients.

The WCCMHB recognizes that small, community-based organizations are also positioned to provide or connect residents to mental health and substance use services within the county. As such, a Grassroots Notice of Funding Opportunity (NOFO) was approved at the August 2025 Board Meeting. \$2 million was allocated to this funding process, with a maximum request amount of \$200,000.00. Nine proposals were funded through the Grassroots Funding initiative for a two-year grant period, from June 1, 2026, to May 31, 2028.

At the beginning of Program Year 4 (PY4), Region 1 Planning Council's Community Impact team developed and released the WCCMHB Data Dashboard, an online tool for the taxpayers of Winnebago County to see the impacts of the half-cent sales tax, including the various metrics and outcomes that Core Funded programs report on. This includes outcome statistics, numbers served, amounts spent, and staffing levels. For more information concerning these metrics, please refer to the [WCCMHB Data Dashboard](#).

## Where We Are Now

Previous iterations of WCCMHB strategic plans were framed around the Community Support System (CSS) framework. This model, developed in the late 1970's, was designed to serve as a basis for planning services for adults with SMI and/or SUD. The 'Coordinating Body' for all these services was intended to be a centralized authority, like state governments; however, this never came to realization. As a result, research into the CSS framework dropped off in the late 1980's, and while the CSS provides valuable insights into how clients interact with systems of care as a whole, it is a legacy model without ongoing research.

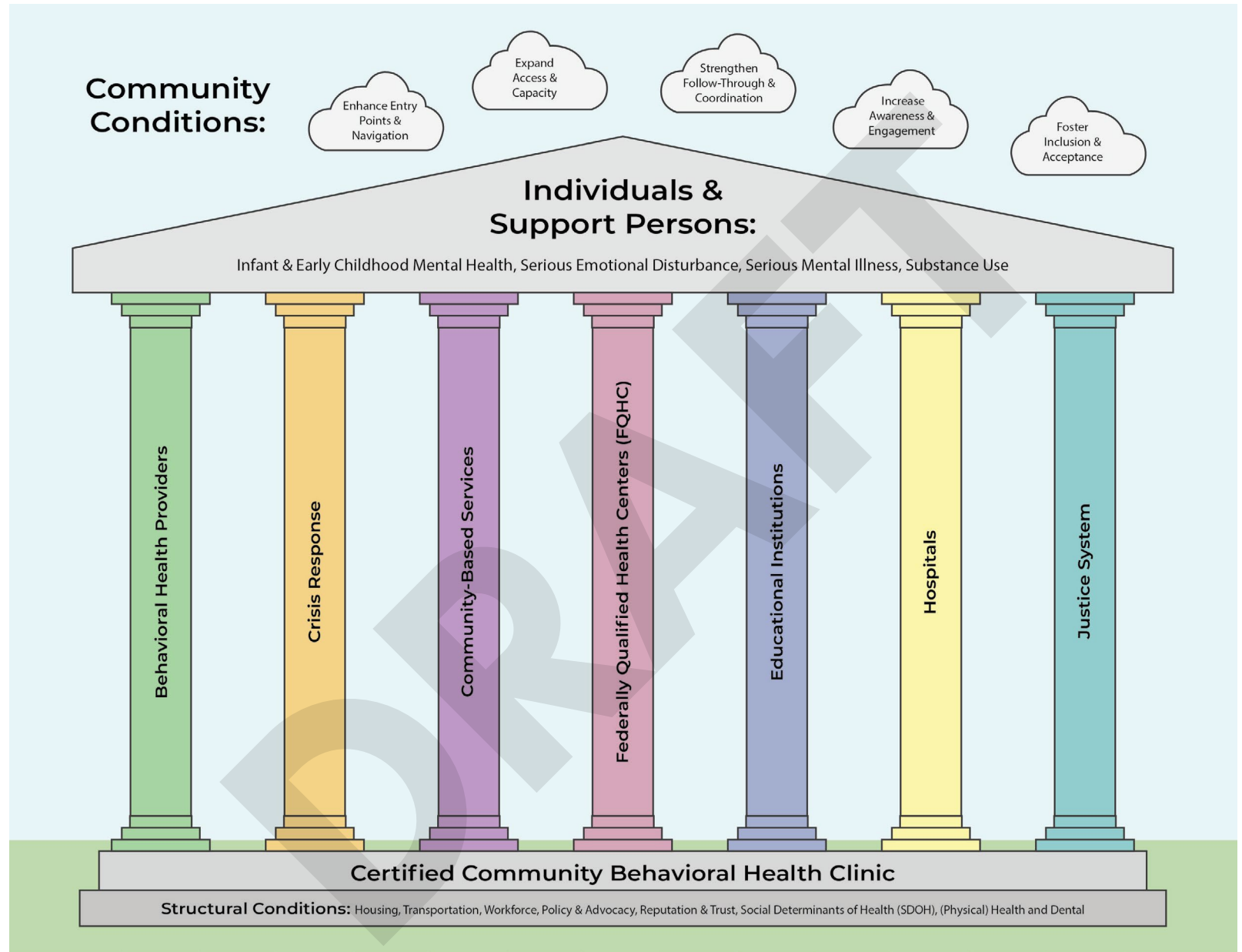
Through an Accelerator Award, WCCMHB funded the Community Foundation of Northern Illinois (CFNIL) to engage a national consultant to support local behavioral health providers in identifying a modern, research-supported model for care coordination in Winnebago County. The final report, conducted by Guidehouse, identified Certified Community Behavioral Health Clinics (CCBHCs) as a central hub for Integrated Behavioral Healthcare in a hub-and-spoke model. As a result of this recommendation, Region 1 Planning Council staff convened Key Informant Interviews with organizations representing the different 'spokes' of the hub-and-spoke model on behalf of WCCMHB. Additional details concerning the Key Informant Interviews can be found on [Page 43](#).

After feedback was collected from participating agencies, Region 1 Planning Council's Community Impact team revised the Guidehouse visual based on key informant feedback that the visual seemed to represent a Single-Point-of-Entry model, whereas, in reality, Guidehouse recommended a No-Wrong-Door approach. The following is an updated visualization containing the key components of a CCBHC countywide system, as identified by Guidehouse.



WHERE WE  
ARE NOW

Figure 24: Certified Community Behavioral Health Clinics (CCBHC) Visual





WHERE WE  
ARE NOW

Structural Conditions' are represented in this visual by comprising the foundational layer. These are the backbone of how an individual lives and functions within a community. Without stable housing, an individual might enter survival mode when trying to find a safe place to sleep at night, leading to neglect of other needs or antisocial behaviors. Barriers to transportation can make it difficult for individuals to travel to appointments, work, and other responsibilities. The Social Determinants of Health (SDOH) must also be considered, as the environment an individual lives in affects their ability to function in everyday life. Finally, an individual's physical health must be considered when referring to an individual's mental health status, as their physical health affects their mental health. The mental health workforce is critical to all these conditions, as these services cannot operate without it. Structural conditions were based on the CSS framework, which effectively acknowledges the multiple factors that affect an individual's ability to live and recover in their community. Additionally, feedback from the Key Informant Interviews, along with recommendations following WCCMHB's first review of the draft visual, led to the addition of 'Reputation & Trust' to the structural conditions. 'Trust & Reputation' is critical for organizations, as outreach and communications will fail if the community does not trust an organization. The community will be hesitant to trust an organization with their vulnerable information, such as traumatic events, their mental health struggles, or substance use issues, when its reputation within the community has been damaged. These 'Structural Conditions' must be met in order to treat the whole individual holistically, as robust foundations make the treatment and maintenance of mental health and/or substance use disorders more effective. While the mental health board recognizes the importance of each of these structural elements, mental health board funding remains primarily focused on mental health services.

The CCBHC-designated organization sits on the structural conditions, serving as an additional foundational layer and 'safety net' for individuals who may fall through the cracks in the system. The CCBHC builds upon the 'Structural Conditions' to provide extra reinforcement to the foundation and its pillars. For agencies that provide services, the CCBHC designation enables streamlined care coordination. For agencies with a Designated Collaborating Organization (DCO) partnership with the CCBHC, it also provides a reimbursement model to support financial sustainability. For clients, this means there will always be sustainable treatment options and continued care, regardless of age, gender, ability to pay, and insurance status. For more detailed information on how the CCBHC acts as a 'safety net', please refer to [Page 10](#) for the CCBHC section.

The pillars represent the key institutions and services that uplift and stabilize the Target Populations and their support networks. This includes Behavioral Health Providers, Crisis Response, Community-Based Services, Federally Qualified Health Center (FQHCs), Educational Institutions, Hospitals, and the Justice System. Represented as pillars within the visual, these institutions must work together to uplift and support the client. Without the stability of each pillar, the whole structure is likely to become unbalanced.

'Community Conditions' are necessary for a CCHBC county-wide system to be successful in Winnebago County and are represented by the "clouds." The 'Community Conditions' are: enhance entry points & navigation, expand access & capacity, increase awareness & engagement, strengthen follow-through & coordination, and foster inclusion & acceptance. These conditions were incorporated from the Guidehouse report, which outlined that community conditions affect all pillars in the community and will strengthen the system of care.



# **The Process of Determination, Terminology & Goals**



THE PROCESS OF  
DETERMINATION

TERMINOLOGY

GOALS

## The Process of Determination

To formulate the goals, objectives, and strategies in this plan, a rigorous research process and accompanying data analysis were conducted. This process began with a review and synthesis of community research conducted within the last five years. In addition, a Community Health Needs Assessment (CHNA) was conducted utilizing the [Metopio platform](#) and [Regional Health Atlas](#). The purpose of the CHNA was to provide the most up-to-date population and health-related statistics in order to understand the current landscape of healthcare in Winnebago County. This data provides valuable insight into the population-level strengths and areas for improvement in Winnebago County.

Following this, Region 1 Planning Council staff conducted an Environmental Scan (ES) of service agencies and other entities in Winnebago County, IL, then analyzed the collected data. The ES helped demonstrate the changes in service capacity and availability from the previous Strategic Plan completed for Program Years 4-6. WCCMHB also released the Public Participation Survey (PPS), which collected public feedback on the mental health care system and its services in Winnebago County.

WCCMHB objectives and strategies based on the completed research and analysis were designated for each goal (previously sub-goals): Programming, Systems Coordination, and Promotion & Awareness. For each goal, measures of success were established to track progress and define what success looks like in each area. Goals, objectives, strategies, and measures of success were kept consistent with Strategic Plan 2.0 and updated based on completed WCCMHB activities, with current and future activities considered in the updates. For example, the Social Worker Opportunity Track (SWOT) Accelerator Award achieved sub-goal 2.4.A in Strategic Plan 2.0; therefore, it was replaced in the Strategic Plan 3.0 update.

In February 2026, WCCMHB Board Members were invited to take a survey that reviewed the previously set mission, vision, values, and principles. Board Members indicated they were satisfied with the current mission, values, and principles; therefore, no changes were made between Strategic Plans.

## Terminology

**Goals** - The goals area determines the three main functions and responsibilities of WCCMHB. The goals outline the tasks that must be maintained to achieve and sustain WCCMHB's mission, vision, values, and principles.

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

**Strategies** - Strategies are the 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 into the desired overall outcomes.

# Goals

## Goal 1: Programming

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

Objectives:	Strategies:	Measures of Success:
<b>1.1: Targeting and Filling Gaps</b> <i>Convening consumers and key stakeholders to identify gaps within the Community.</i>	A: Conduct community research that encompasses both lived and professional experiences.	Evaluation of Winnebago County mental health and substance use gaps and strengths conducted in alignment with the strategic planning process.
	B: Identifying population and service needs lacking in Winnebago County.	Evaluation of Winnebago County mental health and substance use gaps and strengths conducted in alignment with the strategic planning process.
<b>1.2: Funding</b> <i>WCCMHB members have a duty to be fiscally responsible and accountable to taxpayers through the strategic identification of programs needed to address service or systems needs in the community.</i>	A: WCCMHB members review and evaluate submitted and completed grant applications.	At least three Board members review and score grant applications to strategically fill identified gaps.
	B: WCCMHB members vote and approve funding decisions to organizations.	N/A (is done in-person at Board Meetings).
	C: Review and evaluate monthly financial submissions from funded organizations consistent with their contract.	N/A (is a part of the administrative operations & WCCMHB Board gets quarterly finance updates).
<b>1.3: Grant Management</b> <i>Provide accountability, support and guidance to programs seeking or receiving WCCMHB funding.</i>	A: Hold all Funded-Programs accountable to their contractual requirements; additional support given as needed.	Increase or maintain the percentage of programs who successfully complete all intended outcomes for the program year. All agencies report on the progress of their intended outcomes. All agencies are held accountable and are given needed supports.
	B: Maintain a Learning Network Collaborative encompassing leadership of Funded Programs to increase community knowledge and sharing of resources.	N/A (LNC's are held quarterly and are contractual requirements).
	C: Attend site visits to observe Funded Programs and discuss programming as necessary for compliance monitoring.	All agencies participate in a site visit, when requested.
<b>1.4: Evaluation</b> <i>Determine the efficacy individual programs have on overall systems change within Winnebago County.</i>	A: Collect program specific data regarding target populations and measurable outcomes.	All agencies report on the progress of their intended outcomes. 100% of organizations utilize previous program year performance data to inform future program programming.
	B: Measure the efficacy and impact of individual Funded Programs.	All renewal program funding is based on past evaluation data.
	C: Determine the efficacy individual programs have on overall change within community systems.	100% of organizations utilize previous program year performance data to inform future program programming.

## Goal 2: Systems Coordination

Systems coordination is the effort to bring stakeholders together to prioritize issues and outline systemic approaches to resolve them. A Coordinating Group (in this case, WCCMHB) should oversee stakeholder collaboration and ensure it is being utilized effectively for community-based mental health systems planning. The purpose of this 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.

Objectives:	Strategies:	Measures of Success:
<b>2.1: Access</b> <i>Identify and reduce the structural barriers to accessing mental health services.</i>	A: Increase resources for limited English proficiency (LEP) individuals who need mental health or substance use services.	Increase or maintain the percentage of mental health organizations that provide interpretation services and the number of languages in which interpretation is provided.
	B: Promote and maintain last-resort transportation assistance for clients traveling to and from mental health and substance use services.	Increase or maintain the percentage of residents who feel like services are accessible in their community.
	C: Ensuring the affordability of mental health services.	75% of agencies that offer fee-for-service have sliding scale payment options.
<b>2.2: Collaboration and Support</b> <i>Improve network cohesion and coordination of services among funded programs.</i>	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.	60% of Funded Programs enroll in the community referral technology platform.
	B: Invest in a resource sharing platform to ensure all Funded Programs have access to evidence-based literature, practice guides, training, etc.	Increased number of Funded Agency direct service providers have access to an evidence-based resource-sharing platform.
	C: Support maintenance of CCBHC county designation and connection of service providers to CCBHC designated organization.	CCBHC designation is maintained for Winnebago County; 75% of Funded Organizations have MOU with CCHBC for service referrals.
	D: Maintain, and where possible, improve working relationships with local and state government officials.	N/A - Annual report distributed to local elected leadership and membership maintained in state association (ACMHAI).
	E: Be aware of new policies and their implications on local services.	N/A - membership maintained in state association (ACMHAI).
<b>2.3: Cultural Competence</b> <i>Promote cultural competence and cultural humility practices in the mental health system of care.</i>	A: Host and/or attend community events to educate and reframe community members' understanding of mental health and substance use services and keep them engaged and informed about treatment options.	90% of Funded Organizations attend and share information about their organization at the annual community education event, Building Bridges.
	B: Pursue and maintain organizational cultural competence and humility in both WCCMHB and Funded Programs.	N/A - cultural competency and humility practice explanation is a required question in the grant applications.
<b>2.4: Workforce Development</b> <i>Develop and retain an informed and robust mental health workforce.</i>	A: Increase student enrollment into career pathways for entrance into the social work field through tuition and wraparound student support.	Increase number of BSW/MSW credentials achieved from local program enrollment.
	B: Develop a local career pathway for entrance into Certified Recovery Support Specialist (CRSS) / Peer Recovery Support Specialist (PRSS) credentialing.	Increased number of CRSS/PRSS credentials achieved from local program enrollment.
	C: Increase student enrollment into career pathways for psychotropic medication prescribing professionals through tuition and wraparound student support.	Increase number of nurse practitioners and/or medical doctors specializing in mental health and substance use credentials achieved from local program enrollment.
	D: Support retention of mental health workforce in Winnebago County.	50% who graduate from local pathways programs work in Winnebago County upon graduation.

## Goal 3: Promotion and Awareness

The Winnebago County Community Mental Health Board (WCCMHB) aims to help the community become knowledgeable about mental health and have access to high-quality mental health and substance (ab)use services when and where they need them. A large 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 the promotion and awareness, a Communications Working Group that included funded agencies’ marketing and communications leads was convened from October 2022 to May 2025, to develop strategies for increasing community and resident awareness about mental health and access to mental health services when needed, which were codified into funding contracts.

Objectives:	Strategies:	Measures of Success:
<b>3.1: Access</b>  <i>Ensuring that target populations (individuals and families) know how and where to access mental health services (including the Funded Programs).</i>	A: Funded Programs create a social media post each reporting period (based on program type) to promote their program.	90% of programs successfully meet all communications contract requirements.
	B: Funded Programs participate in the annual mental health community event.	90% of Funded Programs attend the annual community event (Building Bridges). Over 300 attendees at the event.
	C: Funded Programs promote their programs through community referral systems (including resource guides, websites, and technology platforms).	60% of Funded Programs enroll in the community referral technology platform.
<b>3.2: Awareness</b>  <i>Increasing overall community member awareness of WCCMHB’s funding strategies.</i>	A: WCCMHB maintains a toolkit for Funded Programs to promote cohesive messaging about WCCMHB’s funding strategies and Funded Programs.	90% of programs meet all communications contract requirements.
	B: Funded Programs use the toolkit to deliver cohesive messaging to raise awareness of WCCMHB’s funding strategies and Funded Programs.	90% of programs meet all communications contract requirements.
	C: WCCMHB handouts and web content (Engage R1, Dashboard) highlight WCCMHB’s funding strategies and Funded Programs.	Over 5,000 visits to the Engage R1 WCCMHB Funded Program Page annually.
	D: WCCMHB promotes funding strategies and Funded Programs through multi-media strategies, including social media, news media, and other communications methods.	Over 2,000 followers on Facebook. Over 300 followers on Instagram.
	E: WCCMHB engages the community through outreach efforts to increase awareness of WCCMHB’s funding strategies and Funded Programs.	60% of residents are aware of WCCMHB Funded Programs based on the resident survey.
	F: Funded Programs co-brand and promote their program in various ways, as outlined in the Communications Contact Requirements as a whole.	90% of programs provide a (Co-Branded Collateral) item of proof in accordance with the communications contract requirements.
<b>3.3: Promotion</b>  <i>Community members know the impact of the Funded Programs.</i>	A: WCCMHB promotes quantitative and qualitative program results on the WCCMHB Data Dashboard.	Over 3,000 visits to the WCCMHB Data Dashboard annually.
	B: Funded Programs promote the outcomes of their program via the impact video or other methods of promotion for the general community.	75% of Core Funded Programs make a post about outcomes on social media each program year.
	C: Funded Programs promote the outcomes of their program with their stakeholders and organization.	90% of programs provide a (Stakeholder Informing) item of proof in accordance with the communications contract requirements.



## Appendices & Endnotes



## APPENDICES

# Appendices

*For Print and Digital Copies of this Strategic Plan: full copies of the Environmental Scan, Public Participation Survey, Key Informant Interviews, and SIM Map updates, can be found on the [WCCMHB Funding Resources webpage](#).*

## Appendix A: Public Comment

Comments for this Strategic Plan to be added after public comment period ends.

## Appendix B: Environmental Scan 3.0

The third iteration of the Environmental Scan (ES) remained open for 72 days, from October 20th to December 31st, 2025. During this two-month window, a total of 53 responses were collected. The Environmental Scan had 38 responses from WCCMHB-funded agencies (either from Core Funding, Accelerator Award Funding, or both) and 15 responses from nonfunded agencies.

There were a total of 169 survey questions, creating 24 sections that organizations answered based on relevance to their own programming. Survey logic was implemented to keep the survey short while still providing relevant programmatic information. Information gathered in the Environmental Scan was used to measure changes in the community and organizations between Strategic Plan processes. This data helps WCCMHB determine community priorities and identify service gaps.

## Appendix C: Public Participation Survey

The Public Participation Survey (PPS) is designed to gauge the public's awareness of the WCCMHB and its Funded Programs. The third iteration of the PPS opened on November 18th, 2025, and stayed open until January 6th, 2026. The PPS consisted of 15 questions that one could take from the perspective of a mental health worker, mental health clients, or community member. Five of the 15 questions pertained to the Resident Awareness Survey, which was an additional section introduced in this iteration of the PPS. If an individual identified with multiple of the previously listed perspectives, they were able to select more than one during completion of the survey. This ensured their answers counted for all applicable perspectives.

A total of 235 responses were collected. Sixty-two of the respondents represented the mental health worker perspective, 105 reflected lived experience, and 68 were community members. Information gathered from the PPS informs the WCCMHB of the public's awareness of the 1/2 cent tax, the Funded Programs, and the impact the Funded Programs have on the community. Additionally, this survey helps pinpoint service gaps, particularly for access to mental healthcare.

## Appendix D: Key Informant Interviews

Eighteen key informant interviews were conducted in person between December 2025 and January 2026. The goal of the semi-structured interviews was to gauge local providers' thoughts on the implementation of the CCBHC model in Winnebago County. Questions were predetermined prior to interviews in order to collect consistent qualitative data from interviewees. Interviewers asked follow-up questions to gather more information and to receive clarification on points made. Follow-up questions were informal and therefore not included in the appendix.

## Appendix E: Sequential Intercept Model (SIM)

In March of 2025, during the third Learning Network Collaborative (LNC) of Program Year 4 (PY4), the Sequential Intercept Model (SIM) was updated from the previous 2021 version to a more recent model to illustrate the persisting diversion gaps, as well as any emerging needs, within the adult justice-involved populations. All WCCMHB Core-Funded Providers who serve adult populations, as well as the local justice system, participated in this update.



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# Endnotes

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