

Sangamon County Recovery Oriented Systems of Care (ROSC) Council

LEAD AGENCY: FAMILY GUIDANCE CENTERS, INC.

FY26 STRATEGIC PLAN

5/4/2026

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Vision: Recovery is possible for everyone, with individuals and families guiding the supports and services that best meet their needs. A responsive, flexible system—coordinated across agencies and phases of care—reflects a shared community commitment to recovery, with continuous improvement driven by measuring quality and outcomes.

Mission: Collaborating to build and empower communities of recovery. There is a lack of understanding in the counties we serve that “recovery happens within the community.” The development of a collaborating Recovery Oriented System of Care will work to create a culture that builds and nurtures recovery.

Background & Demographics

- Sangamon County is located in Central Illinois and includes the state capital, Springfield.
- Total Population: 196,343 (2020 Census)
- Largest cities: Springfield, Chatham, Sherman, Auburn, Rochester, Riverton (29 cities total).
- 82,193 households; average family size: 3.03.
- Racial/ethnic makeup vs. Illinois:
 - White: 77.4% (county) vs. 58.3% (state)
 - Hispanic: 2.7% vs. 18.2%
- Income, education, unemployment, and poverty rates roughly align with statewide averages.

Housing & Homelessness

Housing Stock & Affordability

- 92,982 housing units (2020 Census); 9.2% vacant (8,579 units).
- Largest share of vacant units (3,589) were for rent.
- 83.1% of homes located in urban areas; 16.9% rural.
- Median household income (2018–2022): ~91% of state median.
- Median gross rent: 79% of statewide rent.
- Homeownership rate: 73.9% vs. 67.1% statewide.

[2020 US Census]

Homelessness

Sangamon County has 92,982 housing units, 9.2% of which are vacant, with most vacant units available for rent. Housing is largely urban (83.1%), and while median income is slightly below the state average, rents are more affordable, contributing to a higher homeownership rate (73.9% vs. 67.1%). As of August 2024, 592 people were experiencing homelessness, and the 2023 PIT count identified 306 individuals, including small but significant shares who were unsheltered, under 18, or chronically homeless. [2024 Heartland Housed homelessness and PIT count data]

- Racial disparities:
 - 13.2% of county residents are Black
 - 45.4% of people experiencing homelessness are Black

Economy

- Poverty:
 - 10%+ of residents live below the poverty line (similar to state).
 - 20.9% of children in poverty (2023).
- 2021 Sangamon County Community Survey: 10–22% reported not having enough money for basic necessities (food, shelter, healthcare).

Overdose & Substance Use Disorder

The 2024 Community Health Needs Assessment indicates worsening behavioral health conditions in Sangamon County, including increases in depression, anxiety, suicidal ideation, and substance-related overdoses. In 2023, the coroner recorded 82 fatal overdoses—an 10.8% increase from 2022—with fentanyl involved in most deaths. The county’s overdose fatality rate (3.3 per 10,000) exceeds the state average and continues to rise, disproportionately impacting Black residents and men.

[2024 HSHS St. John’s Hospital Community Health Needs Assessment] [Sangamon County Coroner’s Office]

Community Needs Assessment & Gap Analysis

Gaps in highlighted in survey:

In terms of true gaps in services, several clear trends emerged:

Survey findings indicate that youth behavioral health services in Sangamon County are limited and underrecognized, with only 1–2 outpatient adolescent SUD providers, one inpatient youth mental health facility, and no residential adolescent SUD treatment options. Support groups for families and other specific populations are scarce, and resources for incarcerated and reentering individuals are limited, with low overall awareness of available services.

Communications & Outreach Plan

Communication Plan: Sangamon County ROSC advances its goals through four communication objectives using tailored messaging and multiple outreach methods. Strategies include a regularly updated website and active Facebook page, monthly Zoom meetings with shared agendas and notes, and in-person engagement through print materials, partner meetings, and community events to strengthen collaboration and awareness.

| Communication Goals (Purpose) | Objectives | Target Audiences | Key Messages | Channels & Frequency | Roles and Responsibilities | Evaluation & Feedback |
|-------------------------------|---|--|--|--|--|--|
| Increase ROSC membership | 1. Maintain updated ROSC website and active council meeting links | -General public, Community organizations, People in recovery | -What is ROSC -How and why to join ROSC -ROSC Strategic Plan | -Monthly ROSC Meetings, ROSC New Member Orientation, Monthly Events & Outreach | 1. ROSC program Manager 2. ROSC Program Manager + | 1. Track engagement analytics for website and social media |

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| | 2. Attend a minimum of two community events/ meetings each quarter to promote ROSC 3. Boost recruitment by highlighting gaps in sector representation during council meetings. | | | Meetings, In-person tabling and engagement (ROSC events and community org events) | ROSC Coordinator 3. Program Manager highlights sector gaps; council members invite contacts in those needed sectors. | 2. Track community events and meetings attended 3. Tracking/auditing current membership and sector representation |
| Enhance frequency and quality of resource networking and collaboration across organizations and stakeholders that support recovery | 1. Update resource guide monthly. 2. Maintain a ROSC webpage listing member organizations with logos and website links. 3. Share council members event flyers monthly in meetings and on social media 4. Host one monthly speaker to present their organization and services. | 1. General public, Community organizations 2. Current members of ROSC, public, service providers 3. Current members of ROSC, public, service providers 4. Current members of ROSC, public, service providers | -Resources available - create collaboration opportunities to address service gaps and engage in events | -Monthly updated online public resource guide on website -Website Event Calendar -Active social media pages -Monthly meeting notes & agenda sent to listserv -Event Flyers -Physical resource guide -Updated ROSC brochures -Monthly Zoom meeting, notes, listserv | 1.Coordinator updates; council reviews and reports new or updated resources 2. Program manager updates; council members share their current logo and web site link 3. Council members share event flyers; Coordinator shares in monthly meetings/listserv 4. Program manager identifies monthly speakers | 1.Track engagement analytics for webpage 2. Track engagement analytics for webpage 3. Track engagement and flyer re-sharing on social media 4. Track meeting connections/ engagement between council members and monthly speakers |
| Decrease stigma related to substance use and mental health | 1. Distribute educational stigma reduction campaign messages on quarterly basis 2. Deliver (2-3) presentations on the strategic plan/community survey findings, highlighting key | 1.Community members, service providers, community organizations, people in recovery 2. Community members, service providers & | 1. Positive, evidence-based messages about behavioral health and recovery. 2. Assess and shift public perceptions to reduce | -Social media posts with resources, promotion of appropriate language -Share data from community needs survey related to stigma attitudes | 1. Program manager/Coordinator to share stigma reduction campaign messages & partner with council members in dissemination 2. Program | 1. Track social media engagement and flyer re-sharing, as well as the number of organizations receptive to displaying stigma-reduction messages. |

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| | insights on stigma | community organizations | recovery stigma. | 2. Yearly presentations on the strategic plan/community survey findings, highlighting key insights on stigma | Manager + ROSC Coordinator | 2. Monitor number of presentations and assess audience engagement and feedback |
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Council Goals, Objectives, and Outcome Measures

In response to the findings described in this assessment, the Sangamon County ROSC will work to achieve the following over the next three years:

GOAL 1: Facilitate Improvements to Youth Substance Use Disorder (SUD) Services [Deadline: June 30, 2026]

Objective 1: Develop and Disseminate Youth Service Marketing Materials

- **Deadline:** June 30, 2026
- **Current Progress:** 4 of 5 youth agency partners identified (as of March 16, 2026)
- **Actions Completed:**
 - Presented SIU START Clinic at ROSC meeting
 - Scheduled collaboration with SIU Marketing
 - Partnered with Birth to Five Illinois to update resource guide
- **Next Steps (April–June 2026):**
 - Identify 2–3 additional youth-serving agencies by **April 30, 2026**
 - Finalize participation of 5 agencies by **May 15, 2026**
 - Develop at least 1 marketing material per agency by **May 30, 2026**
 - Distribute materials to at least 10 community locations by **June 15, 2026**
- **Outcome Measures:**
 - 100% agency participation (5 total)
 - Minimum of 5 marketing materials created
 - Materials distributed across 10+ locations
 - Digital reach tracked (clicks, shares, impressions)

Objective 2: Assess Barriers to Youth SUD Treatment

- **Deadline:** December 1, 2025 (Completed; now in analysis phase)
- **Current Progress:** Survey completed; data comparison underway
- **Next Steps (April–May 2026):**

- Complete comparative analysis (Birth to Five survey + Community Needs Assessment) by **April 30, 2026**
- Identify top 3 barriers by **May 10, 2026**
- Develop 2–3 actionable strategies to address barriers by **May 30, 2026**
- **Outcome Measures:**
 - Comprehensive barrier analysis completed
 - At least 2–3 actionable strategies identified and documented

Objective 3: Establish Youth Recovery Support Group Partnerships

- **Deadline:** February 1, 2026 (Completed; moving to sustainability phase)
- **Current Progress:** 2 partners identified
- **Next Steps (Ongoing through June 2026):**
 - Strengthen collaboration with SIU START Clinic and NAMI
 - Support launch and sustainability of youth/family support groups
 - Evaluate participation and engagement by **June 30, 2026**
- **Outcome Measures:**
 - At least 1 active youth recovery support group operating
 - Ongoing partner engagement documented

3-Year Direction (Through December 31, 2028)

Longterm Goal: By December 31, 2028, establish a sustainable, coordinated youth SUD service network that strengthens collaboration among youth-serving organizations and improves access to recovery supports through ongoing, data-informed community partnership.

Long-Term Objectives

Objective 1 (June 30, 2027):

Engage at least five youth-serving organizations in the ROSC network and formalize participation through documented roles, monthly communication processes, and shared outreach activities (e.g., resource sharing, event participation, and referrals).

Objective 2 (December 31, 2027):

Maintain at least two youth-serving organizations attending 75% or more of ROSC meetings and actively contributing to agenda planning, gap identification, and collaborative decision-making.

Objective 3 (June 30, 2028):

Implement and sustain at least two coordinated youth-focused initiatives (e.g., shared marketing/resource campaign, referral pathway agreement, or youth support group collaboration) with documented participation from multiple partner agencies.

Long-Term Outcome Measures

- At least 5 youth-serving organizations actively participating in ROSC meetings, communications, and outreach activities
- At least 2 organizations maintaining 75%+ attendance at ROSC meetings with documented participation in planning activities
- At least 2 youth-focused cross-agency initiatives implemented and sustained (e.g., marketing/resource campaign, referral pathways, or support group collaboration)
- Improved awareness and utilization of youth SUD services measured through annual survey or partner-reported data trends

GOAL 2: Strengthen Partnerships to Expand Family-Focused Behavioral Health Supports [Deadline: June 30, 2026]

Objective 1: Host Family-Focused Events

Frequency: Minimum 5 annually

Current Progress: FY26 annual event goal completed

Actions Completed:

- Participated in and supported family-focused behavioral health events throughout FY26 while distributing recovery and family support resources to community members.
- Collaborated with community partners to increase outreach and family engagement

Next Steps (January–December 2026):

- Schedule all FY26 family-focused events by **September 1, 2025**
- Coordinate with partner agencies to support event planning and outreach
- Host at least:
 - 2 family-focused events by **December 31, 2025**
 - 5 total family-focused events by **June 30, 2026 (completed)**
- Distribute behavioral health and recovery resource materials at each event by **June 30, 2026 (Events in progress)**
- Track attendance, community participation, and partner involvement after each event by **June 30, 2026 (Events in progress)**

Outcome Measures:

- Minimum of 5 family-focused events hosted annually
- Attendance tracked for each event
- Participation from community and behavioral health partners documented
- Behavioral health resources distributed at all events

Objective 2: Establish Family Support Group Infrastructure

Deadline: December 31, 2025 (In progress)

Current Progress:

- Participation in NAMI planning group (***NAMI Chapter in final stages of development***)
- Ongoing Engagement in Youth Whiteboard and Community Health Council groups
- Ongoing collaboration with behavioral health and family-serving organizations

Next Steps (April–June 2026):

- Promote available facilitator trainings to community partners by **May 15, 2026 (In Progress)**
- Identify potential facilitators and referral partners by **June 15, 2026 (In Progress)**
- Support launch of at least 1 family support group by **June 30, 2026 (Nami Chapter in Progress)**
- Assist with outreach and promotion of support group opportunities to families by **June 30, 2026 (In Progress)**
- Track participation and community interest following implementation by **June 30, 2026 (In Progress)**

Outcome Measures:

- At least 1 fully operational family support group established
- Increased participation in facilitator trainings
- Family support group outreach materials distributed through partner organizations
- Participation and engagement data tracked for support group activities
- Ongoing collaboration with NAMI and community partners documented

3-Year Direction (Through June 30, 2028)

Longterm Goal:

By June 30, 2028, establish a sustainable family-focused behavioral health support network that strengthens coordination among community partners, increases access to family support opportunities, and improves awareness of behavioral health, prevention, and recovery resources for families throughout the region.

Objective 1: (June 30, 2027)

Coordinate and sustain at least five family-focused behavioral health events annually in partnership with community organizations to increase family engagement, education, and awareness of available behavioral health resources

Objective 2: (December 31, 2027)

Establish and maintain partnerships with at least three family support groups or family-serving organizations to improve referral pathways, peer support access, and family engagement in behavioral health services.

Objective 3: (June 30, 2028)

Implement and sustain coordinated family-focused outreach and support initiatives, including community events, support groups, and educational activities, that improve access to behavioral health information and family recovery supports.

Long Term Outcome Measures FY27/FY28:

- Coordinated family behavioral health network established with sustained cross-agency collaboration
- 3+ active family-serving partnerships contributing to coordinated services
- 15+ family-focused events, outreach efforts, or support activities completed
- Functional referral pathways established and consistently used across partners
- 2+ sustained family-focused initiatives (e.g., support groups or coordinated outreach) maintained
- Improved family support outcomes demonstrated through year-over-year community survey data, including increased access and satisfaction

GOAL 3: Enhance Access to Behavioral Health Resources for Individuals in the Criminal-Legal System [Deadline: June 30, 2026]

Objective 1: Develop and Distribute Reentry Resource Bundles

Deadline: April 1, 2026 (development) / June 30, 2026 (distribution phase)

Current Progress:

- Planning committee established
- Collaboration underway with jail leadership and Family Guidance Center

Actions Completed:

- Established cross-agency planning structure for reentry supports
- Identified key partners to support content development and implementation

Next Steps (April–June 2026):

- Finalize resource bundle contents by April 15, 2026
- Assemble initial bundles by May 15, 2026
- Begin distribution by June 1, 2026

- Implement monthly distribution tracking system

Outcome Measures:

- Finalized standardized reentry resource bundle completed
- Monthly distribution tracking system implemented
- Consistent distribution process established for individuals reentering the community

Objective 2: Expand 12-Step Programming in Jail

Frequency: Ongoing

Current Progress:

- Needs assessment completed
- Initial facilitator recruitment underway

Actions Completed:

- Completed assessment of programming needs within the facility
- Initiated facilitator recruitment efforts

Next Steps (April–July 2026):

- Recruit at least 3 facilitators by May 30, 2026
- Launch or expand 12-step meetings by June 30, 2026
- Establish monthly participation tracking system by July 15, 2026

Outcome Measures:

- At least 3 active facilitators supporting programming
- Regular 12-step meetings consistently available
- Monthly attendance and participation tracking implemented

3-Year Direction (Through June 30, 2028)

Long-Term Goal: Strengthen behavioral health access and continuity of care for individuals in the criminal-legal system by ensuring consistent reentry supports, expanding recovery programming, and improving coordination between justice and community-based services.

Long-Term Objectives (Through June 30, 2028)

- Maintain consistent distribution of reentry resource bundles for all individuals transitioning from custody to the community
- Sustain year-round 12-step programming within the jail with active facilitator participation and stable scheduling
- Implement and maintain data tracking systems for reentry support use, program participation, and service engagement post-release
- Conduct quarterly reviews of service access, gaps, and outcomes to guide ongoing program improvements
- Expand partnerships with community behavioral health providers to improve linkage to care upon reentry

Outcome Measures (Through June 30, 2028)

- Reentry resource bundles consistently distributed to individuals upon release
- 12-step programming sustained year-round with stable facilitator coverage
- Improved coordination between correctional and community-based behavioral health systems
- Active use of tracking systems to monitor participation, referrals, and reentry service engagement
- Quarterly review process in place to identify gaps and guide service improvements
- Increased continuity of care demonstrated through improved linkage to community behavioral health services after release