CHAMPAIGN COUNTY DEVELOPMENTAL DISABILITIES BOARD
CHAMPAIGN COUNTY MENTAL HEALTH BOARD

Champaign County Mental Health Board (CCMHB)

WEDNESDAY, July 15, 2020 at 5:45 p.m.

This Meeting will be Conducted Remotely at https://us02web.zoom.us/j/87945354242

---

1. Call to Order
2. Roll Call
3. Zoom Instructions **(page 4)**
4. Citizen Input/Public Participation
   The CCMHB reserves the authority to limit individual public participation to 5 minutes and limit total time to 20 minutes.
5. Approval of Agenda*
6. President's Comments
7. Executive Director's Comments
8. New Business
   A. MHFA Training Update **(pages 5-6)**
      Briefing Memorandum on Mental Health First Aid trainings and activities is included in the packet.
   B. Contract Amendment Report **(pages 7-8)**
      Briefing Memorandum on contract amendments is included in the packet.
   C. RACES Counseling Contract* **(pages 9-10)**
      Decision Memorandum on RACES request to substitute another source of funds to fully fund the new therapist position. Action is requested.

9. Agency Information
   The CCMHB reserves the authority to limit individual public participation to 5 minutes and limit total time to 20 minutes.

10. Old Business
    A. CCMHB FY2021 Draft Budget* **(pages 11-27)**
       Decision Memorandum with draft FY2021 CCMHB and CILA budgets attached is included in the packet; action is requested. Additional CCDDB budget documents are included for information only.

    B. UIUC Evaluation Capacity Proposal* **(pages 28-33)**
       Decision Memorandum with UIUC Evaluation Capacity Proposal – Year 6 included in the packet. Action is requested.

    C. 2-1-1 Information and Referral* **(pages 34-35)**
       Decision Memorandum on increase in annual 2-1-1 shared cost with United Way along with copy of the new contract between UW and service provider are included in the packet with supporting documents. Action is requested.

    D. Anti-Stigma Film Virtual Event 2020 **(pages 36-37)**
       Briefing Memorandum with update on possible 2020 and 2021 anti-stigma activities is include for information.

    E. Schedules & Allocation Process Timeline **(pages 38-41)**
       Updated copies of CCMHB and CCDDB meeting schedules and CCMHB allocation timeline are included in the packet.

11. CCDDB Information

12. Approval of CCMHB Minutes* **(pages 42-46)**
    Minutes from the June 17, 2020 meeting are included in the packet. Action is requested.

13. Staff Reports
    Written staff reports from Kim Bowdry ***(pages 47-51)****, Mark Driscoll* **(pages 52-53)**, *Stephanie Howard-Gallo* **(pages 54-55)**, *and Shandra Summerville* **(pages 56-103)** *are included in the packet.*

14. Board to Board Reports

15. Expenditure List* **(pages 104-105)**

Copy of the Expenditure List is included in the packet. Action to accept the list and place on file is requested.

16. Board Announcements

17. Adjournment

Board action

3

Instructions for participating in Zoom Conference Bridge for CCMHB Meeting July 15, 2020 at 5:45 p.m.

You will need a computer with a microphone and speakers to join the Zoom Conference Bridge; if you want your face broadcast you will need a webcam.

Go to Join Zoom Meeting

https://us02web.zoom.us/j/87945354242

Meeting ID: 879 4535 4242

One tap mobile
+13126266799,,87945354242# US (Chicago)
+13017158592,,87945354242# US (Germantown)

Dial by your location
+1 312 626 6799 US (Chicago)
+1 301 715 8592 US (Germantown)
+1 646 558 8656 US (New York)
+1 346 248 7799 US (Houston)
+1 669 900 9128 US (San Jose)
+1 253 215 8782 US (Tacoma)
Meeting ID: 879 4535 4242
Find your local number: https://us02web.zoom.us/u/kbrjFDY8wF

When the meeting opens, choose to join with or without video. (Joining without video doesn't impact your participation in the meeting, it just turns off YOUR video camera so your face is not seen. Joining without video will also use less bandwidth and will make the meeting experience smoother).
Join with computer audio.

Once you are in the meeting, click on "participants" at the bottom of the screen.
Once you've clicked on participants you should see a list of participants with an option to "Raise Hand" at the bottom of the participants screen. **If you wish to speak, click "raise hand" and the Chair will call on you to speak.**

If you are not a member of the CCMHB or a staff person, **please sign in by writing your name and any agency affiliation in the Chat area.** This, like the recording of the meeting itself, is a public document. There are agenda items for Public Participation and for Agency Input, and we will monitor the 'raised hands' during those times.

If you have called in, please speak up during these portions of the meeting if you would like to make a contribution. If you have called in and therefore do not have access to the chat, there will be an opportunity for you to share your 'sign-in' information. If your name is not displayed in the participant list, we might ask that you change it, especially if many people join the call.

Members of the public should not write questions or comments in the Chat area, unless otherwise prompted by the Board, who may choose to record questions and answers there.

8.A.

CHAMPAIGN COUNTY DEVELOPMENTAL DISABILITIES BOARD
CHAMPAIGN COUNTY MENTAL HEALTH BOARD

BRIEFING MEMORANDUM

DATE: July 15, 2020
TO: Members, Champaign County Mental Health Board (CCMHB)
FROM: Shandra Summerville, Cultural and Linguistic Competence Coordinator
SUBJECT: Mental Health First Aid Trainings

Background:

Mental Health First Aid is a course that is designed to identify and understand signs and symptoms to provide the initial support for a person that is experiencing mental health challenges and/or challenges with substance use disorders. In 2015, under a partnership with the Illinois Regional Office of Education, funding was awarded for Project Aware Illinois from the Substance Abuse Mental Health Administration (SAMHA) to begin training individuals from Champaign County to become Youth Mental Health First Aid Instructors. This was a community strategy that would begin to address the stigma of mental illness for adults that are serving youth at school, at day camps, and in neighborhoods.

In 2018, there was an increased report of famers, older adults, and rural area residents that were dying by suicide. There was a member of the CCMHB that wanted to learn about ways that support could be offered to older adults living in rural areas. There were coordinated efforts by Carle and OSF to begin train additional instructors in Mental Health First Aid for Adults. In addition the School of Social Work Education Community Learning Lab and an Agricultural course in Collaborative Leadership at the University of Illinois at Urbana-Champaign, Mental Health First Aid was recommended as part of the community response to address stigma around mental illness.

In April 2019, I became an instructor for Mental Health First Aid for Adults specialized in the Public Safety Module. I have dual certification for Adult and Youth Mental Health First Aid, specialized in Public Safety and virtual and blended learning certification. I have trained 55 people over the past year in Mental Health First Aid and we have an opportunity to build additional capacity to have teens to become mental health first aiders.

For Future Consideration:

Since the impact of COVID-19, there was a clear indication that mental health services for rural residents, under-resourced communities, and young people would have to be innovative, flexible, and non-traditional. Although Mental Health First Aid is not a treatment model, it is an initial

response to provide support to someone that has signs and symptoms of mental health challenge until the appropriate professional help becomes available. Mental Health First Aid for Adults and Adults Assisting Youth has gone to a virtual platform, as well as blended learning for both an in-person and self-paced course. I will be certified to deliver classes virtually as well as the blended learning options. These options will create more opportunity to build Mental Health First Aid in our community.

I have had some initial conversation with Donna Kaufman from Regional Office of Education about creating a site for ***teen Mental Health First Aid***. This in-person training teaches high school students about common mental health challenges and what they can do to support their own mental health and help a friend who is struggling. It is equipping young people with the knowledge and skills they need to foster their own wellness and to support each other. The new instructor training was not made available until after June 15. As we consider to look at the investment for Mental Health First Aid, I believe that it is an opportunity to offer virtual classes and partnering to invest in a ***teen Mental Health First Aid*** site at a local school or after school program with teens.

Number of Anticipated Trainings:

CCMHB will offer a minimum of 6 (3 Adult & 3 Youth) courses annually with up to 20 participants. If the number of participants is over 20 people that class must be taught in person with a co-instructor. If there is a need to host more than six courses, my staff time will be adjusted to accommodate additional courses.

teen Mental Health First Aid must have site a coordinator that will be on site at a school or an afterschool program. It is hard to determine the amount of trainings that will be anticipated. The number of trainings will depend on the number of young people that are available to take the training and the staff time to provide instruction and support for the youth.

Costs:

To maintain the virtual learning certification, I must pay ***$150.00*** annually.

The Virtual Learning and Blended Learning Courses-Each seat is **$28.95** that will include all the notes and the manual for every participant. The seats will be paid for in advance and participants must confirm their attendance before the seat is paid for by CCMHB.

CCMHB has purchased manuals **($18.95)** under the former curriculum that can be used with a crosswalk document with the updated information. The manuals will be for classes that will be taught in person with recommended precautions for in person meetings. When classes are offered in person, there will be a maximum of 10 participants. The average cost covered by CCMHB about **$45.00** for each participant for materials and snacks.

CHAMPAIGN COUNTY MENTAL HEALTH BOARD 8.B.

CHAMPAIGN COUNTY BOARD FOR CARE AND TREATMENT OF PERSONS WITH A DEVELOPMENTAL DISABILITY

BRIEFING MEMORANDUM

TO: Members, Champaign County Mental Health Board
FROM: Mark Driscoll, Associate Director
DATE: July 15, 2020
RE: Contract Amendment Report

The Funding Guidelines include a section on contract amendments. The section gives the Executive Director authority to review and act on amendments, the Board President and the Executive Director discretion to bring amendments to the Board for action, while further stipulating certain requests must have Board approval. Regardless of the process applied to moving forward with an amendment, the Board is to be informed of all contract amendments.

Amendments have been issued to twenty PY20 contracts granted extended terms by the Board last November. The amendments add language on the impact of COVID-19 pandemic as a Special Provision to each contract (All new PY21 contracts also include the language).

> "This contract shall be subject to realignment, reconfiguration, or redirection in scope of services, financial presentation, and/or contract maximum, as deemed necessary by the Board to respond to the COVID-19 pandemic or other declared natural or man-made disasters."

The amended language was approved by the Board at the May 20, 2020 meeting. Amended contracts are:

CCRPC – Community Services "Justice Diversion Program"
CCRPC – Community Services "Youth Assessment Center (YAC)"
Champaign Co. CAC "Children's Advocacy Center"
CSCNCC "Resource Connection"
Crisis Nursery "Beyond Blue Champaign County"
DREAAM House "DREAAM"
Don Moyer Boys and Girls Club "C-U CHANGE"
Don Moyer Boys and Girls Club "Community Coalition Summer Initiatives"
Don Moyer Boys and Girls Club "Youth and Family Services"
ECIRMAC (Refugee Center) "Family Support & Strengthening"
Family Service "Counseling"
Family Service "Self-Help Center"
Family Service "Senior Counseling & Advocacy"
First Followers "Peer Mentoring for Re-entry"
Mahomet Area Youth Club "BLAST"
RACES "Sexual Violence Prevention Education"
Rosecrance Central Illinois "Fresh Start"
Rosecrance Central Illinois "Prevention Services"

BROOKENS ADMINISTRATIVE CENTER • 1776 E. WASHINGTON STREET • URBANA, ILLINOIS 61802
PHONE (217) 367-5703 • FAX (217) 367-5741

Rosecrance Central Illinois "Specialty Courts"
Urbana Neighborhood Connections "Community Study Center"

Another set of amendments have also been completed. The PY20 Promise Healthcare Mental Health Services and Wellness contracts have been amended to extend the contract end date to September 30, 2020. The extension enables the agency to receive payments that were suspended once the overdue audit has been submitted. During the period payments have been held, Promise Healthcare has continued to deliver contracted services.

Four programs involving three agencies were issued contracts with pro-rated award amounts. The four PY21 contracts each include a special provision pro-rating the contract amount until the proposed new staff position(s) are filled. Reference to this special provision was included in the recommendation section of the Decision Memorandum for PY21 Funding.

The amount of each contract was adjusted based on the amount of CCMHB funds supporting each new position not currently filled. Prior to issuing the contract, the three agencies were notified of the amount of the pro-rated contract(s) and that once the new positions were filled the contracts would be amended based on the start date of the new staff. The three agencies/four programs were:

Cunningham Children's Home - Families Stronger Together program
Promise Healthcare – Mental Health Services with Promise
Promise Healthcare – Wellness
RACES – Counseling

Cunningham Children's Home was able to fill two new positions in the Families Stronger Together program prior to the start of the PY21 contract year. As a result, the first two pages of the contract were reissued with new contract maximums equal to the original award. Since the contract now reflects the full award, no amendment will be required to the contract.

For Promise Healthcare amendments will be necessary at a later date. Once the Board has been notified the new positions have been filled and start date of the new hired staff provided, their contracts will be amended and the contract maximum adjusted to account for the period the positions were vacant.

For RACES, the new therapist position is expected to take some time to fill. Because virtually the entire CCCMHB contract supports personnel costs associated with the new position, the question of holding the contract until the position was filled was posed to RACES, whose executive director agreed. The RACES contract will be issued at a later date. However, the contract also carries a Special Provision making the contract contingent on an award of funds from the Illinois Attorney General. The agency recently learned they would not be receiving the funds from the Illinois Attorney General's office and has proposed an alternate source. Please see the RACES Counseling Contract Decision Memorandum for more information.

8.C.

CHAMPAIGN COUNTY DEVELOPMENTAL DISABILITIES BOARD
CHAMPAIGN COUNTY MENTAL HEALTH BOARD

DECISION MEMORANDUM

DATE: July 15, 2020
TO: Members, Champaign County Mental Health Board (CCMHB)
FROM: Lynn Canfield and Mark Driscoll
SUBJECT: RACES Counseling Contract

Background:

During the PY21 allocation cycle, RACES submitted a new proposal to fund a therapist position within the agency's counseling program. Currently the agency has four therapists on staff. The proposal sought new funding from the CCMHB and the Illinois Attorney General to add a fifth fulltime therapist to meet increased demand for services.

Funding from the CCMHB accounts for two thirds of costs associated with the new position. The balance would be paid by the Attorney General funds. However, RACES does not have an existing contractual relationship with the Illinois Attorney General. Making the viability of the new therapist position contingent not only on the award of CCMHB funds but also by the Attorney General. Staff recommended and the Board approved making CCMHB funds contingent on the award of the Attorney General funds.

RACES was informed of that grant condition as well as the contract being pro-rated based on the start date of the therapist. On July 1, 2020, RACES notified the Board the Attorney General would not be allocating funds to support the new therapist position. However, RACES has identified other funds, Victims of Crime Act (VOCA), to fill the void. The VOCA is an existing source of support for the counseling program and RACES has been approved to use more VOCA funds for this purpose but that staff time would not be dedicated to serving residents of Champaign County.

A copy of the e-mail from Adelaide Aime, RACES Executive Director, on not receiving the Attorney General funds and proposed substitution of VOCA funds is attached.

Budget Impact:

The shift in source of supporting funds for adding the therapist position is budget neutral for the Board.

Note the contract is also subject to pro-rating based on the start date of the yet to be hired new therapist. Personnel costs account for 97% of the expenses to be paid by the CCMHB. Because virtually the entire award is allocated to personnel. In prior communications, Ms. Aime has stated it may take as long as six months to fill the position. With her consent, the decision was made to hold the contract until the position is filled and then adjust the amount of the award.

Decision Section:

Options before the board include approving the substitution of VOCA funds, denying the request and withdrawing the award, or deferring consideration of the request.

Motion: Move to approve RACES request to substitute VOCA funds for the Illinois Attorney General funds as the balance of funds necessary to establish the therapist position.

_____ Approved
_____ Denied
_____ Modified
_____ Additional Information Needed

10.A.

CHAMPAIGN COUNTY DEVELOPMENTAL DISABILITIES BOARD
CHAMPAIGN COUNTY MENTAL HEALTH BOARD

DECISION MEMORANDUM

DATE: July 15, 2020
TO: Members, Champaign County Mental Health Board (CCMHB)
FROM: Lynn Canfield, Executive Director
SUBJECT: FY2021 Champaign County CCMHB and CILA Budget Submissions

Overview:

This memorandum presents revised budget information for the Champaign County Mental Health Board (CCMHB), Champaign County Developmental Disabilities Board (CCDDB), and CILA Facilities Funds for County Fiscal Year 2021 (January 1 through December 31, 2021), for approval by the Board. These budgets may be revised with advice from the County Executive and Deputy Director of Finance, incorporating newer revenue and cost estimates, and submitted for information to the Champaign County Board in August. Final budgets will be presented during their appropriations process in November.

Attached are draft proposed 2021 CCMHB, CCDDB, and CILA Fund Budgets, with background details including comparisons of proposed 2021, 2020, and actual revenues and expenditures for fiscal years 2014 through 2019. Also attached is the Intergovernmental Agreement between the CCMHB and CCDDB, defining cost sharing and CILA ownership, among other arrangements. The CILA Fund Budget is under joint authority of the Boards.

Highlights:

- Property tax revenues based on 3.8% (MHB) and 3.3% (DDB) growth over 2020.
- Projected 2021 property tax revenue based on a lower 2020 amount than originally budgeted, due to return of reserved hospital revenue amounts (both boards)
- Miscellaneous revenue includes excess revenue returned by agencies (both boards)
- Fund balances contain small amounts to be paid in relation to the hospital tax ruling, but these amounts are no longer reserved (may be returned during 2020)
- Majority of Expo Coordinator contracts are charged to Expo expense line, with 25% of one charged to Public Relations for other projects. Prior to 2020, these had been charged to Professional Services, and Expo revenues and expenses were combined with other revenue and Public Relations costs, respectively (CCMHB budget)
- Presumes both Boards will participate in the UIUC Evaluation Capacity Project, shared as other costs, with 57.85%/42.15% split (CCMHB budget)
- CCMHB does not transfer an amount to the CILA fund in 2021, due to paying off the mortgage; CCDDB continues to transfer $50,000 per year (CILA budget)
- No mortgage principal or interest expense (CILA budget)

Revisions of June 17 Drafts:

- Recalculation of projected costs of staff benefits, using budget guidance from the County. Some benefits contracts have not been finalized, so these may change again.
- Recalculation of expenses for office rental and for computer services, to conform with practices of the County Auditor's Office.
- Recalculation of CCDDB share of total administrative costs.
- Updates in CILA budget, based on actual 2020 expenditures.
- Further detail in narrative descriptions in background documents, as information becomes available.

Decision Section:

Motion to approve the attached 2021 CCMHB Budget, with anticipated revenues and expenditures of $5,799,576.

_____ Approved
_____ Denied
_____ Modified
_____ Additional Information Needed

Motion to approve the attached 2021 CILA Fund Budget, with anticipated revenues and expenditures of $72,000. Payment to this fund is consistent with the terms of the Intergovernmental Agreement between the CCDDB and CCMHB, and full approval is contingent on CCDDB action.

_____ Approved
_____ Denied
_____ Modified
_____ Additional Information Needed

Draft 2021 CCMHB Budget

LINE ITEM	BUDGETED REVENUE	
311.24	Property Taxes, Current	$5,275,577
313.24	Back Property Taxes	$1,000
314.10	Mobile Home Tax	$4,000
315.10	Payment in Lieu of Taxes	$3,000
336.23	CCDDB Revenue	$384,999
361.10	Investment Interest	$33,000
363.10	Gifts & Donations	$3,000
363.12	Expo Revenue	$15,000
369.90	Other Miscellaneous Revenue	$80,000
	TOTAL REVENUE	***$5,799,576***

LINE ITEM	BUDGETED EXPENDITURES	
511.02	**Appointed Official**	$103,625
511.03	**Regular FTE**	$333,402
511.05	**Temporary Salaries & Wages**	$5,040
511.09	**Overtime Wages**	$1,000
513.01	**FICA**	$34,093
513.02	**IMRF**	$30,617
513.04	**W-Comp**	$2,908
513.05	**Unemployment**	$1,398
513.06	**Health/Life Insurance**	$68,658
513.20	**Employee Development/Recognition**	$200
	Personnel Total	*$580,941*
522.01	**Printing**	$700
522.02	**Office Supplies**	$4,200
522.03	**Books/Periodicals**	$4,000
522.04	**Copier Supplies**	$1,000
522.06	**Postage/UPS/Fed Ex**	$700
522.44	**Equipment Under $5000**	$7,000
	Commodities Total	*$17,600*
533.01	**Audit & Accounting Services**	$11,000
533.07	**Professional Services**	$140,000
533.12	**Travel**	$2,000
533.18	**Non-employee training**	$12,000
533.20	**Insurance**	$19,000
533.29	**Computer Services**	$8,000
533.33	**Telephone**	$1,000
533.42	**Equipment Maintenance**	$500
533.50	**Office Rental**	$26,780
533.51	**Equipment Rental**	$800
533.70	**Legal Notices/Ads**	$200
533.72	**Department Operating**	$300
533.84	**Business Meals/Expense**	$150
533.85	**Photocopy Services**	$4,000
533.89	**Public Relations**	$13,000
533.92	**Contributions & Grants**	$4,879,375
533.93	**Dues & Licenses**	$20,000
533.95	**Conferences/Training**	$8,000
533.98	**disAbility Resource Expo**	$48,000
534.37	**Finance Charges/Bank Fees**	$30
534.70	**Brookens Repair**	$100
	Services Total	*$5,194,235*
571.08	**Interfund Transfer, CCDDB** (Share of Expo and some of Other Misc Rev, *loan in 2019*)	$6,800
571.11	**Interfund Transfer, CILA Fund**	-
	Interfund Transfers TOTAL	*$6,800*
	TOTAL EXPENSES*	***$5,799,576***

13

Draft 2021 CCDDB Budget

LINE ITEM	BUDGETED REVENUE	
311.19	**Property Taxes, Current**	$4,308,511
313.19	**Back Property Taxes**	$2,000
314.10	**Mobile Home Tax**	$3,000
315.10	**Payment in Lieu of Taxes**	$2,000
361.10	**Investment Interest**	$11,000
371.90	**Interfund Transfer (Expo and some Other Misc Rev) from MH Fund**	$6,800
369.90	**Other Miscellaneous Revenue**	$8,000
	TOTAL REVENUE	***$4,341,311***

LINE ITEM	BUDGETED EXPENDITURES	
533.07	**Professional Services** *(42.15% of an adjusted set of CCMHB Admin Expenses)*	$384,999
533.92	**Contributions & Grants**	$3,906,312
571.11	**Interfund Transfer, CILA Fund**	$50,000
	TOTAL EXPENSES	***$4,341,311***

Draft **2021 CILA Fund Budget**

LINE ITEM	BUDGETED REVENUE	
361.10	**Investment Interest**	$4,000
371.54	**From CCDDB 108**	$50,000
371.90	**From CCMHB Fund 090**	-
362.15	**Rents**	$18,000
	TOTAL REVENUE	***$72,000***

LINE ITEM	BUDGETED EXPENDITURES	
522.44	**Equipment Less than $5,000** *(includes a designated gift for the benefit of one individual, accessed at family request, with balance of $13,256.25 as of June 4, 2020)*	$24,600
533.07	**Professional Services** *(property management)*	$8,000
533.20	**Insurance**	$2,400
533.28	**Utilities**	$964
534.36	**CILA Project Building Repair/Maintenance**	$14,000
534.37	**Finance Charges** *(bank fees per statement)*	$36
534.58	**Landscaping Service/Maintenance**	$8,000
544.22	**Building Improvements**	$14,000
	TOTAL EXPENSES	***$72,000***

Background for 2021 CCMHB Budget, with 2020 Adjusted Budget and Earlier Actuals

2021 BUDGETED REVENUE		2020 ADJUSTED BUDGET	2019 ACTUAL	2018 ACTUAL	2017 ACTUAL	2016 ACTUAL	2015 ACTUAL	2014 ACTUAL
Property Taxes, Current	$5,275,577	$5,082,444	$4,813,598	$4,611,577	$4,415,651	$4,246,055	$4,161,439	$4,037,720
Back Property Taxes	$1,000	$1,000	$6,489	$494	$2,731	$2,486	$2,861	$1,612
Mobile Home Tax	$4,000	$4,000	$4,062	$3,909	$3,766	$3,903	$3,995	$3,861
Payment in Lieu of Taxes	$3,000	$3,000	$2,604	$3,406	$3,201	$2,970	$2,869	$2,859
CCDDB Revenue	$384,999	$392,598	$409,175	$310,783	$287,697	$377,695	$330,637	$337,536
Investment Interest	$33,000	$33,000	$45,950	$41,818	$18,473	$3,493	$1,385	$1,015
Gift & Donations	$3,000	$5,000	$4,706					
Expo Revenue (were combined)	$15,000	$14,000	$14,275	$21,613	$5,225	$18,822	$26,221	$28,192
Other Miscellaneous Revenue	$80,000	$50,000	$129,028	$29,955	$117,195	$21,340	$67,599	$85,719
TOTAL REVENUE	**$5,799,576**	**$5,585,042**	**$5,429,887**	**$5,023,555**	**$4,853,939**	**$4,676,764**	**$4,597,006**	**$4,498,514**

2021 BUDGETED EXPENDITURES *(SEE PAGE 5 FOR DETAILS)*		2020 ADJUSTED BUDGET	2019 ACTUAL	2018 ACTUAL	2017 ACTUAL	2016 ACTUAL	2015 ACTUAL	2014 ACTUAL
Personnel	$580,941	$588,351	$519,678	$522,073	$449,220 *(understaffed)*	$577,548	$502,890	$532,909
Commodities	$17,600	$19,000	$11,147	$10,049	$6,263	$7,998	$11,237	$9,282
Services (not Contrib & Grants)	$314,860	$344,080	$286,385	$404,059	$432,828	$410,157	$382,870	$375,735
Contributions & Grants	$4,879,375	$4,625,463	$3,993,283	$3,648,188	$3,593,418	$3,428,015	$3,335,718	$3,673,966
Interfund Expenditures	$6,800	$6,500	$406,505	$56,779	$57,288	$60,673	$0	$0
Interest on Tax Case		$1,648						
TOTAL EXPENSES	**$5,799,576**	**$5,585,042**	**$5,216,998**	**$4,641,148**	**$4,089,797**	**$4,484,391**	**$4,232,715**	**$4,591,892**

Additional Information about Expenses (Proposed 2021 versus Adjusted Budget 2020)

Personnel 2021 v 2020

PERSONNEL	2021	2020
Appointed Official	$103,625	$103,625
Regular FTE	$333,402	$326,512
Temporary Wage/Sal	$5,040	$5,040
Overtime Wages	$1,000	$1,000
FICA	$34,093	$33,368
IMRF	$30,617	$31,885
W-Comp	$2,908	$2,815
Unemployment	$1,398	$1,864
Health/Life Insurance	$68,658	$81,942
Employee Dev/Rec	$200	$300
	$580,941	**$588,351**

Commodities 2021 v 2020

COMMODITIES	2021	2020
Printing	$700	$1,000
Office Supplies	$4,200	$4,100
Books/Periodicals	$4,000	$4,100
Copier Supplies	$1,000	$1,000
Postage/UPS/Fed Ex	$700	$800
Equipment Under $5000	$7,000	$8,000
	$17,600	**$19,000**

Services (not Contributions and Grants)

SERVICES	2021	2020
Audit & Accounting	$11,000	$11,000
Professional Services*	$140,000	$140,000
Travel	$2,000	$3,500
Non-employee conference**	$12,000	$12,000
Insurance	$19,000	$19,000
Computer Services	$8,000	$6,000
Telephone	$1,000	$2,000
Equipment Maintenance	$500	$500
Office Rental	$26,780	$26,000
Equipment Rental	$800	$900
Legal Notices/Ads	$200	$300
Department Operating	$300	$400
Business Meals/Expense	$150	$250
Photocopy Services	$4,000	$4,000
Public Relations***	$13,000	$28,000
Dues/Licenses	$20,000	$21,000
Conferences/Training	$8,000	$11,000
disAbility Resource Expo***	$48,000	$58,000
Finance Charges/Bank Fees	$30	$30
Brookens Repair	$100	$200
	$314,860	**$344,080**

Interfund Expenditures 2021 v 2020

INTERFUND TRANSFERS	2021	2020
CCDDB Share of Expo and some of MHB Misc Revenue	$6,800	$6,500
Payment to CILA Fund	$0	$0
Interest on Tax Case		$1,648
	$6,800	**$8,148**

***Professional Services:**

- legal counsel, website maintenance, human resource services, shredding, graphic design, language access services, accessible document creation, website ADA consultant, independent audit reviews and other CPA consultation, independent reviews of applications, 211/ Path through United Way, UIUC Evaluation Project.
- Previously included Expo Coordinators, but now the cost of these contracts is split with Expo.

****Non Employee Conferences/Trainings**

- Continues Mental Health First Aid trainings and monthly trainings for service providers, with expenses for presenters, materials, refreshments, promotion, supplies. This category also includes expenses related to board members attending conferences and trainings.

*****Public Relations (Community Awareness) and disAbility Resource Expo:**

- Ebertfest (2021 event paid in 2020, not shared with CCDDB), community education/awareness, some consultant support.
- Expo line was added mid-year 2018 to capture 2019 Expo expenses; consultant time is charged here (could be under Professional Services.)

Additional Information about Services

Approval of 2021 Budgets does not obligate the Boards to all expenditures described: most consultant/service contracts are developed by Executive Director with Board officers and, for larger amounts or unusual circumstances, full board review and approval; estimates are based on previous years.

SERVICES	2021		2020	
Professional Services*	$140,000	Approximately $79,000 UI Evaluation, if expanded to include CCDDB. $21,330 to United Way for 211/Path. $500 human resources services (AAIM). $3,000 IT services (BPC). $1,000 Ed McManus. $1,500 website accessibility testing (Falling Leaf). $15,000 online application/reporting systems (EMK). $2000 maintenance of Expo, AIR, and resource guide. Also includes: language access and other accessible document production; graphic design; shredding services; independent reviewers; CPA consultant/reviews; legal counsel. *(Expo/Special Projects consultant costs are split between this line, Public Relations, and disABILITY Resource Expo, per project.)*	$140,000	$78,792 (PY20 amount) UI Evaluation shared with CCDDB. Approx $18,066 United Way for 211/Path (increased mid-year). $500 human resources (AAIM). $3,000 IT services (BPC). $1,500 website accessibility testing (Falling Leaf). $1,000 Ed McManus Consulting. $14,000 online application/reporting systems (EMK). $1800 maintenance of Expo and AIR sites + possible new resource directory. Also includes: graphic design; shredding services; independent reviewer; CPA consult; legal counsel. *(Expo/ Special Projects consultant costs are no longer charged to this line but instead split between Public Relations and Expo, according to projects and subject to change.)*
Public Relations* **	$13,000	PAID IN 2020 -$15,000 Ebertfest film sponsorship, *offset by Alliance member dues and other contributions of $3k-$5k/year.* $2,000 estimated for other community events. $2,000 anti-stigma art show(s) and promotion, including Market in the Square and possible Farmers Market. $2,000 sponsorships of other events. 25% of one Expo Coordinator may be charged to this line for work on non-Expo events and other special projects.	$28,000	$20,000 Ebertfest film sponsorship, *offset by Alliance member dues and other contributions of $3k-$5k/year.* $2,000 estimated for other community events. $2,000 anti-stigma art show(s) and promotion, including Market in the Square. $2,000 sponsorships of other anti-stigma/ community awareness events. 25% of one Expo Coordinator is charged to this line for work on non-Expo events and special projects.
disability Resource Expo* **	$48,000	Support for the 2020 and 2021 Expo events, including venue, supplies, food, interpreters, advertising, t-shirts, storage space, etc. Majority of Expo Coordinators' contracts are here. *Expo costs are offset by exhibitor fees and contributions from sponsors.*	$58,000	Expenses associated with 2020 Expo event and with 2021 Expo but paid in 2020. Coordinator time associated with Expo and related activities charged here rather than to Pro Svcs (in 2018). *Expo costs are offset by exhibitor fees and contributions from sponsors ($14k in 2018.)*
CCMHB Contributions & Grants	*$4,879,375*	Estimated CCMHB payments to agencies from January 1 to June 30, 2021, as authorized in May 2020, plus 1/2 of estimated FY21 annual allocation amount, with agency contract maximums to be authorized by July 1, 2021. *(includes an amount equal to anticipated hospital property tax revenue = $x)*	*$4,625,463*	Actual CCMHB payments to agencies from January 1 to June 30, 2020, as authorized in May 2019, plus payments authorized in May 2020, to be made from June through December 2020.
CCDDB Contributions & Grants	*$3,906,312*	Estimated CCDDB payments to agencies from January 1 to June 30, 2021, as authorized in May 2020, plus 1/2 of estimated FY21 annual allocation amount, with agency contract maximums to be authorized by July 1, 2021. *(includes an amount equal to anticipated hospital property tax revenue = $x)*	*$3,762,511*	Actual CCDDB payments to agencies from January 1 to June 30, 2020, as authorized in May 2019, plus payments authorized in May 2020, to be made from June through December 2020.
Dues/ Licenses	$20,000	$950 national trade association (NACBHDD), $16,000 state trade association (ACMHAI), and smaller amounts Human Services Council, Arc of Illinois, any new membership, e.g., CBHA, NCBH, NADD, or similar.	$21,000	$950 national trade association (NACBHDD), $3,000 AAIM (paid every three years), $16,000 state trade association (ACMHAI), and smaller amounts for Human Services Council, Arc of Illinois, possible new memberships, e.g., CBHA, NCBH, NADD, or similar.
Conferences /Training	$8,000	$1000 registration for NACo and NACBHDD Legislative and Policy Conferences (may be offset by ACMHAI). $350 for NACo Annual Meeting. Costs of travel (plus lodging and food) for staff for NACBHDD and NACo meetings. Costs of travel (plus lodging and food) for staff for ACMHAI meetings. Costs of one other conference/training for staff members, Federation of Families, Arc of IL, NADD, or similar. Kaleidoscope, Inc. training and certification.	$11,000	$1000 registration for NACo and NACBHDD Legislative and Policy Conferences (may be offset by ACMHAI). $350 for NACo Annual Meeting. Costs of travel (plus lodging and food) for staff for NACBHDD and NACo meetings. Costs of travel (plus lodging and food) for staff for ACMHAI meetings. Costs of one other conference/training for staff members, Federation of Families, Arc of IL, NADD or similar. MHFA trainer certification.
Non-Employee Conferences / Trainings**	$12,000	Registration, costs of travel, lodging, and food for board members to attend National or State Association meetings and other conferences or trainings of interest. Also charged here are the costs associated with Mental Health First Aid trainings and trainings for non-employees (e.g., case managers, other service providers, stakeholders), which can include presenters, rental, refreshments, materials, promotion. Unknown whether in person or virtual, or impact on cost.	$12,000	Registration, costs of travel, lodging, and food for board members to attend National or State Association meetings and other conferences or trainings of interest. Also charged here are the costs associated with Mental Health First Aid trainings and trainings for non-employees (e.g., case managers, other service providers, stakeholders), which can include presenters, rental, refreshments, materials, promotion. While travel is unlikely in 2020, virtual MHFA and CM trainings are considered.
Unexpected		Unknown fate of large gatherings (Expo, Ebertfest, conferences, trainings). Possible telework expenses or change in office. Budget transfers if: offices move to a different location or are modified; legal expenses are greater; etc. Budget amendment if hospital tax settlement or employee retirement/resignation. MH and DD fund balances at their lowest point (May) should each include: 6 months operating budget + remaining hospital tax liability (very small) + each board's share (57.85%/42.15%) of accrued staff benefits. If first tax distribution does not occur by June, fund balance may be used.		Unknown fate of large gatherings (Expo, Ebertfest, conferences, trainings). Possible telework expenses or change in office. Budget transfers in the event: staff offices move to a different location or current offices modified; legal expenses are greater; etc. The MH and DD fund balances at their lowest point (May) should each include: six months of operating budget, hospital tax liabilities, other reserved, and each board's share (57.85%/42.15%) of accrued staff benefits. Liabilities associated with hospital tax revenue = $430,716.29 MHB and $359,363.81 DDB, some paid during 2020.

Calculation of the CCDDB Administrative Share ("Professional Services")

Adjustments:	2021	2020
CCMHB Contributions & Grants	*$4,879,375*	*$4,625,463*
UI Evaluation Capacity Project	-	-
Ebertfest anti-stigma film and events	-	*20000*
Payment to CILA fund	-	-
CCDDB Share of Donations & Misc Rev	*6800*	*6500*
MHB Interest on Tax Case		*1648*
Adjustments Total:	**$4,886,175**	**$4,653,611**
CCMHB Total Expenditures:	$5,799,576	$5,585,042
Total Expenditures less Adjustments:	$913,401	$931,431

	2021 CCDDB Share	2020 CCDDB Share
Total Expenditures less Adjustments	$913401	931431
Adjusted Expenditures x 42.15%	**$384,999**	**$392,598**
Monthly Total for CCDDB Admin	*$32,083*	*$32,717*

At the end of the Fiscal Year, actual expenses are updated, some revenues (e.g., Expo) are shared, and adjustments are made to the CCDDB current year share.

Background for 2021 CCDDB Budget, with 2020 Adjusted Budget and Earlier Actuals

2021 BUDGETED REVENUES		2020 ADJ BUDGET	2019 ACTUAL	2018 ACTUAL	2017 ACTUAL	2016 ACTUAL	2015 ACTUAL	2014 ACTUAL
Property Taxes, Current	$4,308,511	$4,170,872	$3,982,668	$3,846,413	$3,684,009	$3,595,174	$3,545,446	$3,501,362
Back Property Taxes	$2,000	$2,000	$5,369	$411	$2,278	$2,105	$2,437	$1,398
Mobile Home Tax	$3,000	$3,000	$3,361	$3,261	$3,142	$3,305	$3,404	$3,348
Payment in Lieu of Taxes	$2,000	$2,000	$2,154	$2,841	$2,671	$2,515	$2,445	$2,479
Investment Interest	$11,000	$11,000	$27,098	$24,062	$10,883	$2,318	$1,486	$812
Gifts & Donations (transfer from MHB)	$6,800	$8,000	$106,505	$6,779	$7,288	$10,673	$0	$0
Other Miscellaneous Revenue	$8,000	$9,600	$8,955	$6,408	$14,432	$0	$0	$11,825
TOTAL REVENUE	***$4,341,311***	***$4,206,472***	***$4,136,110***	***$3,890,175***	**$3,724,703**	**$3,616,091**	**$3,555,220**	**$3,521,224**

2021 BUDGETED EXPENDITURES		2020 ADJ BUDGET	2019 ACTUAL	2018 ACTUAL	2017 ACTUAL	2016 ACTUAL	2015 ACTUAL	2014 ACTUAL
Professional Services *(42.15% of some CCMHB expenses, as above)*	$384,999	$392,598	$309,175	$310,783	*$287,697 (understaffed)*	$379,405	$330,637	$337,536
Contributions & Grants	*$3,906,312*	$3,762,511	$3,445,272	*$3,250,768*	$3,287,911	$3,206,389	$3,069,122	$3,224,172
Interfund Transfer, CILA Fund	$50,000	$50,000	$50,000	$50,000	$50,000	$50,000	$50,000	$0
Interfund Transfer, MH Fund (Repayment of loan)			$100,000					
Interest on Tax Case		$1,363						
TOTAL EXPENSES	***$4,341,311***	**$4,206,472**	**$3,904,447**	**$3,611,551**	**$3,337,911**	**$3,635,794**	**$3,449,759**	**$3,561,708**

INTERGOVERNMENTAL AGREEMENT

THIS INTERGOVERNMENTAL AGREEMENT is entered into this 16th day of March, 2016 by and between the **Champaign County Mental Health Board** (hereinafter the "Mental Health Board") and the **Champaign County Board for the Care and Treatment of Persons with a Developmental Disability** (hereinafter the "Developmental Disabilities Board"). The parties hereby enter into this INTERGOVERNMENTAL AGREEMENT to delineate respective roles, responsibilities, and financial obligations associated with the shared administrative structure that shall be responsible for the staffing and operation of the Mental Health Board and the Developmental Disabilities Board. Both parties understand and agree as follows:

WITNESSETH

WHEREAS, the Mental Health Board has a statutory responsibility (Illinois Community Mental Health Act, 405 ILCS 20 / Section 0.1 et.seq.) to plan, fund, monitor, and evaluate mental health, substance abuse, and developmental disability services in Champaign County;

WHEREAS, the Developmental Disabilities Board has a statutory authority (County Care for Persons with Developmental Disabilities Act, 55 ILCS 105 / Section 0.01 et. seq.) to fund services and facilities for the care and treatment of persons with a developmental disability;

WHEREAS, the Mental Health Board and Developmental Disabilities Board have overlapping responsibilities pertaining to planning, funding, monitoring, and evaluating developmental disability programs and services in Champaign County;

WHEREAS, the members of the Mental Health Board and the Developmental Disabilities Board are appointed by the Chair of the Champaign County Board with consent of the Champaign County Board and as such have committed to share the same administrative structure to maximize the funding available for direct mental health and developmental disabilities programs and services;

WHEREAS, the Parties agree sharing an administrative structure will reduce administrative costs, maximize available funding for direct services, and assure an integrated planning process for developmental disabilities and behavioral health programs and services;

NOW, THEREFORE, it is the agreement of the parties that this INTERGOVERNMENTAL AGREEMENT is entered into in order to assure an efficient, ongoing, cooperative effort that will benefit people with disabilities in Champaign County.

The Parties Agree to the Following Arrangements for a Shared Executive Director and Joint Programs:

1. The chief administrative employee shall serve in a dual (i.e., shared) capacity as Executive Director of the Mental Health Board as well as Executive Director of the Developmental Disabilities Board.

2. The terms and conditions of the Executive Director's employment shall be delineated in an employment contract with both the Developmental Disabilities Board and the Mental Health Board as Parties to the agreement.

3. Each Board shall complete a separate annual performance evaluation of the Executive Director. If either Board rates the Executive Director as "less than satisfactory," a Joint Personnel Committee comprising two (2) officers of the Mental Health Board and two (2) officers of the Developmental Disabilities Board shall be convened to assess the situation and formulate recommendations. A recommendation of termination by the Joint Personnel Committee, or any other action proposed, shall require ratification by each Board by majority vote. The Joint Personnel Committee shall have no other function.

   An annual performance review conference with the Executive Director shall be convened by the Presidents of the two Boards. This conference shall be used to provide feedback about performance and discuss goals and objectives for the coming year.

4. Process for selection of a new shared Executive Director: At such time as it becomes necessary to fill the shared position of Executive Director for the Mental Health Board and the Developmental Disabilities Board, the search and decision process shall include the following steps and processes.

   a. The Mental Health Board and the Developmental Disabilities Board shall develop and agree upon selection criteria and job description for the shared Executive Director position. If necessary, a separate document delineating the search process shall be developed and agreed upon by each Board.
   b. The Presidents of the two Boards, with the advice and consent of the two Boards, shall appoint a Search Committee to manage the search and selection process for the shared Executive Director using the job description and selection criteria.
   c. The Search Committee shall report, in advance, a general schedule for the search process, any advertising content to be used, shall request budget support for the search process, and shall keep the two Boards informed about activities and progress associated with the search with regular reports at each Board meeting during the search schedule.
   d. Ultimately, finalists for the shared Executive Director position will be determined by majority vote of the Search Committee and forwarded to the two Boards.

e. If within 45 days of the planned time of completion of the search, from the schedule in part (c) above, the Search Committee is unable to come to a decision about finalists, then the two Boards may elect to extend the search time to a specific later date or to start the search again from the beginning. If the two Boards do not so elect, this shall be considered to imply that a shared Executive Director is no longer viable and the process of termination or amendment of this agreement shall commence.

f. The Executive Director shall be chosen from among the final candidates by majority vote of each Board. If the two Boards do not reach mutual agreement, then the two Boards may elect to start the search again from the beginning. If the two Boards do not so elect, this shall be considered to imply that a shared Executive Director is no longer viable and the process of termination or amendment of this agreement shall commence.

The Parties Agree to the Following Financial Commitments:

5. There shall be ongoing communication between the Mental Health Board and the Developmental Disabilities Board. On at least a quarterly basis, the shared Executive Director shall meet with the Presidents of the Mental Health Board and the Developmental Disabilities Board to review the status of the provision of administrative services, to discuss coordination of funding for developmental disabilities services, to coordinate regarding joint projects and activities, and to address any other items pertinent to the operations of either Board. The Presidents shall report on the discussion and any actions taken at regular meetings of each Board.

6. The Mental Health Board shall provide funding for developmental disabilities services using the FY12 amount of $529,852 as a base with annual increases or decreases predicated on the percentage of increase or decrease in the levy fund in subsequent years.

7. The organization of Champaign County Government makes it cumbersome for administrative costs to be paid by both the Mental Health Board and the Developmental Disabilities Board. To simplify matters, all administrative costs shall be paid through the Mental Health Board fund/account. The Developmental Disabilities Board will transfer their share of administrative costs to the Mental Health Board for this purpose.

8. The split for administrative costs on the date of execution of this agreement is 42.15% for the Developmental Disabilities Board share with the remainder paid by the Mental Health Board. This percentage is based on a time study of staff effort to determine the salary cost split between the Boards. Subsequent appropriate cost sharing adjustments, based on time studies, pro rata allocation, or other mutually agreed approach shall be determined through the regular meetings between the Presidents of the Mental Health Board and the

Developmental Disabilities Board with the advice and consent of the two Boards.

9. In preparation for the annual budget process, the Executive Committee shall review the proposed administrative costs of the Mental Health Board budget to assure the share in paragraph (8) above is applied only to expenditures which are common for both boards. Administrative costs which are specific to the Mental Health Board or to the Developmental Disabilities Board shall be excluded from (i.e., backed out of) the shared cost pool.

10. All current and future "jointly sponsored programs and activities" shall be shared equally between the Boards unless each Board agrees to some other allocation. These include, but are not limited to, various Acceptance, Inclusion, and Respect programs intended to address discrimination, violations of civil rights, and other stigma directed to people with disabilities.

Miscellaneous Provisions:

11. Nothing contained herein serves to limit, alter, or amend either party's duties, rights, or responsibilities as set out in applicable State statutes, laws, or regulations.

12. This agreement can be amended at any time based on needs identified at the quarterly Presidents Meeting or by either of the two Boards.

13. This agreement may be terminated by first providing notification of intent to terminate the agreement at the President's Meeting, followed by majority vote of either Board, or in the event of disagreement about candidates for the Executive Director position as described in Paragraph 4 above. In the event of a decision to terminate the Intergovernmental Agreement, full implementation of the termination and separation shall be coordinated and concurrent with the Champaign County Budget and fiscal year (January 1).

Governing Law:

14. This Agreement shall be interpreted, construed, and governed by the laws of the State of Illinois.

Entirety of Agreement:

15. This Agreement embodies all representations, obligations, agreements, and conditions in relation to the subject matters hereof, and no representations, obligations, understandings, or agreements, oral or otherwise, in relation thereto exist between the parties except as expressly set forth herein and incorporated herein by reference. This Agreement constitutes the entire agreement between the Mental Health Board and the Developmental Disabilities Board on the subject matters hereof and supersedes and replaces any and all other understandings, obligations, representations, and agreements, whether written or oral, express or implied, between or by the Mental Health Board and the Developmental Disabilities Board. This

Agreement may be amended or terminated only by an instrument in writing duly executed by the parties hereto.

IN WITNESS WHEREOF, the Parties have caused this INTERGOVERNMENTAL AGREEMENT to be executed by their authorized representatives on the 16th day of March, 2016.

For the Champaign County Board for the Care and Treatment of Persons with a Developmental Disability:
Philip T. Krein, President Philip T. Krein March 16, 2016

For the Champaign County Mental Health Board Deborah Townsend
Deborah Townsend, President

ADDENDUM TO INTERGOVERNMENTAL AGREEMENT

This Addendum to Intergovernmental Agreement is entered into this 17th day of September, 2014, by and between the Champaign County Mental Health Board ("MHB") and the Champaign County Board for the Care and Treatment of Persons with a Developmental Disability ("DDB").

Whereas, MHB and DDB entered into an Intergovernmental Agreement dated June 30, 2012 ("Agreement").

Whereas, MHB and DDB desire to amend the Agreement by providing for the sharing of costs related to the acquisition of residences to be used to provide Community Integrated Living Arrangement Services ("CILA").

Now, therefore, MHB and DDB hereby agree as follows:

1. MHB shall acquire residences in Champaign County to be leased to a CILA provider to provide housing to residents in Champaign County that qualify for CILA services.

2. MHB shall acquire such residences with financing provided by one or more local banks.

3. MHB and DDB agree that for so long as a residence is owned by MHB and used to provide CILA services to residents of Champaign County, each party shall be responsible for one-half of all costs associated with the acquisition of such residences, the debt payments associated with such residences, the maintenance costs of such residences and the costs associated with any disposition of a residence.

4. MHB and DDB agree that once a residence is no longer to be used to provide CILA services, MHB shall enter into a listing agreement with a realtor in an attempt to sell such residence. The parties agree that the proceeds, net of all selling expenses, from the sale of such residence shall be distributed equally to MHB and DDB.

In witness whereof, the parties have executed this Addendum as of the date first written above.

For the Champaign County Board for the Care and Treatment of Persons with a Developmental Disability

_____

For the Champaign County Mental Health Board

_____

ADDENDUM TO INTERGOVERNMENTAL AGREEMENT

This Addendum to Intergovernmental Agreement is entered into this 20th day of February, 2019, by and between the Champaign County Mental Health Board ("MHB") and the Champaign County Board for the Care and Treatment of Persons with a Developmental Disability ("DDB") and replaces the agreements outlined in the addendum dated September 17, 2014.

Whereas, MHB and DDB entered into an Intergovernmental Agreement dated June 30, 2012 and revised March 16, 2016 ("Agreement") and amended September 17, 2014, and

Whereas, MHB and DDB desire to amend the Agreement by providing for the sharing of costs related to the acquisition, maintenance, and disposition of residences to be used to provide Community Integrated Living Arrangement ("CILA") Services,

Now, therefore, MHB and DDB hereby agree as follows:

1. MHB will pay the remaining mortgage balance (interest and principal) which allowed for acquisition of residences in Champaign County to be leased to a CILA provider to provide housing to residents in Champaign County that qualify for CILA services.

2. By this action, as of May, 2019, the MHB will have contributed a total of $500,000, and the DDB $300,000, to the project.

3. MHB and DDB agree that for so long as a residence is owned by MHB and used to provide CILA services to residents of Champaign County, each party shall be responsible for one-half of all costs associated with the acquisition of such residences, the debt payments associated with such residences, the maintenance costs of such residences and the costs associated with any disposition of a residence.
   A. Prior to the contributions of the DDB becoming equal to those of the MHB, if expenses related to the CILA fund exceed the amount available in the annual budget, the DDB will transfer the additional amount to the CILA fund, reducing the remaining DDB obligation.
   B. After the contributions of each Board have become equal, the CILA fund will continue to receive equal contributions from each board, by annual interfund transfers, for ongoing expenses associated with the properties. This annual amount will be based on most recently completed fiscal year actual expenses plus 10%.
   C. If expenses related to the properties exceed the amount available in annual CILA fund budget, a request to transfer from CILA fund balance may be made. If fund balance is insufficient or transfer not possible, the Boards may agree to contribute equally to the fund as needed.

4. MHB and DDB agree that once a residence is no longer to be used to provide CILA services, MHB shall enter into a listing agreement with a realtor in an attempt to sell such residence. The parties agree that the proceeds, net of all selling expenses, from the sale of such residence shall be distributed equally to MHB and DDB.
   A. If the homes are sold prior to such time as the total DDB contribution has become equal to that of the MHB, revenue from sale of the homes will be adjusted to balance them, after which, any reserve in the CILA fund will be split equally between the two Boards, as interfund transfers from the CILA fund to each of the MHB fund and DDB fund.
   B. If the homes are sold after the contributions have become equal, the current balance of the CILA fund and proceeds from the sale of the homes will be split equally between the two boards, per the original agreement.

In witness whereof, the parties have executed this Addendum as of the date first written above.

For the Champaign County Board for the Care and Treatment of Persons with a Developmental Disability

Debra A Rueck

For the Champaign County Mental Health Board

10.B.

CHAMPAIGN COUNTY DEVELOPMENTAL DISABILITIES BOARD
CHAMPAIGN COUNTY MENTAL HEALTH BOARD

DECISION MEMORANDUM

DATE: July 15, 2020
TO: Members, Champaign County Mental Health Board (CCMHB)
FROM: Lynn Canfield, Mark Driscoll, and Kim Bowdry
SUBJECT: University of Illinois "Building Evaluation Capacity: Year 6" Proposal

Background:

For the last five years, the CCMHB has contracted with the University of Illinois to build evaluation capacity of funded programs. The initial proposal was the result of meetings with evaluators, staff, and Board representatives. This same group meets annually in June as the Program Evaluation Committee to review past performance and agency engagement and to gauge interest in continuing the project. CCMHB representatives are Dr. Moore and Dr. Rappaport. Staff participating are Lynn Canfield, Mark Driscoll, and Kim Bowdry. The consultants are Dr. Nicole Allen and Dr. Mark Aber, who have worked with funded agencies for many years and are familiar with the mission and work of the Boards. Last year, Dr. Gingold, a member of the CCDDB Board at the time, also participated in the meeting.

On June 24, 2020, the Committee met virtually via Zoom to discuss the proposal and renewal of the contract. Due to short notice, only members of the CCMHB were able join the meeting. Dr. Allen and Dr. Aber discussed positive experiences working with agencies the past year including the DDB funded programs. In addition to implementing the approved work plan, the evaluation team, as part of a self-evaluation exercise, surveyed agencies on their experiences working with the evaluation team in the past or present to inform future engagement. One outcome of the exercise, and reflected in the proposal, is a need to strengthen the back-end partnership with targeted programs by providing additional support on data collection and analysis and how to use these results to inform change in program services.

The evaluation team presents an annual report on the outcome of work with funded programs to the Board and to funded agencies each year. The presentation to the Mental Health Board is scheduled for the September 23, 2020 meeting. Part of the presentation is expected to include a summary of the program evaluation team's self-evaluation exercise. The evaluators and agencies with PY20 targeted programs will present at the August 25, 2020 meeting of the Mental Health and Developmental Disabilities Agencies Council (MHDDAC).

Throughout the last year, a representative of the evaluation team has periodically attended meetings of the MHDDAC to report on activities and services available to CCMHB/CCDDB funded programs. A brief update on how evaluation technical assistance has continued through remote access during the COVID-19 shelter at home order was made by the evaluation team at the May MHDDAC meeting.

Last year as initial discussion of renewing the contract was starting, the CCDDB expressed interest in the evaluation project. The CCDDB had not participated in the past, limiting access to program evaluation support services to CCMHB-funded programs. CCDDB participation has increased the number of targeted programs with the expressed intent of serving DDB funded programs, along with opening access to logic model workshops, consultation bank, and online resource repository to CCDDB funded programs.

A copy of the University of Illinois "Building Evaluation Capacity: Year 6" Proposal for Program Year 2021 is attached.

Budget Impact:

The first year the CCMHB contracted for evaluation support was for an assessment of evaluation requirements and agency reports. Building off that assessment, years 2-5 focused on developing evaluation capacity within programs, including targeted intensive support to a small set of programs each year as well as quarterly follow-up with previously assisted targeted programs. Other services include supporting any CCMHB funded program through what is known as the "consultation bank" where a program can request technical assistance, holding Logic Model workshops, and building an online resource of documents and other evaluation related materials developed with supported agencies. In year five, targeted programs increased to five with two earmarked for CCDDB funded programs.

Renewal is recommended, to continue the progress achieved by prior targeted programs, to engage new programs with intensive evaluation technical assistance, and to offer consultation and other supports to all CCMHB and CCDDB funded programs and to the Boards. The proposed cost is $80,198 and includes services to CCDDB programs. CCDDB participation offsets the total contract amount by $33,803 for a final cost to the Board of $46,395.

Contingent on continued participation by the CCDDB, staff recommends the Board approve the contract proposal. Under the Intergovernmental Agreement, CCDDB participation would equal the agreed upon administrative cost rate of 42.15%.

Decision Section:

Motion: Move to accept the University of Illinois Capacity Building Evaluation: Year 6 Proposal, and authorize the Executive Director to enter into a contract with the University of Illinois at a cost of $80,198, contingent upon the Champaign County Developmental Disabilities Board participation offsetting the contract amount by $33,803.

_____ Approved
_____ Denied
_____ Modified
_____ Additional Information Needed

July 1, 2020

ILLINOIS

SPONSORED PROGRAMS ADMINISTRATION
1901 S. First St., Suite A, MC-685
Champaign, IL 61820-7406

Proposal Approval Letter

The Board of Trustees of the University of Illinois ("Illinois") endorses this proposal for Dr. Nicole Allen entitled "A Proposal to Build Evaluation Capacity for Programs" and submitted to Champaign Co (IL) Mental Health Board. The period of performance for this project is 07/01/2020 through 06/30/2021, and the total requested amount is $80,198. The internal proposal transmittal number is 10218.

This proposal has been reviewed and approved by the appropriate official of the University of Illinois and certified to its accuracy and completeness. The appropriate programmatic and administrative personnel at Illinois approve this proposal submission, and our organization will actively participate in the project in accordance with the agreed upon terms.

Human Subjects:	Yes	Assurance #: 00008584
Vertebrate Animals:	No	Assurance #: A3118-01

Illinois is registered in the System for Award Management (SAM), and offers the following information and assurances:

Legal Name:	Board of Trustees of the University of Illinois
DUNS Number:	04-154-4081
EIN:	37-6000511
Place of Performance:	Henry Administration Building 506 S Wright Street Urbana, IL 61801-3620
Congressional District:	IL-013

Additional institutional information, including institutional rates and assurances, are available in the FDP Expanded Clearinghouse.

If awarded or if there are questions of a non-technical nature, please notify:

Robin Beach, Director, Pre-Award
spa@illinois.edu
Sponsored Programs Administration
1901 S First Street, Suite A
Champaign, IL 61820-7406

Illinois reserves the right to negotiate the terms, conditions and provisions included in any agreement prior to acceptance.

Sincerely,

30

A Proposal to Build Evaluation Capacity for Programs
Funded by the Champaign County Community Mental Health Board (CCMHB)
Year 6, FY 2021

Abstract

The aim of this effort is to continue to build evaluation capacity for programs funded by the Champaign County Mental Health Board (CCMHB). In Year 6, we propose to continue to implement the recommendations and specific plans identified via Year 1 assessment of current evaluation activities and priorities and to build upon previous effort. Specifically, we will provide evaluation support to CCMHB funded agencies, work closely with agencies identified for intensive partnership to develop evaluation activities, and provide training/workshops on the development of logic models. However, in addition, in the coming year we wish to intensify partnerships with previously targeted programs to encourage greater data usage and translation.

Proposal and Deliverables

Statement of Purpose:
The aim of this effort is to continue to build evaluation capacity for programs funded by the Champaign County Mental Health (CCMHB) and Developmental Disabilities Board (CCDDB). In Year 6, we propose to continue to implement the recommendations and specific plans identified via Year 1 assessment of current evaluation activities and priorities and to build upon our previous efforts over the last few years. In particular, we aim to intensify partnerships with previously targeted programs to encourage greater data usage and translation.

Specifically, we propose the following activities and deliverables.

1. Continue to Create a Learning Organization among Funded Agencies and the CCMHB/CCDDB
    a. Prepare new "targeted" agencies to share information at MHDDAC meetings once/year by Summer, 2021 (as schedules allow). The actual presentation will occur in the July or August following the end of the fiscal year at the MHDDAC meeting

2. Continue to Support the Development of Theory of Change Logic Models.
    a. Offer 2 logic modeling workshops to support funded programs in model development in Fall 2020
    b. Schedule and announce logic model training dates with 30 days advance notice
    c. Provide follow-up support to targeted agencies who submit a model to the team for review (and to agencies who choose to develop the model using "hours" from the consultation bank)

3. Choose three Programs for Targeted Evaluation Development in Consultation (up to two CCMHB and one CCDDB)
    a. Work in collaboration with up to three funded programs to develop evaluation plans and support them in the implementation of those plans (e.g., instrument development, data gathering, data reporting)
    b. The goal would be to guide an evaluation plan and process that can be implemented and sustained by the program in subsequent years

4. Choose three Programs for Targeted Evaluation Data Usage in Consultation (up to two CCMHB and one CCDDB)
    a. Work in collaboration with up to three funded programs to support ongoing evaluation implementation (e.g., data collection, data usage, data translation).
    b. The goal would be to emphasize translating evaluation findings to inform program activities and facilitate usage of evaluation data to make informed programmatic decisions.

5. Invite follow-up with all previously targeted agencies via the Consultation Bank. This could include (depending on agency need):
    a. Reviewing evaluation implementation progress
    b. Revising and refining logic models
    c. Reviewing gathered data and developing processes to analyze and present data internally and externally

6. Continue the Evaluation Consultation Bank with Agencies Who Have not Had Targeted Partnerships
    a. Offer a bank of consultation hours for use by funded programs
    b. Funded programs would request hours based on specific tasks
        i. Developing an evaluation focus
        ii. Completing a logic model
        iii. Developing and sustaining evaluation activities (particularly in targeted agencies)
        iv. Reporting data

7. Continue to Build a "Buffet" of Tools
    a. Maintain and expand a Google drive or other web-based repository for measures developed with and/or for funded programs

8. Offer two workshops with CCMHB/CCDDB funded agencies regarding data usage fundamentals including, for example:
    a. Data storage (setting up excel, confidential storage, identity keys)
    b. Basic analysis (shareware, means, standard deviations, change over time)
    c. Conceptualizing process and outcome evaluation questions based on the theory of change logic model
    d. Applying evaluation findings to inform programmatic decision-making

9. Meet with CCMHB/CCDDB members as requested to provide information on, for example:
    a. The varied uses of evaluation
    b. Logic modeling process
    c. CCMHB/CCDDB goals and priorities with regard to evaluation
    d. Instantiating evaluation practices for the CCMHB and the boards' funded programs

Budget and Justification

Nicole Allen (.50 mo) and Mark Aber (1 mo) (14,255 x 36.93%% benefits). Drs. Nicole Allen and Mark Aber would co-lead these evaluation activities. Both would reserve time throughout the year and intensively during a summer month (most likely May 15th to June 15th) to execute project deliverables.

Two Research Assistants- 11 mos *($49,278- 11mo 50% fte x 8.34%% benefits).* A research assistant would assist in all facets of project execution which would but not be limited to supporting evaluation planning, workshop development, and collaboration/funded program partnership.

Indirect Costs (10% of Total Direct Costs $72,907) = $7,291

GRAND TOTAL $80,198

10.C.

CHAMPAIGN COUNTY DEVELOPMENTAL DISABILITIES BOARD
CHAMPAIGN COUNTY MENTAL HEALTH BOARD

DECISION MEMORANDUM

DATE: July 15, 2020
TO: Members, Champaign County Mental Health Board (CCMHB)
FROM: Lynn Canfield, Executive Director
SUBJECT: 211 Information and Referral

Background:

The purpose of this memorandum is to seek approval for renewal of CCDDB and Champaign County Mental Health Board (CCMHB) involvement with the United Way of Champaign County (UWCC) in support of the 211information and referral call service provided by PATH. This includes an increase in the annual total cost, which is split by the boards, along with a revised memorandum of understanding.

Also attached is a copy of the contract between PATH and United Way for the upcoming contract year, with total cost of $42,660. If approved, the CCMHB and CCDDB would pay $21,330 combined, with cost to the CCDDB of $8,991 and cost to the CCMHB $12,339. Under this MOU, this cost sharing would continue, with annual changes up to the new maximum amount.

CCMHB/CCDDB staff meet as needed with UWCC staff on many issues related to this project, especially as we learn from providers and community members about their use of this and other information and referral services. Agencies update PATH about programs, contacts, and capacities in order to ensure best 211 service to residents of the County. 211 is a project of National United Way and meets Alliance of Information and Referral Systems standards. We will continue to explore the possibility of partnership with the National Suicide Prevention Lifeline and online resource enhancements currently being designed by the UIUC Community Data Clinic.

Decision Section:

Motion to authorize the Executive Director to enter into an updated Memorandum of Understanding with the United Way of Champaign County for 211 service:

_____ Approved
_____ Denied
_____ Modified
_____ Additional Information Needed

Motion to approve the annual total cost of $21,330 to be shared with the CCDDB as described and subject to future adjustment per the terms of the new Memorandum of Understanding:

_____ Approved
_____ Denied
_____ Modified
_____ Additional Information Needed

2-1-1 Illinois Call Center Contract

The Parties to this Contract are PATH, Inc. and United Way of Champaign County. The Contract consists of this signature page, the following pages detailing the contents described below, and any attachments identified on these pages.

1. **TERM AND TERMINATION** — **07/1/2020-6/30/2021**
2. **DESCRIPTION OF SERVICES** — **Annual Fee $42,660**
3. **STANDARD TERMS AND CONDITIONS**
4. **SUPPLEMENTAL PROVISIONS**

In consideration of the mutual agreements contained in this Contract, and for other good and valuable consideration, the receipt and sufficiency of which are acknowledged, the Parties agree to the terms set forth herein and have caused this Contract to be executed by their duly authorized representatives on the dates shown below.

United Way of Champaign County

Signature Susan Grey

Printed Name Susan Grey

Title Pres. + CEO

Date 6/9/2020

Address: 5 Dunlap Court

City & State: Savoy, IL

Zip: 61874

Phone: 217-352-5151

Fax

E-mail sue@unwayhelps.org

PATH, Inc.

Signature Karen Zangerle

Printed Name: Karen Zangerle

Title: Executive Director

Date: 6/4/2020

Address: 201 E. Grove Street #200

City & State: Bloomington, IL

Zip: 61701

Phone: 309-834-0500

Fax: 309-827-7485

Email: kzangerle@pathcrisis.org

10.D.

CHAMPAIGN COUNTY DEVELOPMENTAL DISABILITIES BOARD
CHAMPAIGN COUNTY MENTAL HEALTH BOARD

BRIEFING MEMORANDUM

DATE: July 15, 2020
TO: Members, Champaign County Mental Health Board (CCMHB)
FROM: Lynn Canfield, Shandra Summerville
SUBJECT: Anti-Stigma Films through Roger Ebert's Virtual Festivals 2020

Background:

The purpose of this memorandum is to provide the Board with an update on our partnership with the Alliance for Inclusion and Respect (AIR) for sponsorship of an anti-stigma film during the Roger Ebert's Film Festival's smaller scale 2020 virtual events. AIR involvement with this high-profile annual festival event has been central to our anti-stigma efforts over many years, with a sponsored film and the festival's support for related community activities. AIR builds on the festival's momentum for year-round activities. Preparations for the 2020 festival, art shows, and promotions were underway when the event was cancelled due to COVID-19. The movie "A Most Beautiful Thing" had been selected, with themes of trauma, community violence, innovative approaches to youth engagement, and resilience. It may not be available for the 2021 festival, so the organizers suggested, and the CCMHB approved during their June meeting, that an alternative film be offered in 2021, with 2020 sponsorship payment applied. For AIR engagement with the festival and filmmakers of "A Most Beautiful Thing" during summer 2020, the Board also approved support of an online event, pending coordination and promotion of as much AIR and community participation as possible. See https://www.amostbeautifulthing.com/.

Update on 2020 Activities:

June 25: The festival invited AIR members and their networks to participate in a free online screening of the documentary "No Small Matter" which had been a contender for 2020 sponsorship and focuses on early childhood - https://www.nosmallmatter.com/ Prior to the film itself, this virtual event featured a children's activity. Alfre Woodard introduced the film, which was followed by an Ebertfest panel discussion. Depending on success of this event, the festival may explore future discussions with people associated with this film and our local experts.

Mid to Late July 2020: At the time of this writing, the plan begins with 50 Eggs, the studio and distributor of "A Most Beautiful Thing," providing us a Vimeo link to the film, to be shared with the Ebertfest audience and AIR members, pending licensing issues and practical considerations. They could use the code to view the film from a Monday through Wednesday. On Thursday of that week, community and AIR members will participate in a discussion with filmmakers, likely moderated by Chaz Ebert or Eric Pierson. Virtual meetings of the filmmakers and local youth will happen that Friday. On behalf of the film, participants would include Mary Mazzio, Alvin Ross, and Arshay Cooper, whose bios are below. Youth and leadership would be invited from

DREAAM House, Goal Getters, Paign to Peace, or other Coalition groups and other youth serving groups.

Bios of potential panelists from the film:
ALVIN ROSS lives in Chicago where he owns and operates MOVE MASTERS, one of the top ranked moving companies in the city. Alvin makes a point of hiring ex-felons and others who have difficulty finding employment in the traditional job economy. Like other members of the Manley Rowing Team, Alvin learned entrepreneurship skills as part of the rowing program. Alvin has two children.

ARSHAY COOPER is a Benjamin Franklin award-winning author, a Golden Oar recipient for his contributions to the sport of rowing, a motivational speaker, and an activist, particularly around issues of accessibility for low-income young people. He is currently based in New York City. Arshay grew up on the West Side of Chicago, witnessing family and friends become products of their environment. But a chance encounter changed Arshay's life. In 1997, he joined (and later became captain of) the first African American high school rowing team at Manley High School, an experience which catapulted Arshay out of the West Side. He dedicated two years of his life to AmeriCorps, focusing on diversity and inclusion, and soon thereafter attended Le Cordon Bleu, becoming a personal chef for hotels and professional athletes. After years of working in the food service industry, Arshay returned to his true passion, working with young people. He coached rowing at the Chicago Urban Youth Rowing Club and worked as the youth program director for the Victory Outreach's Midwest/Gulf Coast region, recruiting young people of color to the sport. Arshay has also started several rowing programs for low-income children across the country, including The East Side Indoor Rowing afterschool program for New York City 7th to 12th graders. *A Most Beautiful Thing* is based on his memoir, *Suga Water*, which Flatiron will republish in July 2020 under the new title *A Most Beautiful Thing*. Seeking to share his experience, Arshay now travels the country speaking at events and venues far and wide, from prisons to colleges to professional sports teams.

MARY MAZZIO, an award-winning documentary film director, Olympic athlete, and former law firm partner, is Founder and CEO of 50 Eggs, Inc., an independent film production company dedicated to making socially impactful films. Mary wrote, directed, and produced the highly-acclaimed films, *Underwater Dreams*, *TEN9EIGHT, The Apple Pushers, A Hero for Daisy, Contrarian, Apple Pie,* and *Lemonade Stories.* Her newest documentary film, *I AM JANE DOE*, narrated by Academy Award nominee, Jessica Chastain, opened in select cities with AMC Theatres in 2017 and is now on Netflix. The film catalyzed (on a bipartisan basis) legislation signed by the President in 2018. She is currently Filmmaker-in-Residence at Babson College.

10.E.

CHAMPAIGN COUNTY DEVELOPMENTAL DISABILITIES BOARD
CHAMPAIGN COUNTY MENTAL HEALTH BOARD

CCMHB 2020-2021 Meeting Schedule

First Wednesday after the third Monday of each month at 5:45 p.m.
Lyle Shields Room, Brookens Administrative Center
1776 E. Washington St., Urbana, IL (unless noted otherwise)

July 15, 2020 *– Zoom meeting (off cycle) at*
https://us02web.zoom.us/j/87945354242
September 23, 2020
September 30, 2020 *– study session (tentative, ending by 6:30PM)*
October 21, 2020
October 28, 2020 *– study session*
November 18, 2020
December 16, 2020 *(tentative)*
January 20, 2021
January 27, 2021- *study session*
February 17, 2021
February 24, 2021- *study session*
March 17, 2021
March 24, 2021- *study session (tentative)*
April 21, 2021
April 28, 2021- *study session*
May 12, 2021- *study session*
May 19, 2021
June 23, 2021
July 21, 2021

****This schedule is subject to change due to unforeseen circumstances. Please call the CCMHB-CCDDB office to confirm all meetings.***

DRAFT July 2020 to December 2021 Meeting Schedule with Subject and Allocation Timeline, moving into PY2022 Process

The schedule provides dates and subject matter of meetings of the Champaign County Mental Health Board through June 2021. The subjects are not exclusive to any given meeting, as other matters requiring Board review or action may also be addressed or may replace the subject listed. Study sessions may be scheduled with potential dates listed; topics will be based on issues raised at meetings, brought by staff, or in conjunction with the Champaign County Developmental Disabilities Board. Included are tentative dates for steps in the funding allocation process for Program Year 2022 (July 1, 2021 – June 30, 2022) and deadlines related to PY2021 agency contracts. **2020-2021 meetings are scheduled to begin at 5:45PM; these may be confirmed by contacting Board staff.**

7/15/20	**Regular Board Meeting**, Zoom online *(off cycle)* Approve FY2021 Draft Budgets
8/28/20	*Agency PY2020 4th Quarter Reports, CLCP Progress Reports, and Annual Performance Measures reports due*
09/23/20	**Regular Board Meeting**
09/30/20	**Study Session** (tentative, end by 6:30PM)
10/21/20	**Regular Board Meeting** Draft Three Year Plan 2019-2021 with 2021 Objectives Release Draft Program Year 2022 Allocation Criteria
10/28/20	**Study Session** (tentative)
10/28/20	*Agency Independent Audits, Reviews, or Compilations Due*
10/30/20	*Agency PY2021 First Quarter Reports Due*
11/18/20	**Regular Board Meeting** Approve Three Year Plan with FY2021 Objectives Allocation Decision Support – PY22 Allocation Criteria
12/11/20	*Public Notice to be published on or before this date, giving at least 21-day notice of application period.*
12/16/20	**Regular Board Meeting** (tentative)
01/04/21	*Online System opens for Agency Registration an Applications for PY2022*
1/20/21	**Regular Board Meeting:** Election of Officers
1/27/21	**Study Session:** Mid-Year Program Presentations

1/29/21	*Agency PY21 2nd Q Reports and CLC Progress Reports due*
2/12/21	*Agency deadline for submission of applications for PY2022 funding. Online system will not accept forms after 4:30PM.*
2/16/21	*List of Requests for PY2022 Funding assembled*
2/17/21	**Regular Board Meeting** Discussion of Board Members' Review of Proposals; Mid-year updates on new agency programs
2/24/21	**Study Session:** Mid-Year Program Presentations
3/17/21	**Regular Board Meeting** FY2020 Annual Report (includes performance data from agencies for PY20)
3/24/21	**Study Session** (tentative)
4/14/21	*Program summaries released to Board, copies posted online with CCMHB April 21, 2021 meeting agenda*
4/21/21	**Regular Board Meeting** Program Summaries Review and Discussion
4/28/21	**Study Session** Program Summaries Review and Discussion
4/30/21	*Agency PY2021 3rd Quarter Reports due*
5/5/21	*Allocation recommendations released to Board, copies posted online with CCMHB meeting agenda*
5/12/21	**Study Session:** Allocation Recommendations
5/19/21	**Regular Board Meeting:** Allocation Decisions; Authorize Contracts for PY2022
6/23/21	**Regular Board Meeting**
6/23/21	*PY2022 Contracts Completed*
7/21/21	**Regular Board Meeting**
8/27/21	*Agency PY2021 4th Q Reports, CLC Progress Reports, and Annual Performance Measure Reports due*

CHAMPAIGN COUNTY DEVELOPMENTAL DISABILITIES BOARD
CHAMPAIGN COUNTY MENTAL HEALTH BOARD

CCDDB 2020-2021 Meeting Schedule

Board Meetings
8:00AM except where noted
Brookens Administrative Building
1776 East Washington Street, Urbana, IL

July 15, 2020 – Zoom meeting https://us02web.zoom.us/j/87028164506
(3:30 PM) – *off cycle, different time*

August 19, 2020 – Lyle Shields Room (8AM) - *tentative*

September 23, 2020 – Lyle Shields Room (8AM)

October 21, 2020 – John Dimit Conference Room (8AM)

November 18, 2020 – John Dimit Conference Room (8AM)

December 16, 2020 – Lyle Shields Room (8AM) – *tentative*

January 20, 2021 – Lyle Shields Room (8AM)

February 17, 2021 – Lyle Shields Room (8AM)

March 17, 2021 – Lyle Shields Room (8AM)

April 21, 2021 – Lyle Shields Room (8AM)

May 19, 2021 – Lyle Shields Room (8AM)

June 23, 2021 – Lyle Shields Room (8AM)

July 21, 2021 – Lyle Shields Room (8AM)

This schedule is subject to change due to unforeseen circumstances.
Please call the CCMHB/CCDDB office to confirm all meetings.

41

12

CHAMPAIGN COUNTY MENTAL HEALTH BOARD
BOARD MEETING

Minutes—June 17, 2020

This Meeting Was Held Remotely.

5:45 p.m.

MEMBERS PRESENT:	Susan Fowler, Thom Moore, Joseph Omo-Osagie, Elaine Palencia, Kyle Patterson, Julian Rappaport, Jane Sprandel, Jon Paul Youakim
MEMBERS EXCUSED:	Kathleen Wirth-Couch
STAFF PRESENT:	Kim Bowdry, Lynn Canfield, Mark Driscoll, Stephanie Howard-Gallo, Shandra Summerville
OTHERS PRESENT:	Nicole Sikora, DSC; Alison Meaner, NAMI; Gail Raney, Rosecrance, Inc. Laura Lindsey, Courage Connection

CALL TO ORDER:

Mr. Joe Omo-Osagie called the meeting to order at 5:45 p.m.

ROLL CALL:

Roll call was taken and a quorum was present.

CITIZEN INPUT / PUBLIC PARTICIPATION:

None.

APPROVAL OF AGENDA:

The agenda was in the Board packet. Board members approved the document.

PRESIDENT'S COMMENTS:

Mr. Omo- Osagie spoke regarding recent Black Lives Matter events in the community.

42

EXECUTIVE DIRECTOR'S COMMENTS:

Ms. Canfield reviewed the agenda.

NEW BUSINESS:

Impact of COVID-19 Discussion:
A Briefing Memorandum with agency updates on operation of funded services during COVID-19 pandemic was included in the Board packet.

Anti-Stigma Film – Ebertfest 2021:
A Decision Memorandum on sponsorship of films at the 2021 Ebertfest and a 2020 virtual event was included in the packet. The purpose of the memorandum was to seek approval, in partnership with the Alliance for Inclusion and Respect (AIR), of sponsorship of an anti-stigma film at the 2021 Roger Ebert's Film Festival and for a smaller scale virtual festival event during 2020.

Preparations for the 2020 festival, art shows, and promotions were well along when the event was cancelled to slow the spread of COVID-19. The movie "A Most Beautiful Thing" had been selected, with themes of trauma, community violence, innovative approaches to youth engagement, and resilience: https://www.amostbeautifulthing.com/the-film/. Due to rights issues, the festival organizer cannot guarantee this movie will be available for showing during the 2021 festival dates. They suggest an alternative film to be offered in 2021, with 2020 sponsorship payment applied directly to that showing. In addition, there remains a possibility for AIR to meaningfully engage with the festival and filmmakers of "A Most Beautiful Thing" during 2020, taking online as many features of AIR collaboration as possible. Ebertfest will work on an online showing of this movie, together with online engagements between filmmakers and Champaign County organizers and participants. The cost for sponsorship is $5,000 to make AIR the dedicated sponsor of this 2020 virtual event.

The cost for our sponsorship had been lowered to $15,000. This amount was approved for 2020, and the payment issued. Members of AIR had contributed a total of $3,475 toward participation ($1,980 more was pledged but not received). Upon cancellation of the 2020 festival, all chose prepayment for 2021 over refunds, provided the CCMHB approves involvement in 2021. This means that there will be no charge for involvement during 2021, if the Board approves. The cost of sponsorship for the virtual innovation during 2020 is $5,000, to be included in the Public Relations line of approved budget.

MOTION: Dr. Fowler moved to approve sponsorship of an anti-stigma film in Roger Ebert's Film Festival 2021, with 2020 payment applied so that no payment will be due in 2021. Mr. Patterson seconded. A voice vote was taken and the motion passed.

MOTION: Dr. Fowler moved to approve sponsorship of an anti-stigma film to be shown online as a virtual Ebertfest event during 2020, for an additional 2020 expenditure of $5,000. Ms. Palencia

43

seconded the motion. A roll call vote was taken and the motion passed unanimously.

DisABILITY Resource Expo Update:
A Briefing Memorandum was included for information only, along with an attachment on Whova, a virtual platform for conferencing. Ms. Canfield, Ms. Summerville, and Ms. Sprandel provided additional information from recent Expo steering committee meetings.

CILA Facilities Project Update:
A Briefing Memorandum offered some history and an update, with an attached 2019 financial report and an update from the service provider, IAG.

2-1-1 Information and Referral:
A Briefing Memorandum presented history of CCMHB and CCDDB collaboration with the United Way of Champaign County providing mutual support of the 211 call service provided by PATH. The initial MOU and other attachments were included in the Board packet.

Regional Health Plan Partnership:
For information only, a Briefing Memorandum on the collaborative effort toward community needs assessment, health plan, and initial agreement was included in the Board packet.

UIUC Evaluation Project:
A Briefing Memorandum summarizing the history of the program evaluation project and list of targeted programs was included in the Board packet for information only.

Draft CCMHB and CILA FY2021 Budgets:
A Briefing Memorandum and drafts budgets with background information and intergovernmental agreement between the CCMHB and CCDDB were included in the packet for information only.

AGENCY INFORMATION:

None.

OLD BUSINESS:

Carle Foundation Property Tax Interest:
An update on budget amendments, along with a copy of County Board Memorandum with further details was included in the Board packet for information only.

Schedules & Allocation Process Timeline:
Updated copies of CCMHB and CCDDB meeting schedules and CCMHB allocation timeline were included in the packet.

44

CCDDB Information:
The CCDDB met earlier in the day.

Approval of CCMHB Minutes
Minutes from May 20, 2020 meeting are included in the Board packet.

MOTION: Dr. Moore moved to approved the CCMHB minutes from May 20, 2020 as presented. Dr. Rappaport seconded the motion. A voice vote was taken and the motion passed unanimously.

Staff Reports
Staff reports were deferred, with exception of a FY20 first quarter financial report from Chris Wilson.

Board to Board Reports:
Elaine Palencia attended a Community Coalition march, along with Dr. Moore and Mr. Patterson.

Board Announcements:

Other Business – Closed Session:

MOTION: At 7 p.m., Dr. Fowler moved to enter into closed session pursuant to 5 ILCS 120/2 (c) 21 to consider the minutes of meetings lawfully closed under this Act, whether for purposes of approval by the body of the minutes or semi-annual review of the minutes as mandated by Section 2.06, and that the following individuals remain present: members of the Champaign County Mental Health Board and Operations and Compliance Coordinator, Stephanie Howard-Gallo. Mr. Patterson seconded the motion. A roll call was taken and all members voted aye.

Board members returned to open session at 7:05 p.m. with a roll call vote.

MOTION: Dr. Rappaport moved to approve the minutes of June 22, 2016 closed session, open the minutes to the public, and destroy the recording. Dr. Youakim seconded the motion. A roll call vote was taken and the motion passed unanimously.

MOTION: Mr. Omo-Osagie moved to approve the minutes of July 12, 2016 closed session, open the minutes to the public, and destroy the recording. Ms. Sprandel seconded the motion. A roll call vote was taken and the motion passed unanimously.

MOTION: Dr. Moore moved to approve the minutes of August 15, 2016 closed session, open the minutes to the public, and destroy the

45

recording. Dr. Youakim seconded the motion. A voice vote was taken and the motion passed unanimously.

MOTION: Ms. Sprandel moved to approve the minutes of August 17, 2016 closed session, open the minutes to the public, and destroy the recording. Dr. Youakim seconded the motion. A voice vote was taken and the motion passed unanimously.

MOTION: Ms. Palencia moved to approve the minutes of August 18, 2016 closed session, open the minutes to the public, and destroy the recording. Mr. Patterson seconded the motion. A voice vote was taken and the motion passed unanimously.

MOTION: Dr. Fowler moved to approve the minutes of September 21, 2016 closed session, open the minutes to the public, and destroy the recording. Ms. Sprandel seconded the motion. A voice vote was taken and the motion passed unanimously.

MOTION: Dr. Youakim moved to approve the minutes of November 16, 2016 closed session, open the minutes to the public, and destroy the recording. Ms. Sprandel seconded the motion. A voice vote was taken and the motion passed unanimously.

ADJOURNMENT:

The meeting adjourned at 7:10 p.m.

Respectfully
Submitted by: Stephanie Howard-Gallo
CCMHB/CCDDB Staff

*Minutes are in draft form and are subject to CCMHB approval.

46

13

Kim Bowdry, Associate Director for Intellectual & Developmental Disabilities
Staff Report – July 2020

CCDDB: During March, April, May, and June a significant portion of time was spent working on Program Summaries, recommendations for funding, creating special provisions for each of the contracts, and then developing contracts. PY20 3rd Quarter reports were also reviewed during this time.

New claims were developed for the online reporting system for use during PY21. I created the claims options in the online reporting system and created the 1st Quarter programs for agency reporting. Service claims are reported as With Person Served or On Behalf of Person Served. Contacts with TPCs will be entered as hours, rather than quarter hours in previous years. The place option has also changed to 'On Site' (any agency building) or 'Off Site' (community or the participants' home).

I worked with the agencies and the software developer to make necessary changes to any Excel files used for data entry. I also created cheat sheets for the new service and place options and shared those with agency staff.

In late June, two contract orientation meetings were held with CU Autism Network, this is the only newly funded CCDDB program for PY21. Contract negotiations were completed via email with DSC regarding the Community First contract. The agency rejected the original benchmarks in the contract due to concerns related to the pandemic. Decreased benchmarks were created and were also rejected due to service concerns related to Covid-19. At the time of this writing, a Zoom meeting has been scheduled to discuss the benchmarks.

CCDDB Mini-Grant: Mini-grant purchases were initially slowed due to the pandemic. Several more purchases have been made during recent months. I continue to have difficulty reaching some of the Mini-Grant recipients to confirm their items to be purchased. I also created the Mini-Grant Survey using Survey Monkey and mailed out paper copies of the survey to the Mini-Grant recipients with no email address on file.

Learning Opportunities: Due to the Covid-19 pandemic, in-person learning opportunities were put on hold. I am currently planning virtual presentations and have reached out to presenters. All library reservations for in-person events were canceled through the end of the year, due to the pandemic and access to the library.

MHDDAC: I participated in the monthly meetings of the MHDDAC, as well as the Special Meetings that were held over the past few months.

NACBHDD: I participated in monthly I/DD committee calls. The NACBHDD Summer Board Meeting is scheduled for late July 20-22, 2020. This will be a virtual event.

ACMHAI: I participated in the ACMHAI I/DD committee calls. I also participated in an ACMHAI Town Hall meeting held in April and an additional webinar hosted by the ACMHAI Children's Behavioral Health Committee.

Disability Resource Expo: I participated in multiple Expo Steering Committee meetings. I also participated in a webinar, exploring online platforms for use for a possible virtual Expo. I participated in the Abilities Expo virtual event to gain knowledge on the accessibility of the platform used for the event.

I have also participated in multiple Zoom meetings with the Expo Consultants and U of I Students who are working on behalf of the Expo to create short videos. The Students are reaching out to Expo exhibitors to create short 'faces and places' videos about the services the agency offers and the staff person someone might encounter on an initial visit.

47

Other activities: I participated in nearly 100 webinars, including several hosted by The Arc of Illinois and IDHS-DDD, topics included closures due to Covid-19 and looking at safely reopening.

I also participated in a Zoom meeting with Community Choices' members. This was a check-in to create connections with the Community Choices members and people in the community. I was asked questions by the members and we had a great conversation.

I participated in the LEAP sponsored Griffin-Hammis Customized Employment webinar on June 8-11, 2020.

I also participated in multiple Zoom meetings with the United Way, Cunningham Township, the CCMHB, Path, Anita Chan, and other students from UIUC to continue the discussion of a pilot app or a responsive website using enhanced data from the 2-1-1 PATH website resource list.

I participated in a Program Evaluation Committee meeting with the UIUC Program Evaluation Team.

I participated in the Local Interagency Council meeting, held virtually.

Prioritization of Urgency of Needs for Services (PUNS) Summary Reports: 1,247 PUNS selection letters were mailed out by the Illinois Department of Human Services Division of Developmental Disabilities (IDHS-DDD) in late August. 33 PUNS Selection letters were mailed to people in Champaign County.

21 of 33 people have received an award letter Home Based Services (HBS). **1** person has been awarded CILA funding. The remaining people are working with CCRPC ISC to complete the PAS process, **5** want HBS funding, **2** want CILA with a specific provider/geographic location, **2** want Family CILA, **1** was denied eligibility & plans to appeal, and **1** moved out of the area.

From Allison Stark on June 16, 2020:
"The Division is in the process of preparing PUNS selection letters to be sent out. We expect to send out around 1,589 PUNS selection letters the week of July 13. Most of the individuals who will receive selection letters previously received early notification letters in December 2019. We are currently working with the ISC agencies to finalize the list of individuals that will be included in this selection."

23 people from Champaign County will be receiving a PUNS selection letter.

Updated "PUNS Summary by County and Selection Detail for Champaign County" and the "Division of Developmental Disabilities Prioritization of Urgency of Needs for Services (PUNS) Summary of Total and Active PUNS by Zip Code" reports are attached. IDHS posted updated versions on June 8, 2020. These documents detail the number of Champaign County residents enrolled in the PUNS database.

Division of Developmental Disabilities
Prioritization of Urgency of Needs for Services (PUNS)
Summary By County and Selection Detail

June 08, 2020

County: Champaign

Reason for PUNS or PUNS Update	937
New	38
Annual Update	317
Change of Category (Seeking Service or Planning for Services)	19
Change of Service Needs (more or less) - unchanged category (Seeking Service or Planning for Services)	17
Person is fully served or is not requesting any supports within the next five (5) years	233
Moved to another state, close PUNS	24
Person withdraws, close PUNS	26
Deceased	18
Individual Stayed in ICF/DD	1
Individual Moved to ICF/DD	2
Individual Determined Clinically Ineligible	6
Unable to locate	53
Submitted in error	2
Other, close PUNS	181
CHANGE OF CATEGORY (Seeking Service or Planning for Services)	**422**
PLANNING FOR SERVICES	**145**
EXISTING SUPPORTS AND SERVICES	**381**
Respite Supports (24 Hour)	9
Respite Supports (<24 hour)	13
Behavioral Supports (includes behavioral intervention, therapy and counseling)	153
Physical Therapy	47
Occupational Therapy	101
Speech Therapy	127
Education	181
Assistive Technology	49
Homemaker/Chore Services	5
Adaptions to Home or Vehicle	4
Personal Support under a Home-Based Program, Which Could Be Funded By Developmental Disabilites, Division of Rehabilitation Services or Department on Aging (can include habilitation, personal care, respite, retirement supports, budgeting, etc.)	40
Medical Equipment/Supplies	33
Nursing Services in the Home, Provided Intermittently	5
Other Individual Supports	167
TRANPORTATION	**415**
Transportation (include trip/mileage reimbursement)	109
Other Transportation Service	281
Senior Adult Day Services	1
Developmental Training	82
"Regular Work"/Sheltered Employment	64
Supported Employment	85
Vocational and Educational Programs Funded By the Division of Rehabilitation Services	62
Other Day Supports (e.g. volunteering, community experience)	24
RESIDENTIAL SUPPORTS	**80**
Community Integrated Living Arrangement (CILA)/Family	3
Community Integrated Living Arrangement (CILA)/Intermittent	4
Community Integrated Living Arrangement (CILA)/Host Family	1
Community Integrated Living Arrangement (CILA)/24 Hour	31
Intermediate Care Facilities for People with Developmental Disabilities (ICF/DD) 16 or Fewer People	1
Intermediate Care Facilities for People with Developmental Disabilities (ICF/DD) 17 or More People	2
Skilled Nursing Facility/Pediatrics (SNF/PED)	5
Supported Living Arrangement	6

Division of Developmental Disabilities

Prioritization of Urgency of Needs for Services (PUNS)

Summary By County and Selection Detail

June 08, 2020

Community Living Facility	1
Shelter Care/Board Home	1
Nusing Home	2
Children's Residential Services	4
Child Care Institutions (Including Residential Schools)	9
Other Residential Support (including homeless shelters)	12
SUPPORTS NEEDED	**389**
Personal Support (includes habilitation, personal care and intermittent respite services)	342
Respite Supports (24 hours or greater)	19
Behavioral Supports (includes behavioral intervention, therapy and counseling)	148
Physical Therapy	42
Occupational Therapy	73
Speech Therapy	84
Assistive Technology	47
Adaptations to Home or Vehicle	18
Nursing Services in the Home, Provided Intermittently	5
Other Individual Supports	78
TRANSPORTATION NEEDED	**344**
Transportation (include trip/mileage reimbursement)	282
Other Transportation Service	315
VOCATIONAL OR OTHER STRUCTURED ACTIVITIES	**266**
Support to work at home (e.g., self employment or earning at home)	4
Support to work in the community	236
Support to engage in work/activities in a disability setting	88
Attendance at activity center for seniors	2
RESIDENTIAL SUPPORTS NEEDED	**110**
Out-of-home residential services with less than 24-hour supports	55
Out-of-home residential services with 24-hour supports	63
Total PUNS:	**56,883**

http://www.dhs.state.il.us/OneNetLibrary/27897/documents/DD%20Reports/PUNS/PUNS_sum_by_Count_and_Selection_Detail.pdf

Division of Developmental Disabilities Prioritization of Urgency of Needs for Services (PUNS)
Summary of Total and Active PUNS by Zip Code
Updated 06/08/20

Zip Code		Active PUNS	Total PUNS	
60949	Ludlow	1	3	
61801	Urbana	29	82	
61802	Urbana	62	124	
61815	Bondville (PO Box)	1	1	
61816	Broadlands	2	3	
61820	Champaign	45	91	
61821	Champaign	73	183	
61822	Champaign	55	106	
61826	Champaign	0	1	
61840	Dewey	0	2	
61843	Fisher	8	12	
61845	Foosland	1	1	
61847	Gifford	1	1	
61849	Homer	0	5	
61851	Ivesdale	1	2	
61852	Longview	1	1	
61853	Mahomet	32	69	
61859	Ogden	4	13	
61862	Penfield	1	2	
61863	Pesotum	1	2	
61864	Philo	3	11	
61866	Rantoul	27	86	
61871	Royal (PO Box)	--	--	no data
61872	Sadorus	2	2	
61873	St. Joseph	14	26	
61874	Savoy	9	16	
61875	Seymour	2	3	
61877	Sidney	4	10	
61878	Thomasboro	0	2	
61880	Tolono	8	26	
Total		387	886	

http://www.dhs.state.il.us/OneNetLibrary/27897/documents/DD%20Reports/PUNS/PUNS_Sum_by_Zip-Code.pdf

Mark Driscoll
Associate Director for Mental Health & Substance Abuse Services

Staff Report – July 15, 2020 Board Meeting

Summary of Activity

PY21 Contracts: Since the Board made the allocation decisions in May, the primary focus has been on managing the process to ensure contracts were executed prior to the start of the new contract year. While I have primary responsibility for the mental health and substance use disorder contracts, it requires a team effort to complete the various steps in the process.

A spreadsheet is created to track multiple points in the contracting phase including brief notes on any special provisions required or other unique aspects of the award that need to be considered. This year such notes referenced whether the contract required the award to be pro-rated due to new but vacant staff positions, a mid-year report was required, or the program was considered for an extended two year term. Columns track when contracts are issued and then returned, and whether a contract requires only a signature or if revisions to the application are needed. Revisions may involve changes or corrections to the Cultural and Linguistic Competence Plan, scope of work, or budget.

Drafting the contracts is fairly straightforward but does require some advance work. Special provisions can be somewhat involved as they can vary from contract to contract or be appropriate for a certain set of contracts but not others. There is also consideration of retaining special provisions from the prior contract year. Elements of the provisions are included in the Allocation Decision Memorandum so the intent is defined and full text may be drafted but not finalized. The Special Provisions are compiled and then referenced back to individual contracts. They are then inserted into the respective contract as each contract has the standard information added to the boilerplate. All contracts were completed and mailed out no later than June 5.

Communication with agencies occurs throughout the contract phase. Initially, this is to inform agencies of any required revisions, supplemented with copies of the program summaries with notes on what changes or corrections are needed highlighted. Access to the online system is provided and program applications forms reopened. All revisions and signed contracts were expected to be completed and returned by June 24th.

Since the revision notices, various agencies have been in contact regarding the required adjustments to submitted application forms. Technical assistance and clarification was provided throughout the process. The CU Autism network, a new agency funded through the CCDDB, had two contract orientation meetings; one to provide an overview of the contract requirements and a follow-up meeting to answer additional questions primarily about financial management. I participated while the meetings were led by Kim Bowdry. No such meetings were held with CCMHB agencies as the two new contracts awarded were with existing agencies.

Champaign County Head Start did contact me and other members of the team about the amount of the award for the Early Childhood Mental Health Services contract. CCHS made an error in the amount requested versus the amount expensed in the application. This discrepancy was noted in the program summary but not specifically addressed by CCHS during the allocation review process. The contract award matched the amount requested and required revisions to the

personnel and expense forms. The end result is that while the application proposed adding a new fourth social skills coach position, the award will only support the existing three coach positions. Considering budget constraints, it is unlikely an increase would have been recommended supporting the fourth position. The new contract does carry a special provision requiring the agency to demonstrate it has pursued other funding to expand support for the program as the CCMHB is currently the sole source of support.

Separate communications were also sent to agencies recommended for multi-year contracts and to those with new staff positions that required the award be pro-rated based on the new vacant positions. Of the eleven programs offered a multi-year contract, only Mahomet Area Youth Club declined the opportunity for its Members Matter program. Four programs were notified the contract award would be pro-rated. Of the four, one filled the new positions prior to the start of the contract year and had the contract amount restored to the full award. For more information on the pro-rated contracts please see the amendment report and the RACES Counseling Contract Decision Memorandum included in the Board packet under New Business.

The set of PY20 contracts with terms extended through the end of PY21 also required attention during the contracting phase. Just as some PY21 awards required revisions to the original application, all the PY20 extended contracts needed to update the PY20 applications for PY21. All were reminded of this requirement with a detailed e-mail. The PY20 applications were cloned over to PY21 to aid them in the process. And technical assistance provided on request. This set of contracts also were issued amendments to add the COVID contract language as a special provision. For more details, see the Amendment Report in the Board packet.

Program Evaluation Committee: Following a meeting with the Program Evaluation Committee, a draft proposal has been received from the University of Illinois Program Evaluation Team. A Decision Memorandum with proposed scope of work and budget is included in the Board packet.

Criminal Justice - Mental Health: The CIT Steering Committee met via ZOOM for the first time since March. While some time was allotted for agency updates, the majority of the meeting was spent reviewing data on CIT contacts for the first half of 2020 and getting a progress report on the One Door Crisis Response Initiative. Based on my notes, a few highlights from the data include of 842 CIT contacts by law enforcement, 5% resulted in arrest with another 1% getting a notice to appear and 82 individuals have had five or more contacts and account for 23% of all contacts. Regarding progress on One Door, planning has been impacted by the pandemic but the principals have started to talk again. Target date for opening has been pushed back to early 2021.

The Reentry Council will reconvene on July 8 via ZOOM. Updates from participating agencies and stakeholders will likely be the focus. The Council last met in early March.

Other Activity:

- Continued participation in various meetings including the Mental Health Developmental Disabilities Agencies Council, the United Way Community Impact Committee, the Council of Service Providers to the Homeless, and the Rantoul Service Providers Group.
- Viewed a number of webinars on wide range of topics. I am currently in the midst of a three part series on Mental Health Care for Farming and Rural Communities. The series has placed an emphasis on understanding the unique cultural aspects of farm communities.

Stephanie Howard-Gallo

Operations and Compliance Coordinator Staff Report –

July 2020 Board Meeting

SUMMARY OF ACTIVITY:

Audits:
As previously reported, Promise Healthcare (CCMHB funded) did not submit an audit by their extended due date. Payments continue to be withheld.

Compliance:
3rd Quarter financial and program reports for all funded programs were due at the end of April. A funding suspension letter was sent to UP Center for not submitting reports; however, they quickly resolved the compliance issue.

Community Awareness/Anti-Stigma Efforts/Alliance for Inclusion and Respect (AIR):
A Facebook page promotes AIR's mission, members, artists, events, and news articles of interest. I am one of the administrators of the page.

International Galleries at Lincoln Square in Urbana has hosted AIR artists free of charge for well over a year. This was stopped during COVID-19 and we are discussing when to resume safely.

Contracts:
Following the Board's allocation decisions at the May Board meeting, contracts were drafted for close to programs whose term begins July 1, 2020. A spreadsheet developed by Mark Driscoll and Kim Bowdry tracks the processing of contracts. The spreadsheet indicates which contracts require negotiations, special provisions, revised CLC plans, and if revised program and/or budget forms must be submitted. I track the date the contract is issued and date that it is returned.

I sent out contracts with an "award" letter. The award letter indicates the amount of money allocated to the program and if negotiation or revised forms are necessary. A copy of the "Contract Process and Information Sheet" is included with the award letter and contracts. The sheet provides a summary of the process and key dates, notes on revised plan requirements, refers to potential special provisions, and a reminder to read the contract. Once the contracts are signed and returned, copies are provided to the Financial Manager (Chris Wilson) and the Champaign County Auditor before payments can be issued. Contracts returned after the deadline will usually result in delayed payments. Completing the contract process is time consuming. It's a group effort among staff members.

There were several agencies that returned contracts after the deadline, which has resulted in delayed payments.

Records and Data Retention:
Master files are being set up for the new contract year beginning July 1. Paper files are kept on contracts, funding applications, audits, board minutes, site visit reports, program/financial reports, and any correspondence being sent or received. Generally, we keep 10 years of paper files in the master file room.

DisABILITY Expo:
I am attending Steering Committee meetings.

Thrivent Financial's grant(s) for the purchase of snacks and water could not be used at the in-person event we had planned for March. Because the refreshments had already been purchased, they were donated to two organizations involved with service to the Champaign County public. Lynn and I delivered the boxes of refreshments to Urbana Neighborhood Connections and the Cunningham Township Office. Both organizations were very thankful for the food items and water.

Other:

- Preparing meeting materials for CCMHB/CCDDB regular meetings and study sessions/presentations.
- Composing minutes from the meetings.
- Attending meetings and study sessions for the CCDDB/CCMHB.
- Attended two National Association of Counties (NACo) calls.
- Virtually attended Community Coalition meetings and First Followers forum.
- Participated in contract orientation with CU Autism Network (CCDDB funded).
- Attended a MHDDAC meeting.

2020 July Staff Report- Shandra Summerville
Cultural and Linguistic Competence Coordinator

Agency Cultural and Linguistic Competence (CLC) Technical Assistance, Monitoring, Support and Training for CCMHB/DDB Funded Agencies

COVID 19:

COVID-19(Aka-Coronavirus, "this Virus Thing", "The Rona", "The Virus") has changed how life is viewed about how life is viewed. Our community (the world) has experienced a level of change that no one would have anticipated that would impact how we would provide care to the most vulnerable people. There was flexibility and adjustment that had to be made quickly, as the CLC Coordinator there was a level of preparation that I did not know I would actually be ready for such a transition to working virtually versus, actually working at home during a pandemic. To say that this time has been hard, that is an understatement. With all of the training and support that I have provided to organizations on how to shift to be understanding of the most vulnerable communities, I was in a position to provide support to people that were once viewed as strong, become vulnerable to cultural shift that did not allow services to be provided in person. To say the least, work still had to go on, and late-night hours in the office are now, all from the very space that was once considered a place of peace and solitude.

This month's report will provide a snapshot of the CCMHB/DDB CLC Journey and resources to begin thinking about how we move forward to think about how to address racism as funder.

CLC Coordinator Direct Service Activities

Mental Health First Aid-

On June 15, 2020 there was an updated Mental Health First Aid Instructor Training. I am completing the virtual training and blended learning option. Once I have completed the instructor training, classes will be offered to members of our community.

Anti-Stigma Activities/Community Collaborations and Partnerships

Disability Resource Expo: I worked with the committee members to look at how to realize an opportunity to do a virtual Expo. We looked at several platforms and there was an issue with accessibility for people living with disabilities that would limit full participation in a virtual experience. The members of the committee will decide on what the next steps will be. I will no longer serve in the volunteer coordination role moving forward. I will provide support to Jim and Barb as needed as staff member of CCMHB/DDB.

AIR- Alliance for Inclusion and Respect: I met with Ebertfest representatives to discuss the opportunity of a virtual screening for the sponsored film.

2020 July Staff Report- Shandra Summerville
Cultural and Linguistic Competence Coordinator

C-HEARTS African American Story Telling Project: I have been meeting with the C-Hearts Group to discuss the future direction and how our work will serve the community. I have also attached the article that was published to show how the Community Healing Framework was used in our community.

Snapshot of the CCMHB/DDB Journey of Cultural and Linguistic Competence

1999	2001	2002-2003	2003-2004	2005
Mental Health: A Report of the Surgeon General was released that talked about the stigma of receiving mental health treatment	Mental Health: Culture Race and Ethnicity: A Supplement to the Report of the Surgeon General. To give a deeper understanding to show there is a clear history and context of Minority Mental Health.	CCMHB hired Dr. Carl Bell and local experts Multicultural Professional Consultants to assess cultural competence of Human Services in Champaign County.	The First CLC Plans were submitted with funding applications	CCMHB Monitored CLC Plans for feedback to ensure that culture was represented in the services that were provided.
2006	**2006-2009**	**2005-2009**	**2010**	**2010-2012**
CCMHB begin to promote community-based services to provide mental health services to underserved youth that were targeted to address the mental health to include culture, race, and ethnicity	Effective Black Parenting was offered by the U of I Psychology Department Community Outreach Department funded by CCMHB	**System of Care Values were Family Driven Youth Guided Cultural and Linguistic Competence introduced to provide support to youth that were overrepresented in child-serving systems**	**CLC Coordinator position was created in community-based organization to provide technical assistance and training to funded organizations.**	**System of Care Funded by SAMHSA, CLC Coordinator Position was part of the CCMHB SOC administrative team.**

2020 July Staff Report- Shandra Summerville
Cultural and Linguistic Competence Coordinator

2011	2012	2012	2013-Present	2014-Present
CCDDB required funded agencies to submit CLC Plans	**DDB/CCMHB co-funded position of the CLC Coordinator**	Standardized CLC Template was required for organizations to show accountability and involvement of the individuals served,	Enhanced National CLAS Standards were used to guide CLC work in CCHMB/DDB Funded Agencies.	CCMHB/DDB Hired CLC Coordinator to monitor, provide training, and leadership for Cultural Competence and Cultural Diversity

I realize this is only a snapshot of CLC Journey, and this is an opportunity to begin looking at your progress and decide how you want to continue to move forward. You should celebrate that as a decision maker CCMHB/DDB started a process to address the disparities and quality care of marginalized people and underrepresented communities. You can identify and what you value moving forward and how racism impacts the people that are receiving services in our community.

2020 July Staff Report- Shandra Summerville
Cultural and Linguistic Competence Coordinator

Short Resource List to Start the Conversation About Racism as a Decision Maker

As the CLC Coordinator, I am amazed about the wealth of perspective and reading lists that so many people have just passed along. As I continue to look at the value of cultural competence, I have realized that this journey I have been challenged to think beyond, my lived experience and appreciate the culture that every person brings. I have also learned that it is time to look at the foundation of why every culture is not appreciated or accepted. This list of some resources to begin to start the process of how we can begin to reset and see how cultural and linguistic competence will continue to impact the programs and the quality of care that we can provide to our most vulnerable communities.

Foundational Information- These are the resources that were used to begin to define our journey of cultural competence.

MENTAL HEALTH: Culture, Race, and Ethnicity
A SUPPLEMENT TO
MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL
https://drum.lib.umd.edu/bitstream/handle/1903/22834/sma-01-3613.pdf?sequence=1&isAllowed=y

National CLAS Standards Fact Sheet
https://thinkculturalhealth.hhs.gov/pdfs/NationalCLASStandardsFactSheet.pdf

News Articles

Seven Ways Funders Can Support Racial Justice
https://movementstrategy.org/seven-ways-funders-can-support-racial-justice/

"Long overdue": Lawmakers declare racism a public health emergency
Black and Brown Americans are susceptible to higher rates of infant mortality, heart disease and even an advanced aging process
https://www.theguardian.com/society/2020/jun/12/racism-public-health-black-brown-coronavirus

Harvard Public Health Review Editorial Board. Racism is a public health problem. Harvard Public Health Review. Winter 2015;3.
http://harvardpublichealthreview.org/hphr-editorial-racism-is-a-public-health-problem/

Why Racism, Not Race, Is a Risk Factor for Dying of COVID-19

https://www.scientificamerican.com/article/why-racism-not-race-is-a-risk-factor-for-dying-of-covid-191/?fbclid=IwAR2dKsnqQPqbOrSlcmqVjwp_LfwtFR0BsZnYxdIQ5tePqeglchR5Og3mwDA

Healing America: A Funder's Commitment to Racial Equity
https://bjn9t2lhlni2dhd5hvym7llj-wpengine.netdna-ssl.com/wp-content/uploads/2016/12/RP-Summer10-Christopher.pdf

Videos

Unnatural Natural Causes: Is Inequality Making Us Sick
https://www.pbs.org/unnaturalcauses/

The danger of a single story | Chimamanda Ngozi Adichie
https://www.youtube.com/watch?v=D9Ihs241zeg

Emancipation from Mental Slavery | Dr. Cheryl Tawede Grills
https://www.youtube.com/watch?v=kkXseTHxusw

DREAMing and Designing Spaces of Hope in a "Hidden America" | Ruby Mendenhall | TEDxUIUC
https://www.youtube.com/watch?v=O8t-auPPFOo

Podcasts

Julie Wurth. November 27, 2019. Campus Conversations. News-Gazette
https://www.news-gazette.com/podcasts/campus-conversation-ui-professor-ruby-mendenhall/audio_42e81376-1086-11ea-89a0-9f1ff47e88a9.html

Listen to What They are Saying
Learn to see through protesters' eyes with these podcasts
https://www.nytimes.com/2020/06/06/arts/podcasts-about-race-and-racism.html

Article

Journal of Black Psychology
1–27

DOI: 10.1177/0095798420929468
journals.sagepub.com/home/jbp
SAGE

Community Healing and Resistance Through Storytelling: A Framework to Address Racial Trauma in Africana Communities

Nkechinyelum A. Chioneso[1], Carla D. Hunter[2], Robyn L. Gobin[2], Shardé McNeil Smith[2], Ruby Mendenhall[2], and Helen A. Neville[2]

Abstract

Racial trauma, an ongoing consequence of historical trauma, has deleterious effects on the well-being of Africana communities. The psychological literature primarily reflects individual processes in the relationship between racial trauma and healing. Going beyond individualistic approaches, we present a community healing framework informed by multidisciplinary scholarship: Community Healing and Resistance Through Storytelling (*C-HeARTS*). Three major components of the framework are delineated: (a) justice as both a condition of and an outcome of community healing; (b) culturally syntonic processes (i.e., storytelling and resistance) that direct the renarrating of trauma and act as conduits for transformation; and (c) psychological dimensions (i.e., connectedness, collective memory, and critical consciousness) that promote justice-informed outcomes. In the

[1]Florida A&M University, Tallahassee, FL, USA
[2]University of Illinois at Urbana-Champaign, Champaign, IL, USA

Corresponding Author:
Nkechinyelum A. Chioneso, Department of Psychology, Florida A&M University, 501 Orr Drive, Tallahassee, FL 32307, USA.
Email: n.chioneso@famu.edu

61

C-HeARTS framework, community is advanced as an agent of change while centering justice and the important role of cultural practices to facilitate community healing.

Keywords
African Americans, community healing, justice, racial trauma, storytelling

Systems of oppression, rooted in *historical trauma*—massive violence with the intent to impair and/or kill a group of people that cumulatively manifests as chronic psychological wounding across surviving generations—undermine the well-being of Africana communities (Burkett, 2017; Karlsen et al., 2005; Pieterse et al., 2012; Reitz & Banerjee, 2007). An ongoing consequence of historical trauma is racial trauma, which has deleterious effects on its victims. *Racial trauma* is defined as real and perceived danger, threats, witnessing harm, or humiliating and shaming events to ethnoracial individuals similar to the self that may be sudden, beyond their control, and emotionally overwhelming (Comas-Díaz et al., 2019). Racial trauma may emerge in response to racism (e.g., racial discrimination and microaggressions) that evoke stress and trauma reactions (Anderson & Stevenson, 2019; Carter, 2007; Nadal, 2018; Pieterse et al., 2010); and may be recurring, systemic, and intergenerational (Comas-Díaz et al., 2019). Thus, racial trauma encompasses cumulative experiences of racism and has detrimental effects on psychological well-being (Helms et al., 2010; Williams et al., 2018). Among people of African ancestry living in the United States, racial trauma has contributed to poor physical health (Kaholokula, 2016; Kendall-Tackett, 2009) and psychological distress (Polanco-Roman et al., 2016). Additionally, the psychosocial impacts of racial trauma may include the devaluation of the self (Graham et al., 2016; Williams et al., 2018), erosion of family ties (Anderson & Stevenson, 2019), and weakened community relationships (Riina et al., 2013).

Increasing numbers of clinical models identify the impact of racial trauma on individual well-being and suggest personal healing strategies (e.g., Bryant-Davis & Ocampo, 2006; Carter, 2007; Comas-Díaz, 2016). Both family and community-oriented scholarship that focus on racial trauma recognize not only the importance of personal healing strategies but also advocate for collective healing processes (Anderson et al., 2018; Chavez-Dueñas et al., 2019; French et al., 2019). Taking community-oriented scholarship a step further, we recommend partnering with communities in ways that focus on community strengths and address community challenges to restore a healthy balance within persons and among individuals (Grills et al., 2018; Myers et al., 2018; Somé, 1993).

Thus, we propose a culturally syntonic community healing framework pertaining to racial trauma that highlights justice-informed outcomes demonstrated in psychology and health literatures. In so doing, the Community Healing and Resistance Through Storytelling (C-HeARTS) framework is delineated. Our framework synthesizes the existing scholarship on racial trauma and healing strategies to reflect the multiple processes associated with community healing. To establish a common language within the racial trauma scholarship, community healing is first defined. Next, justice as a foundational concept is discussed before we elaborate on the roles of two proposed culturally syntonic mechanisms: storytelling and resistance. Finally, we review and synthesize the literature on trauma and healing to illustrate three psychological dimensions and accompanying collective interventions that together inform processes that promote community healing. Ultimately, our goal is to advance community as an agent of change while centering justice and the important role of cultural practices to facilitate community healing.

Community Healing

Community and *healing* are often separate concepts in scholarly discourse, whereas *community healing* is rarely discussed in psychological literature. Although *community* has multiple meanings, community as locality (e.g., neighborhood) and community as a relational group without place restrictions (e.g., membership in a labor union) are two salient distinctions made in the social sciences (Bradford, 2017; Kloos et al., 2012). Irrespective of disciplinary lens, most concepts of community reflect a sense of connectedness—through geography, shared history, culture, a sense of belonging, influence, the fulfillment of needs, and effective mediums of communication (Farwell & Cole, 2002; McMillan & Chavis, 1986). What is also emphasized here is that community is a collective change agent, a "unit of solution in society" through which people can proactively address trauma-related problems within their locality and relational groups (Checkoway, 1995, p. 3).

Like the term community, *healing* is a positively described term that lacks an easily recognizable definition. Some healing definitions emphasize spirituality. In Latino ethnic psychology, healing and *sabiduría* are interlinked. Sabiduría is to perceive illness as a spiritual development opportunity that requires personal evolvement and connectedness with others (Comas-Díaz, 2006). While healing is more readily understood as physiological and behavioral improvements, healing is often perceived as an individual journey toward wellness that involves the personal transcendence of suffering (Egnew, 2005). However, other definitions of healing rooted in trauma scholarship indicate that creating a collective memory is a key aspect of healing trauma that

involves transitioning an individual's private pain to the public domain (Puvimanasinghe & Price, 2016; Stepakoff et al., 2006). When personal healing is embedded within a communal framework, we argue that a greater transformational process will be facilitated by a shared collective memory, which can help shift bodies, minds, and spirits from a status of suffering to repair and create opportunities to evolve (Myers, 2013; Somé, 1993).

Given the importance ascribed to the terms community and healing, the existence of *community healing* scholarship is a reasonable expectation. To date, a body of literature that promotes communal practices, and increasing critical consciousness has been unfolding for over 20 years within Indigenous (Brave Heart & DeBruyn, 1998; Duran et al., 2008; Kowanko et al., 2009; Warry, 1998) and African-centered scholarship (Akbar et al., 1980; Grills & Rowe, 1998; Kambon, 1992; Myers, 1993). Identifying links between prevalent psychosocial diseases (e.g., suicidality) among North American Indigenous peoples and macrostructures (e.g., colonialism) resulted in the coining of the term "historical trauma" and the development of the Historical Trauma and Unresolved Grief (HTUG) Intervention for American Indians (Brave Heart, 2003; Brave Heart & DeBruyn, 1998).

Using the HTUG model, Brave Heart and DeBruyn (1998) described American Indian participants' community healing as occurring through facilitated communal grief rituals that incorporate traditional practices (e.g., storytelling) and involve extended kin networks. Engaging in these processes had a positive impact on participants' identity formation, a sense of belonging, recognition of a shared history, and future survival of the group (Brave Heart & DeBruyn, 1998). A major outcome of their community healing engagement processes was the Takini Network, a Lakota Nation holocaust survivors' association that provides historical trauma training to human service providers (Brave Heart & DeBruyn, 1998). Other structural-focused community healing approaches used by North American Indigenous communities have included the following: (a) designing culturally appropriate health care initiatives such as the People Awakening Team, an Alaska Native people's project that records life stories in narrative format to identify protective variables that prevent alcohol abuse (Duran et al., 2008); and (b) restoring cultural values, language, and traditions by establishing a Sagamok First Nation controlled school (Warry, 1998).

From an African-centered perspective, healing is a community endeavor that involves maintaining a harmonious balance between the spiritual realm and physical world (Jackson-Lowman, 2004; Mariette, 2013; Somé, 1993). This holistic perspective regards animate life forms and inanimate objects as divine sources of energy within an African metaphysical hierarchy: God, gods, spirits, ancestors, and then humans (Omonzejele, 2008). God is considered the

supreme source of healing from which all sources of healing are derived. Special deities (e.g., *Osanyin* and *Agwu*, Yoruba and Igbo deities, respectively) and spirits are guardians who guide the curative use of nature's vast healing energies (Opoku, 1978; Washington, 2010). (Re)establishing spiritual harmony with one's ancestors is a healing prerequisite that allows for access to special cures (Omonzejele, 2008). To meet human needs, the interdependency of a community creates opportunities to achieve what is difficult to achieve alone when the following commitments are upheld: unity, trust, openness, love and caring, uplifting elders who are the collective memory of the community, respect for nature's medicinal wisdom, and honoring the ancestors (Somé, 1993). Cultural healing practices may include specific rituals, drumming, dancing, singing, and storytelling (Monteiro & Wall, 2011; Somé, 1993; Stepakoff et al., 2006). While African concepts of wellness generally characterize a person's health status as a communal affair, it also characterizes human knowledge as limited: incapable of explaining all that exists on Earth and beyond (Fu-Kiau, 1991). Therefore, healing is predicated on the maintenance of positive relations between humans and the spiritual realm, nature, and among fellow human beings (Jackson-Lowman, 2004; Omonzejele, 2008; Opoku, 1978).

Mental and physical pain represents a soul seeking realignment with the spiritual world, restoration of inner power, and the opportunity to grow (Fu-Kiau, 1991; Somé, 1993). Operating from an African-centered worldview, the Community Healing Network and the Association of Black Psychologists sought to heal soul wounds within Africana communities. They jointly developed Emotional Emancipation Circles (EECs) to expose historical trauma and overturn "the pernicious lies of Black inferiority [narratives that] fall under the broader rubric of racism" (Grills et al., 2016, p. 337). EECs are designed to be safe cultural spaces for people of African ancestry to share their stories and engage in critical community reflection through a facilitated group process. While engendering self-determination and cultural integrity, the sign of an effective EEC is the development of civically engaged participants organizing community actions that reduce systemic violence in Africana communities (Grills et al., 2016).

Racial trauma occurs within an oppressive sociopolitical context (Comas-Díaz et al., 2019). Treatment models that promote a client's resistance strategies (e.g., filing charges against racist perpetrators and lobbying for antiracist policies; Bryant-Davis & Ocampo, 2006); social action (e.g., framing racism as a form of ethnoviolence while advocating for racial equality; Comas-Díaz, 2016); and connections among individuals, families, and communities to their collective cultural strengths (Chavez-Dueñas et al., 2019) highlight the importance of critical consciousness in the healing process. The need for clinical solutions is important but limited without community healing interventions

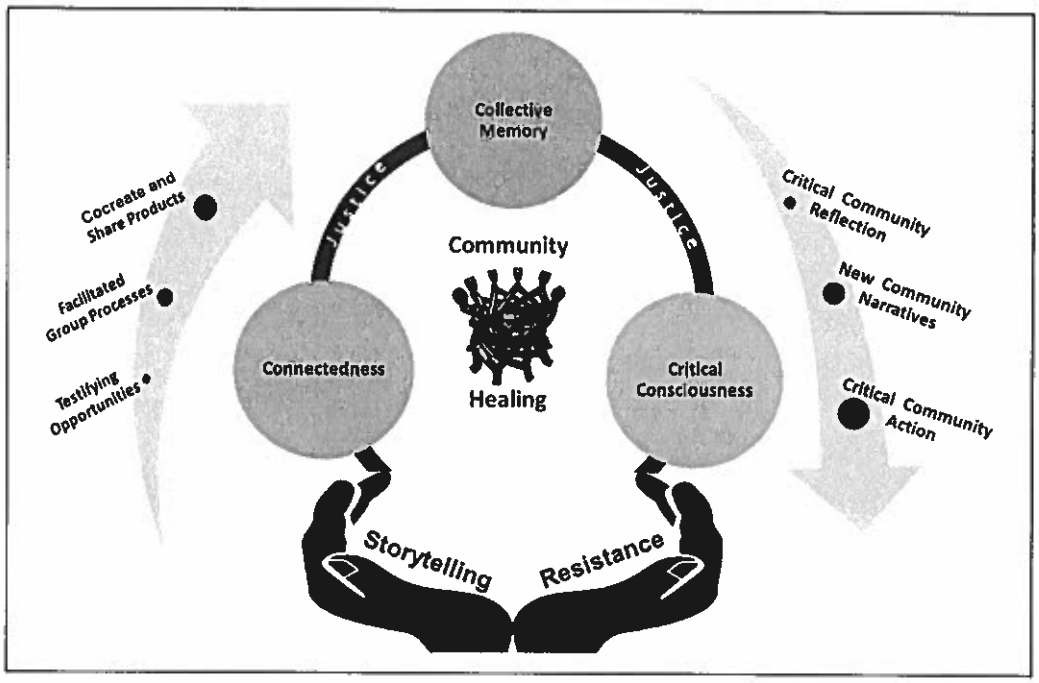

Figure 1. C-HeARTS framework.

that develop collective critical discourse and actions to dismantle systems of oppression (Grills et al., 2016; Hartmann et al., 2019). Therefore, the community healing concept emphasizes collective responsibility and advances a critical consciousness that resists disempowerment using culturally restorative practices to enable self-determined realities, which should be understood as justice (Fanon, 2018; McCaslin, 2005).

Based on our review of community healing scholarship, we argue that community healing is a multilevel process that is composed of three components as illustrated in Figure 1. First, at the core of community healing is justice; a guiding principle that is both a condition of and outcome of community healing (Myers et al., 2018; Prilleltensky, 2012). Second, culturally syntonic processes working in tandem, such as storytelling and resistance, may facilitate the renarrating of trauma and serve as motivating factors that bring behaviors into focus and ideas into action (Burkett, 2017; Harrell, 2015; Myers, 2013). Finally, community healing consists of three key psychological dimensions: connectedness, collective memory, and critical consciousness. We integrate these various perspectives to define community healing as *an ongoing multilevel process whereby oppressed groups strengthen their connectedness and collective memory through culturally syntonic processes in ways that promote critical consciousness to achieve optimal states of justice.*

C-HeARTS Framework

Justice

If "justice is what love looks like in public" (West, 2014), then justice in the United States is obscure, at best, for significant numbers of African descent people (Alexander, 2012). When examining racial trauma within Africana communities, the meaning of mental health and well-being within an oppressive context cannot be ignored (Anderson & Stevenson, 2019; Myers & Speight, 2010). For example, with the overpolicing of predominately Africana communities, research indicates that a disproportionate number of Black women are incarcerated (approximately 19%) or under correctional surveillance and experience high rates of depression (Malcolme et al., 2019). Black males have greater dire encounters with the police (e.g., increased negative perceptions of their personhood) and are twice as likely to be killed by the police before the age of 21 years compared with their White male counterparts (Harris & Amutah-Onukagha, 2019). Thus, conceptualized as a moral ideal in the C-HeARTS framework, *justice* is a commitment to right interrelationships between the spiritual realm, nature, and among humans; it encompasses ethical behaviors such as seeking truth, harmony, balance, and reciprocity (Karenga, 2004).

By centralizing justice as a guiding principle within healing, a community's status will more profoundly shift from suffering to thriving when justice-informed outcomes are promoted at multiple psychosocial levels (Myers et al., 2018; Prilleltensky, 2012; Watts et al., 2011). Centralizing justice requires assessing, what Prilleltensky (2012) described as, objective well-being (e.g., access to food, nonabusive relationships, adequate pay, and a clean environment) and subjective well-being (e.g., perceptions of life satisfaction, emotional support, positive working climate, and freedom to express political opinions). Objective and subjective indicators of well-being occur within three spheres of life: (a) personal sphere (e.g., feeling safe and accepted; more access to social capital); (b) interpersonal sphere (e.g., making decisions; fair sharing of obligations and privileges); and (c) organizational sphere (e.g., reward and effort are aligned; systems in place to promote fairness). When both indicators of well-being are promoted in each sphere of life, then realizing justice-informed outcomes are experienced at higher levels of thriving (Prilleltensky, 2012). Centralizing justice will also call public attention to the fact that "soul wounds—the cumulative psychological wounds that result from historical traumatic experiences, such as colonization, genocide, slavery, dislocation, and other related trauma"—are as detrimental as bodily wounds (Comas-Díaz et al., 2019, p. 2).

Equally important, justice is incomplete without embodying cultural integrity. For example, *Moving to the Beat*, a 4-year social action research project used hip hop as a language of social change to generate a "social therapeutic space" between youth in Sierra Leone and the United States seeking positive collective identities that "encompasses the trauma, ideals, hopes and losses born of their common and differing histories" (Haaken et al., 2012, p. 64). Similarly, African American youth residing in violent and underresourced neighborhoods reported that the development of urban dance cultures (e.g., Krumping) cultivated sacred community healing spaces that allowed them to make statements, construct collective identities, elevate the importance of their lives, and reconnect to their spirit (Monteiro & Wall, 2011). In other words, achieving justice requires a community to proactively engage its cultural systems to experience justice as healing (McCaslin, 2005).

Culturally Syntonic Processes: The Roles of Storytelling and Resistance

Culturally syntonic processes in the C-HeARTS framework are understood to be "historical, socio-politically-situated, and organizing . . . patterns of being, believing, bonding, belonging, behaving, and becoming" that are evident, for example, in communication styles and healing practices among a group of people with shared identities or defining experiences (Harrell, 2015, p. 19). For a community to function optimally (i.e., justly), culturally syntonic processes that involve storytelling and resistance will likely nurture community bonds (Banks-Wallace, 2002) and direct the development of a community action plan grounded in cultural wisdom (Armah, 2010; Mariette, 2013; Myers & Speight, 2010; Woods, 2009). Thus, storytelling in tandem with resistance are proposed culturally syntonic processes deemed appropriate for Africana communities to support the renarrating of trauma and act as conduits for transformation (Denham, 2008).

Storytelling. Although not unique to Africana communities, storytelling is a rich oral tradition found to be an effective healing intervention (Brave Heart & DeBruyn, 1998; Bryant-Davis & Ocampo, 2006; Carter, 2007; Comas-Díaz, 2007). Narrative therapy and testimonio, as two examples, involve the process of sharing one's personal stories with others to facilitate reprocessing and reframing negative cognitions to positive cognitions (Comas-Díaz, 2016; Parks, 2007). A *story* is an umbrella term that includes a *personal story* (i.e., idiosyncratic cognitive representations of events) and a *narrative* (i.e., communal representations of commonly experienced events;

Mankowski & Rappaport, 2000). Two distinct narrative subtypes exist. A *community narrative* is a common story about the group itself in a particular setting, consisting of personal and paralleling stories among group members; whereas a *dominant cultural narrative* is an overlearned (positive or negative) story communicated by major socializing institutions, often controlled by powerful people in a society, that impact the identities, beliefs, and values of the populace (Mankowski & Rappaport, 2000).

Increasingly, among racial trauma survivors, the legacy of historical trauma in presenting symptomology is being acknowledged (Comas-Díaz, 2016; Duran et al., 2008; Jernigan & Daniel, 2011). Storytelling not only facilitates an understanding of human behavior, it also functions as a tool for resisting oppression (Comas-Díaz, 2016; Denham, 2008), fostering healing (Sunwolf, 2005), and promoting spiritual communion (Banks-Wallace, 1998; 2002). In community settings, storytelling has contributed to restoring cultural identities (Lawson-Te Aho, 2014), building a sense of community (Mankowski & Rappaport, 2000), and serving as counterhegemonic stories to refute negative stories about oppressed groups (Bell, 2003; Haaken et al., 2012). Therefore, as a response to racial trauma, storytelling approaches (e.g., testimony therapy, sociotherapy, and digital storytelling) have been incorporated into treatment plans (Bryant-Davis & Ocampo, 2006; Carter, 2007; Comas-Díaz, 2007) and community healing practices (Grills et al., 2016).

Resistance. A critical understanding of the sociopolitical movements of Africana communities (e.g., antilynching, Pan African, and Black Power) reveals an ongoing struggle for community healing, whereby resistance coupled with cultural tools and liberatory practices nurture organized collective demands for justice (Myers et al., 2018). Resistance is conceptualized as the dynamic interplay between self-determination and defiance. *Self-determination* is the process of choosing thoughts and behaviors that positively shapes one's destiny; it drives the fulfillment of human needs and is a desired end state (Bulhan, 1985). Historically through social movements, Africana communities equated self-determination with freedom, and therefore pursued ideas and experiences that defied the status quo. *Defiance* allowed for intentional planning to achieve more adaptive conditions that may ensure the realization of (individual and collective) self-determined goals (Gordon, 2004). The review of the literature on culturally syntonic processes, considered together, has demonstrated that storytelling about and resistance to obstructive or destructive systems of oppression is a healthy response that cultivates opportunities for community healing (Burkett, 2017).

Three Psychological Dimensions

The overview of the literature thus far highlights key factors necessary to promote community healing within the C-HeARTS framework. Synthesizing research on storytelling, resistance, and justice, we now demonstrate the specific ways that three psychological dimensions—connectedness, collective memory, and critical consciousness—may contribute to community healing processes. As summarized in Table 1, we propose that community healing is advanced when collective interventions and liberatory practices are used to promote justice-informed outcomes that can be assessed using objective and subjective indicators of well-being within three spheres of life (i.e., personal, interpersonal, and organizational). To lend credibility to our proposal, we review the literature on each psychological dimension emphasizing the role of storytelling and resistance in community healing. Then, we succinctly review relevant psychological and health related literature to provide suggested collective interventions and accompanying justice-informed outcomes.

Dimension I: Connectedness. A multidimensional concept consisting of mutual interdependence, a shared identity, and a sense of belonging, connectedness includes relationships between the mental, physical, emotional, and spiritual realms of people and their environments (Hill, 2006; Nobles, 1991; Schiele, 1996). A sense of connectedness may result in fostering a heightened sense of comfort or wellness, and reducing anxiety (Hagerty et al., 1993), while increasing access to social support and the ability to effectively engage in daily functioning among traumatized individuals (Stepakoff et al., 2006). Within a personal sphere of life, connectedness can be fostered through understanding, validating, and nurturing individual experiences. Storytelling and resistance have been found to provide opportunities for tellers to self-reflect on their experiences, and witnesses to gain insight into their own lives when they understand how others have overcome similar challenges (East et al., 2010). Listening attentively and avoiding judgmental feedback encourages the teller to halt self-rejecting thoughts and negative emotions, which serves to validate shared trauma (Comas-Díaz, 2016; Richters et al., 2008). Such validation nurtures connections with both the self and the collective because there is a refocusing on the teller's strengths and redeemable qualities (Banks-Wallace, 1998). Given that promoting and maintaining connectedness is vital for community healing (Schultz et al., 2016), we propose that collective interventions, such as testifying opportunities and facilitating group processes, help participants experience connectedness, thereby, making justice-informed outcomes possible.

Table 1. C-HeARTS Framework: Psychological Dimensions, Culturally Syntonic Processes, Collective Intervention Examples, and Justice-Informed Outcomes.

Three psychological dimensions and key components	Culturally syntonic processes	Collective intervention examples	Justice-informed outcomes		
			Spheres of life	Objective indicators of well-being	Subjective indicators of well-being
Dimension I: Connectedness					
Understand	Storytelling promotes understanding, validates shared trauma, and nurtures community bonds; while resistance diminishes psychological states of indifference, devaluation of the self and others, and ruptured community ties.	Testifying opportunities	Personal	Reduced symptoms of depression, more smiling, less crying	Feeling safe, accepted, respected
Validate		Facilitated group processes		More access to social bonding and social capital	Life satisfaction evaluations, perceived sense of control
Nurture					
Dimension II: Collective memory					
Trust	Storytelling promotes trust in the group processes, recall of historical traumas and triumphs, and psychological decolonization; while resistance disrupts interpersonal distrust, historical amnesia, and inaccurate personal stories and distorted community narratives.	Cocreate and share products	Interpersonal	Exercise voice and choice, growth in relationship	Feeling heard, sense of growth as person and unit, making decisions
Remember		Critical community reflection		Fair sharing of obligations and privileges	Feeling valued and respected, not taken for granted, free of stereotypes
Decolonize					
Dimension III: Critical consciousness					
Empower	Storytelling promotes personal empowerment, collective organizing, and advocacy for community needs; while resistance helps reduce disempowering thought patterns, inertia, and systemic inequities.	New community narratives	Organizational	Opportunities to express opinions, exercise control, and to build and display strengths	Feeling that reward and effort are aligned, control and demands are aligned, satisfaction with competency level
Organize		Critical community action		Policies, procedures, and practices that respect all individuals equally, systems in place to promote fairness	Being treated with fairness and respect, perceiving collaborators as fair and equitable
Advocate					

Collective intervention examples and justice-informed outcomes. Testifying opportunities, like testimony therapy or "testimonio" invite survivors and community members to resist internalizing blame through first-person testimonio accounts. With the community bearing witness, first-person accounts include pre-trauma experiences that can provide emotional release, validate and document the storyteller's lived experience, and facilitate posttraumatic meaning making (Akinyela, 2005; Aron, 1992; Cienfuegos & Monelli, 1983). Testimonials in the form of collaborative poems that depicted trauma and memory cloths that connected recent history with personal tragedies enabled West African survivors of torture and civil war to step outside their pain and bear witness to an ethnopolitical phenomenon (Stepakoff et al., 2006). These public truth telling experiences contributed to reduced depression and traumatic stress, while it increased access to social bonding and social capital: objective indicators of well-being (Stepakoff et al., 2006). Testifying opportunities for war-affected Mayan children in Guatemala were designed as a creative workshop that encouraged participants to engage in cultural activities (e.g., making masks, weaving, and storytelling; Farwell & Cole, 2002). Subjective indicators of well-being were noted when the workshops not only helped children and their parents to better understand their collective trauma but also inspired their feelings of safety, acceptance, and respect in ways that allowed them to actively nurture their social bonds.

The revolutionary psychiatrist Frantz Fanon recognized the link between oppression and mental health among colonized communities in Africa. He advocated for the use of sociotherapy, a communal healing strategy, to support social bonding and rebuilding communities among patients in psychiatric institutions (Fanon, 2018). Sociotherapy is a facilitated group process that addresses mental health and well-being, and has been found to be particularly effective in the aftermath of war and political violence (Richters et al., 2008). Characterized as the "community acting as a doctor," sociotherapy groups are comprised of phases (e.g., safety, care, and respect) and guiding principles (e.g., democracy, nondirectivity, and a focus on reality) that inform core procedural rules (e.g., two-way communication, shared decision making, and collaborative leadership; Richters et al., 2008).

In 2005, sociotherapy groups were implemented in Rwanda to address ethnopolitical trauma. Groups included 10 to 12 individuals who lived in the same community and met for 2 to 3 hours weekly at a local venue for approximately 15 weeks, and each group was facilitated by trained group leaders, who were community residents (Richters et al., 2008). As social bonding and commitments to aid each other's well-being increased among participants, objective indicators of well-being were evident when participants gained greater access to social capital that could be leveraged for self and community needs. In a subsequent study, subjective indicators of well-being were

demonstrated. Selected from 10 sociotherapy groups, 100 Rwandan participants completed presurveys and postsurveys, in addition to an 8-month follow-up questionnaire, used to screen for common mental health disorders (Scholte et al., 2011). Compared with a demographically similar control group who did not participate in a sociotherapy intervention, experimental group participants reported better mental health; that is, greater perceived sense of control and higher levels of life satisfaction.

Dimension II: Collective memory. Collective memory, a group's shared understanding of the recent or distant past, is at the heart of psychological health (Zaromb et al., 2014). It aids in the healing process by unearthing the lived experiences of those whose histories have been hidden or erased from public record (Ainslie, 2013). Simultaneously, the exploration of a community's collective memory may limit the internalization of oppression by outlining how racial trauma is systemically embedded and institutionally perpetuated (Burkett, 2017; Grills et al., 2016; Myers et al., 2018).

To trust, remember, and decolonize minds help foster collective memory at the interpersonal sphere of life. Storytelling in a safe environment builds trust within group processes as community members resist interpersonal distrust that is tied to denigrating dominant cultural narratives (Case & Hunter, 2012; Farwell & Cole, 2002). With greater trust, opportunities to resist the perpetuation of historical amnesia can develop, allowing personal stories and community narratives that highlight traumas and triumphs to be actively remembered (Comas-Díaz, 2016; Rappaport, 2000). By helping community members interrogate their potentially inaccurate personal stories and distorted community narratives, storytelling and resistance may enhance their psychological decolonization process (Ainslie, 2013; Banks-Wallace, 1998; Comas-Díaz, 2016; Lawson-Te Aho, 2014). The goal is to promote movement from internalized oppression and self-blame to restoring self-worth, reestablishing a sense of competency, and grieving what has been lost due to historical trauma (Bulhan, 1985; David & Okazaki, 2006; Lawson-Te Aho, 2014). Thus, we propose that cocreating and sharing products such as digital stories (Rolón-Dow, 2011), memory cloths (Stepakoff et al., 2006), documentary films (Haaken et al., 2012), and dramatizations (Farwell & Cole, 2002), and using these products to aid critical community reflection, support the construction of a collective memory that may challenge dominant cultural narratives and give voice to pursuing justice-informed outcomes.

Collective intervention examples and justice-informed outcomes. Interventions that involve cocreating and sharing products, such as digital storytelling methods, are integral to reaching populations traditionally underserved in health research. With digital storytelling approaches, participants have

control over both the development and dissemination of their stories. They typically attend a group workshop to collaboratively tell a short story by learning how to produce a final (2- to 4-minute) digital product that incorporates multimedia (Briant et al., 2016). Briant et al. (2016), for example, interviewed Latinx cancer patients who created digital stories focused on cancer and found that their digital storytelling experience promoted the exercise of voice and choice, objective indicators of well-being (Prilleltensky, 2012). This exercise subsequently contributed to growth in their interpersonal relationships with family members who gained a deeper understanding of cancer as an illness. The digital storytellers also experienced subjective indicators of well-being such as, a sense of growth as a person and feeling heard regarding their illness. Tellers' heightened subjective well-being contributed to their ability to make more appropriate health-related decisions (e.g., eating healthier foods) with the support of their loved ones.

Opportunities for critical community reflection are important for naming, reengaging, and diminishing anger associated with historical trauma, and opening possibilities for developing a collective memory (Ainslie, 2013; Freire, 2000). An example of this can be found in relation to a long-standing historical trauma in a Texas community involving the "Sam Schwarz School," a segregated school for African American residents. The Sam Schwarz School was destroyed without the consent and despite the historical significance the school held for African American residents. Although the local school district had no official account of the school or its closing, decades later, a new building renamed the "Sam Schwarz Campus" was resurrected at the same site for students with academic/behavioral problems; and memories of positive community contributions were erased and became associated with deficiencies (Ainslie, 2013). Three interventions to promote community healing were developed: testimonial opportunities, a documentary film, and a public critical community reflection event. During the third intervention, African American alumni shared their educational successes and community narratives with all community members as witnesses. Several subjective indicators of well-being for the alumni emerged, such as feeling valued, not taken for granted, and disproving stereotypes. Important changes were also made by White school administrators that illustrated objective indicators of well-being, primarily, a fair sharing of obligations and privileges. For example, the academic/behavioral problems program was removed from the Sam Schwarz Campus, and a permanent display of African American alumni photographs and memorabilia were erected at the school district's office (Ainslie, 2013). Through critical community reflection, dominant cultural narratives were interrogated, which prompted actions to construct a more authentic collective memory that increased the visibility and significance of African American history in the community's collective memory.

Dimension III: Critical consciousness. Referring to the social, political, and economic forces shaping lived experiences and community well-being, critical consciousness is a process predicated on a person's belief in their ability to engage in actions that will produce change (i.e., political efficacy; Freire, 2000). Emerging data support key tenets of critical consciousness among Africana communities (Hope & Jagers, 2014). Specifically, among youth of African ancestry, data suggest that civic related actions contribute to both youth development (Sherrod et al., 2010) and the development of their communities (Watts & Flanagan, 2007). Data also suggest that an activism-oriented humanities curriculum that supports the development of particular character strengths (e.g., critical thinking about racial oppression as interpersonal, institutional, and internalized oppression) foster critical consciousness among youth to challenge oppressive systems (Seider et al., 2017). The crux of critical consciousness, thus, demands increasing the abilities of community members to address commonly identified concerns and taking action to challenge oppressive forces.

At the organizational sphere of life, vast opportunities for individuals to empower themselves, organize, and advocate for community needs through storytelling and collective acts of resistance are essential to critical consciousness. Telling counternarratives can empower storytellers because it creates occasions for them to name and debunk the larger dominant racial narrative, which is often hidden or denied. Additionally, storytellers are able to educate witnesses about an important social issue (Bell, 2016; Benmayor, 2008). Sharing stories using multimedia (e.g., flyers, web-videos, and blogs) may inform and galvanize others to organize. In the case of #BlackLivesMatter, people share video stories to stimulate critical awareness about long-standing state violence (e.g., police brutality) directed against people of African descent to encourage local communities to organize and demand changes (e.g., improve police-community relations, policies, and practices; Canella, 2017). Advocating for community needs can occur in multiple ways, whereby storytelling and resistance can reduce disempowering thought patterns, inertia, and systemic inequities that exclude oppressed communities (Hoffman & Mitchell, 2016; Kimball et al., 2016). Eleven-year-old student activist Naomi Walder (2018), for example, advocated for females of African descent who are omitted in dominant cultural narratives about gun violence in the United States. At *March for Our Lives* (a student antigun violence demonstration held in Washington, DC, on March 24, 2018), she issued a call to action: "I represent the African American girls [and women who are victims of gun violence but] whose stories don't make the front page of every national newspaper" because they "have been just numbers. . . . [H]elp me write the narrative for this world to understand so that these girls and women are never forgotten" (Walder, 2018). Because storytelling and acts of resistance reveal

Article

Journal of Black Psychology
1–27

DOI: 10.1177/0095798420929468
journals.sagepub.com/home/jbp
SAGE

Community Healing and Resistance Through Storytelling: A Framework to Address Racial Trauma in Africana Communities

Nkechinyelum A. Chioneso[1], Carla D. Hunter[2], Robyn L. Gobin[2], Shardé McNeil Smith[2], Ruby Mendenhall[2], and Helen A. Neville[2]

Abstract

Racial trauma, an ongoing consequence of historical trauma, has deleterious effects on the well-being of Africana communities. The psychological literature primarily reflects individual processes in the relationship between racial trauma and healing. Going beyond individualistic approaches, we present a community healing framework informed by multidisciplinary scholarship: Community Healing and Resistance Through Storytelling (*C-HeARTS*). Three major components of the framework are delineated: (a) justice as both a condition of and an outcome of community healing; (b) culturally syntonic processes (i.e., storytelling and resistance) that direct the renarrating of trauma and act as conduits for transformation; and (c) psychological dimensions (i.e., connectedness, collective memory, and critical consciousness) that promote justice-informed outcomes. In the

[1]Florida A&M University, Tallahassee, FL, USA
[2]University of Illinois at Urbana-Champaign, Champaign, IL, USA

Corresponding Author:
Nkechinyelum A. Chioneso, Department of Psychology, Florida A&M University, 501 Orr Drive, Tallahassee, FL 32307, USA.
Email: n.chioneso@famu.edu

Article

Journal of Black Psychology
1–27

DOI: 10.1177/0095798420929468
journals.sagepub.com/home/jbp
SAGE

Community Healing and Resistance Through Storytelling: A Framework to Address Racial Trauma in Africana Communities

Nkechinyelum A. Chioneso[1], Carla D. Hunter[2], Robyn L. Gobin[2], Shardé McNeil Smith[2], Ruby Mendenhall[2], and Helen A. Neville[2]

Abstract

Racial trauma, an ongoing consequence of historical trauma, has deleterious effects on the well-being of Africana communities. The psychological literature primarily reflects individual processes in the relationship between racial trauma and healing. Going beyond individualistic approaches, we present a community healing framework informed by multidisciplinary scholarship: Community Healing and Resistance Through Storytelling (*C-HeARTS*). Three major components of the framework are delineated: (a) justice as both a condition of and an outcome of community healing; (b) culturally syntonic processes (i.e., storytelling and resistance) that direct the renarrating of trauma and act as conduits for transformation; and (c) psychological dimensions (i.e., connectedness, collective memory, and critical consciousness) that promote justice-informed outcomes. In the

[1]Florida A&M University, Tallahassee, FL, USA
[2]University of Illinois at Urbana-Champaign, Champaign, IL, USA

Corresponding Author:
Nkechinyelum A. Chioneso, Department of Psychology, Florida A&M University, 501 Orr Drive, Tallahassee, FL 32307, USA.
Email: n.chioneso@famu.edu

C-HeARTS framework, community is advanced as an agent of change while centering justice and the important role of cultural practices to facilitate community healing.

Keywords
African Americans, community healing, justice, racial trauma, storytelling

Systems of oppression, rooted in *historical trauma*—massive violence with the intent to impair and/or kill a group of people that cumulatively manifests as chronic psychological wounding across surviving generations—undermine the well-being of Africana communities (Burkett, 2017; Karlsen et al., 2005; Pieterse et al., 2012; Reitz & Banerjee, 2007). An ongoing consequence of historical trauma is racial trauma, which has deleterious effects on its victims. *Racial trauma* is defined as real and perceived danger, threats, witnessing harm, or humiliating and shaming events to ethnoracial individuals similar to the self that may be sudden, beyond their control, and emotionally overwhelming (Comas-Díaz et al., 2019). Racial trauma may emerge in response to racism (e.g., racial discrimination and microaggressions) that evoke stress and trauma reactions (Anderson & Stevenson, 2019; Carter, 2007; Nadal, 2018; Pieterse et al., 2010); and may be recurring, systemic, and intergenerational (Comas-Díaz et al., 2019). Thus, racial trauma encompasses cumulative experiences of racism and has detrimental effects on psychological well-being (Helms et al., 2010; Williams et al., 2018). Among people of African ancestry living in the United States, racial trauma has contributed to poor physical health (Kaholokula, 2016; Kendall-Tackett, 2009) and psychological distress (Polanco-Roman et al., 2016). Additionally, the psychosocial impacts of racial trauma may include the devaluation of the self (Graham et al., 2016; Williams et al., 2018), erosion of family ties (Anderson & Stevenson, 2019), and weakened community relationships (Riina et al., 2013).

Increasing numbers of clinical models identify the impact of racial trauma on individual well-being and suggest personal healing strategies (e.g., Bryant-Davis & Ocampo, 2006; Carter, 2007; Comas-Díaz, 2016). Both family and community-oriented scholarship that focus on racial trauma recognize not only the importance of personal healing strategies but also advocate for collective healing processes (Anderson et al., 2018; Chavez-Dueñas et al., 2019; French et al., 2019). Taking community-oriented scholarship a step further, we recommend partnering with communities in ways that focus on community strengths and address community challenges to restore a healthy balance within persons and among individuals (Grills et al., 2018; Myers et al., 2018; Somé, 1993).

Thus, we propose a culturally syntonic community healing framework pertaining to racial trauma that highlights justice-informed outcomes demonstrated in psychology and health literatures. In so doing, the Community Healing and Resistance Through Storytelling (C-HeARTS) framework is delineated. Our framework synthesizes the existing scholarship on racial trauma and healing strategies to reflect the multiple processes associated with community healing. To establish a common language within the racial trauma scholarship, community healing is first defined. Next, justice as a foundational concept is discussed before we elaborate on the roles of two proposed culturally syntonic mechanisms: storytelling and resistance. Finally, we review and synthesize the literature on trauma and healing to illustrate three psychological dimensions and accompanying collective interventions that together inform processes that promote community healing. Ultimately, our goal is to advance community as an agent of change while centering justice and the important role of cultural practices to facilitate community healing.

Community Healing

Community and *healing* are often separate concepts in scholarly discourse, whereas *community healing* is rarely discussed in psychological literature. Although *community* has multiple meanings, community as locality (e.g., neighborhood) and community as a relational group without place restrictions (e.g., membership in a labor union) are two salient distinctions made in the social sciences (Bradford, 2017; Kloos et al., 2012). Irrespective of disciplinary lens, most concepts of community reflect a sense of connectedness—through geography, shared history, culture, a sense of belonging, influence, the fulfillment of needs, and effective mediums of communication (Farwell & Cole, 2002; McMillan & Chavis, 1986). What is also emphasized here is that community is a collective change agent, a "unit of solution in society" through which people can proactively address trauma-related problems within their locality and relational groups (Checkoway, 1995, p. 3).

Like the term community, *healing* is a positively described term that lacks an easily recognizable definition. Some healing definitions emphasize spirituality. In Latino ethnic psychology, healing and *sabiduría* are interlinked. Sabiduría is to perceive illness as a spiritual development opportunity that requires personal evolvement and connectedness with others (Comas-Díaz, 2006). While healing is more readily understood as physiological and behavioral improvements, healing is often perceived as an individual journey toward wellness that involves the personal transcendence of suffering (Egnew, 2005). However, other definitions of healing rooted in trauma scholarship indicate that creating a collective memory is a key aspect of healing trauma that

involves transitioning an individual's private pain to the public domain (Puvimanasinghe & Price, 2016; Stepakoff et al., 2006). When personal healing is embedded within a communal framework, we argue that a greater transformational process will be facilitated by a shared collective memory, which can help shift bodies, minds, and spirits from a status of suffering to repair and create opportunities to evolve (Myers, 2013; Somé, 1993).

Given the importance ascribed to the terms community and healing, the existence of *community healing* scholarship is a reasonable expectation. To date, a body of literature that promotes communal practices, and increasing critical consciousness has been unfolding for over 20 years within Indigenous (Brave Heart & DeBruyn, 1998; Duran et al., 2008; Kowanko et al., 2009; Warry, 1998) and African-centered scholarship (Akbar et al., 1980; Grills & Rowe, 1998; Kambon, 1992; Myers, 1993). Identifying links between prevalent psychosocial diseases (e.g., suicidality) among North American Indigenous peoples and macrostructures (e.g., colonialism) resulted in the coining of the term "historical trauma" and the development of the Historical Trauma and Unresolved Grief (HTUG) Intervention for American Indians (Brave Heart, 2003; Brave Heart & DeBruyn, 1998).

Using the HTUG model, Brave Heart and DeBruyn (1998) described American Indian participants' community healing as occurring through facilitated communal grief rituals that incorporate traditional practices (e.g., storytelling) and involve extended kin networks. Engaging in these processes had a positive impact on participants' identity formation, a sense of belonging, recognition of a shared history, and future survival of the group (Brave Heart & DeBruyn, 1998). A major outcome of their community healing engagement processes was the Takini Network, a Lakota Nation holocaust survivors' association that provides historical trauma training to human service providers (Brave Heart & DeBruyn, 1998). Other structural-focused community healing approaches used by North American Indigenous communities have included the following: (a) designing culturally appropriate health care initiatives such as the People Awakening Team, an Alaska Native people's project that records life stories in narrative format to identify protective variables that prevent alcohol abuse (Duran et al., 2008); and (b) restoring cultural values, language, and traditions by establishing a Sagamok First Nation controlled school (Warry, 1998).

From an African-centered perspective, healing is a community endeavor that involves maintaining a harmonious balance between the spiritual realm and physical world (Jackson-Lowman, 2004; Mariette, 2013; Somé, 1993). This holistic perspective regards animate life forms and inanimate objects as divine sources of energy within an African metaphysical hierarchy: God, gods, spirits, ancestors, and then humans (Omonzejele, 2008). God is considered the

supreme source of healing from which all sources of healing are derived. Special deities (e.g., *Osanyin* and *Agwu*, Yoruba and Igbo deities, respectively) and spirits are guardians who guide the curative use of nature's vast healing energies (Opoku, 1978; Washington, 2010). (Re)establishing spiritual harmony with one's ancestors is a healing prerequisite that allows for access to special cures (Omonzejele, 2008). To meet human needs, the interdependency of a community creates opportunities to achieve what is difficult to achieve alone when the following commitments are upheld: unity, trust, openness, love and caring, uplifting elders who are the collective memory of the community, respect for nature's medicinal wisdom, and honoring the ancestors (Somé, 1993). Cultural healing practices may include specific rituals, drumming, dancing, singing, and storytelling (Monteiro & Wall, 2011; Somé, 1993; Stepakoff et al., 2006). While African concepts of wellness generally characterize a person's health status as a communal affair, it also characterizes human knowledge as limited: incapable of explaining all that exists on Earth and beyond (Fu-Kiau, 1991). Therefore, healing is predicated on the maintenance of positive relations between humans and the spiritual realm, nature, and among fellow human beings (Jackson-Lowman, 2004; Omonzejele, 2008; Opoku, 1978).

Mental and physical pain represents a soul seeking realignment with the spiritual world, restoration of inner power, and the opportunity to grow (Fu-Kiau, 1991; Somé, 1993). Operating from an African-centered worldview, the Community Healing Network and the Association of Black Psychologists sought to heal soul wounds within Africana communities. They jointly developed Emotional Emancipation Circles (EECs) to expose historical trauma and overturn "the pernicious lies of Black inferiority [narratives that] fall under the broader rubric of racism" (Grills et al., 2016, p. 337). EECs are designed to be safe cultural spaces for people of African ancestry to share their stories and engage in critical community reflection through a facilitated group process. While engendering self-determination and cultural integrity, the sign of an effective EEC is the development of civically engaged participants organizing community actions that reduce systemic violence in Africana communities (Grills et al., 2016).

Racial trauma occurs within an oppressive sociopolitical context (Comas-Díaz et al., 2019). Treatment models that promote a client's resistance strategies (e.g., filing charges against racist perpetrators and lobbying for antiracist policies; Bryant-Davis & Ocampo, 2006); social action (e.g., framing racism as a form of ethnoviolence while advocating for racial equality; Comas-Díaz, 2016); and connections among individuals, families, and communities to their collective cultural strengths (Chavez-Dueñas et al., 2019) highlight the importance of critical consciousness in the healing process. The need for clinical solutions is important but limited without community healing interventions

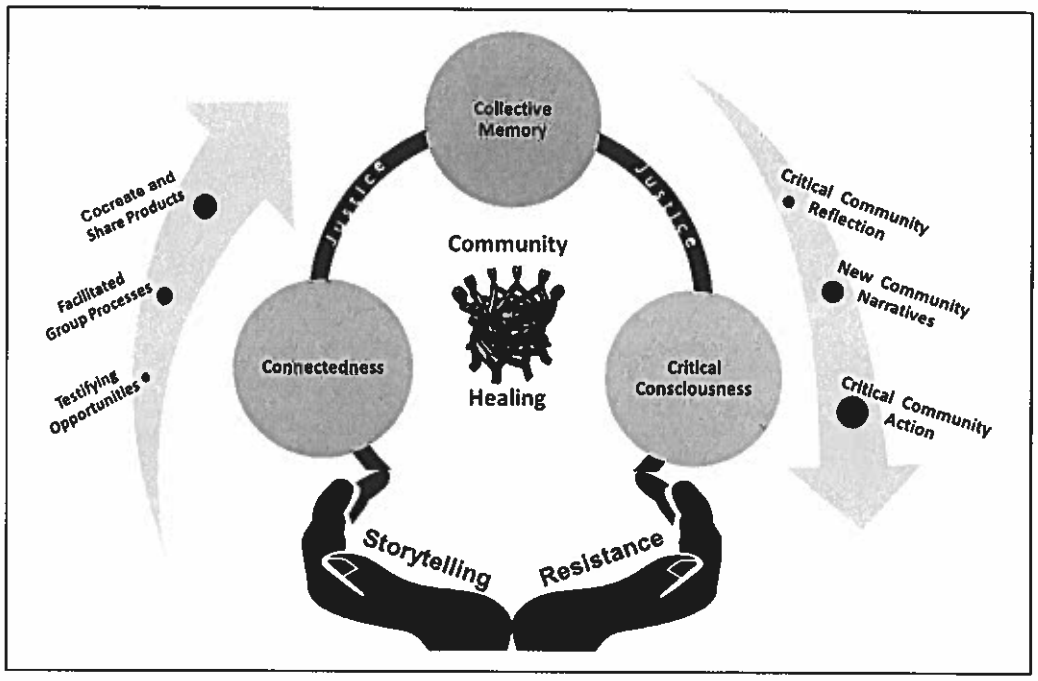

Figure 1. C-HeARTS framework.

that develop collective critical discourse and actions to dismantle systems of oppression (Grills et al., 2016; Hartmann et al., 2019). Therefore, the community healing concept emphasizes collective responsibility and advances a critical consciousness that resists disempowerment using culturally restorative practices to enable self-determined realities, which should be understood as justice (Fanon, 2018; McCaslin, 2005).

Based on our review of community healing scholarship, we argue that community healing is a multilevel process that is composed of three components as illustrated in Figure 1. First, at the core of community healing is justice; a guiding principle that is both a condition of and outcome of community healing (Myers et al., 2018; Prilleltensky, 2012). Second, culturally syntonic processes working in tandem, such as storytelling and resistance, may facilitate the renarrating of trauma and serve as motivating factors that bring behaviors into focus and ideas into action (Burkett, 2017; Harrell, 2015; Myers, 2013). Finally, community healing consists of three key psychological dimensions: connectedness, collective memory, and critical consciousness. We integrate these various perspectives to define community healing as *an ongoing multilevel process whereby oppressed groups strengthen their connectedness and collective memory through culturally syntonic processes in ways that promote critical consciousness to achieve optimal states of justice.*

C-HeARTS Framework

Justice

If "justice is what love looks like in public" (West, 2014), then justice in the United States is obscure, at best, for significant numbers of African descent people (Alexander, 2012). When examining racial trauma within Africana communities, the meaning of mental health and well-being within an oppressive context cannot be ignored (Anderson & Stevenson, 2019; Myers & Speight, 2010). For example, with the overpolicing of predominately Africana communities, research indicates that a disproportionate number of Black women are incarcerated (approximately 19%) or under correctional surveillance and experience high rates of depression (Malcolme et al., 2019). Black males have greater dire encounters with the police (e.g., increased negative perceptions of their personhood) and are twice as likely to be killed by the police before the age of 21 years compared with their White male counterparts (Harris & Amutah-Onukagha, 2019). Thus, conceptualized as a moral ideal in the C-HeARTS framework, *justice* is a commitment to right interrelationships between the spiritual realm, nature, and among humans; it encompasses ethical behaviors such as seeking truth, harmony, balance, and reciprocity (Karenga, 2004).

By centralizing justice as a guiding principle within healing, a community's status will more profoundly shift from suffering to thriving when justice-informed outcomes are promoted at multiple psychosocial levels (Myers et al., 2018; Prilleltensky, 2012; Watts et al., 2011). Centralizing justice requires assessing, what Prilleltensky (2012) described as, objective well-being (e.g., access to food, nonabusive relationships, adequate pay, and a clean environment) and subjective well-being (e.g., perceptions of life satisfaction, emotional support, positive working climate, and freedom to express political opinions). Objective and subjective indicators of well-being occur within three spheres of life: (a) personal sphere (e.g., feeling safe and accepted; more access to social capital); (b) interpersonal sphere (e.g., making decisions; fair sharing of obligations and privileges); and (c) organizational sphere (e.g., reward and effort are aligned; systems in place to promote fairness). When both indicators of well-being are promoted in each sphere of life, then realizing justice-informed outcomes are experienced at higher levels of thriving (Prilleltensky, 2012). Centralizing justice will also call public attention to the fact that "soul wounds—the cumulative psychological wounds that result from historical traumatic experiences, such as colonization, genocide, slavery, dislocation, and other related trauma"—are as detrimental as bodily wounds (Comas-Díaz et al., 2019, p. 2).

Equally important, justice is incomplete without embodying cultural integrity. For example, *Moving to the Beat*, a 4-year social action research project used hip hop as a language of social change to generate a "social therapeutic space" between youth in Sierra Leone and the United States seeking positive collective identities that "encompasses the trauma, ideals, hopes and losses born of their common and differing histories" (Haaken et al., 2012, p. 64). Similarly, African American youth residing in violent and underresourced neighborhoods reported that the development of urban dance cultures (e.g., Krumping) cultivated sacred community healing spaces that allowed them to make statements, construct collective identities, elevate the importance of their lives, and reconnect to their spirit (Monteiro & Wall, 2011). In other words, achieving justice requires a community to proactively engage its cultural systems to experience justice as healing (McCaslin, 2005).

Culturally Syntonic Processes: The Roles of Storytelling and Resistance

Culturally syntonic processes in the C-HeARTS framework are understood to be "historical, socio-politically-situated, and organizing . . . patterns of being, believing, bonding, belonging, behaving, and becoming" that are evident, for example, in communication styles and healing practices among a group of people with shared identities or defining experiences (Harrell, 2015, p. 19). For a community to function optimally (i.e., justly), culturally syntonic processes that involve storytelling and resistance will likely nurture community bonds (Banks-Wallace, 2002) and direct the development of a community action plan grounded in cultural wisdom (Armah, 2010; Mariette, 2013; Myers & Speight, 2010; Woods, 2009). Thus, storytelling in tandem with resistance are proposed culturally syntonic processes deemed appropriate for Africana communities to support the renarrating of trauma and act as conduits for transformation (Denham, 2008).

Storytelling. Although not unique to Africana communities, storytelling is a rich oral tradition found to be an effective healing intervention (Brave Heart & DeBruyn, 1998; Bryant-Davis & Ocampo, 2006; Carter, 2007; Comas-Díaz, 2007). Narrative therapy and testimonio, as two examples, involve the process of sharing one's personal stories with others to facilitate reprocessing and reframing negative cognitions to positive cognitions (Comas-Díaz, 2016; Parks, 2007). A *story* is an umbrella term that includes a *personal story* (i.e., idiosyncratic cognitive representations of events) and a *narrative* (i.e., communal representations of commonly experienced events;

Mankowski & Rappaport, 2000). Two distinct narrative subtypes exist. A *community narrative* is a common story about the group itself in a particular setting, consisting of personal and paralleling stories among group members; whereas a *dominant cultural narrative* is an overlearned (positive or negative) story communicated by major socializing institutions, often controlled by powerful people in a society, that impact the identities, beliefs, and values of the populace (Mankowski & Rappaport, 2000).

Increasingly, among racial trauma survivors, the legacy of historical trauma in presenting symptomology is being acknowledged (Comas-Díaz, 2016; Duran et al., 2008; Jernigan & Daniel, 2011). Storytelling not only facilitates an understanding of human behavior, it also functions as a tool for resisting oppression (Comas-Díaz, 2016; Denham, 2008), fostering healing (Sunwolf, 2005), and promoting spiritual communion (Banks-Wallace, 1998; 2002). In community settings, storytelling has contributed to restoring cultural identities (Lawson-Te Aho, 2014), building a sense of community (Mankowski & Rappaport, 2000), and serving as counterhegemonic stories to refute negative stories about oppressed groups (Bell, 2003; Haaken et al., 2012). Therefore, as a response to racial trauma, storytelling approaches (e.g., testimony therapy, sociotherapy, and digital storytelling) have been incorporated into treatment plans (Bryant-Davis & Ocampo, 2006; Carter, 2007; Comas-Díaz, 2007) and community healing practices (Grills et al., 2016).

Resistance. A critical understanding of the sociopolitical movements of Africana communities (e.g., antilynching, Pan African, and Black Power) reveals an ongoing struggle for community healing, whereby resistance coupled with cultural tools and liberatory practices nurture organized collective demands for justice (Myers et al., 2018). Resistance is conceptualized as the dynamic interplay between self-determination and defiance. *Self-determination* is the process of choosing thoughts and behaviors that positively shapes one's destiny; it drives the fulfillment of human needs and is a desired end state (Bulhan, 1985). Historically through social movements, Africana communities equated self-determination with freedom, and therefore pursued ideas and experiences that defied the status quo. *Defiance* allowed for intentional planning to achieve more adaptive conditions that may ensure the realization of (individual and collective) self-determined goals (Gordon, 2004). The review of the literature on culturally syntonic processes, considered together, has demonstrated that storytelling about and resistance to obstructive or destructive systems of oppression is a healthy response that cultivates opportunities for community healing (Burkett, 2017).

Three Psychological Dimensions

The overview of the literature thus far highlights key factors necessary to promote community healing within the C-HeARTS framework. Synthesizing research on storytelling, resistance, and justice, we now demonstrate the specific ways that three psychological dimensions—connectedness, collective memory, and critical consciousness—may contribute to community healing processes. As summarized in Table 1, we propose that community healing is advanced when collective interventions and liberatory practices are used to promote justice-informed outcomes that can be assessed using objective and subjective indicators of well-being within three spheres of life (i.e., personal, interpersonal, and organizational). To lend credibility to our proposal, we review the literature on each psychological dimension emphasizing the role of storytelling and resistance in community healing. Then, we succinctly review relevant psychological and health related literature to provide suggested collective interventions and accompanying justice-informed outcomes.

Dimension I: Connectedness. A multidimensional concept consisting of mutual interdependence, a shared identity, and a sense of belonging, connectedness includes relationships between the mental, physical, emotional, and spiritual realms of people and their environments (Hill, 2006; Nobles, 1991; Schiele, 1996). A sense of connectedness may result in fostering a heightened sense of comfort or wellness, and reducing anxiety (Hagerty et al., 1993), while increasing access to social support and the ability to effectively engage in daily functioning among traumatized individuals (Stepakoff et al., 2006). Within a personal sphere of life, connectedness can be fostered through understanding, validating, and nurturing individual experiences. Storytelling and resistance have been found to provide opportunities for tellers to self-reflect on their experiences, and witnesses to gain insight into their own lives when they understand how others have overcome similar challenges (East et al., 2010). Listening attentively and avoiding judgmental feedback encourages the teller to halt self-rejecting thoughts and negative emotions, which serves to validate shared trauma (Comas-Díaz, 2016; Richters et al., 2008). Such validation nurtures connections with both the self and the collective because there is a refocusing on the teller's strengths and redeemable qualities (Banks-Wallace, 1998). Given that promoting and maintaining connectedness is vital for community healing (Schultz et al., 2016), we propose that collective interventions, such as testifying opportunities and facilitating group processes, help participants experience connectedness, thereby, making justice-informed outcomes possible.

Table 1. C-HeARTS Framework: Psychological Dimensions, Culturally Syntonic Processes, Collective Intervention Examples, and Justice-Informed Outcomes.

Three psychological dimensions and key components	Culturally syntonic processes	Collective intervention examples	Justice-informed outcomes		
			Spheres of life	Objective indicators of well-being	Subjective indicators of well-being
Dimension I: Connectedness					
Understand	Storytelling promotes understanding, validates shared trauma, and nurtures community bonds; while resistance diminishes psychological states of indifference, devaluation of the self and others, and ruptured community ties.	Testifying opportunities	Personal	Reduced symptoms of depression, more smiling, less crying	Feeling safe, accepted, respected
Validate		Facilitated group processes		More access to social bonding and social capital	Life satisfaction evaluations, perceived sense of control
Nurture					
Dimension II: Collective memory					
Trust	Storytelling promotes trust in the group processes, recall of historical traumas and triumphs, and psychological decolonization; while resistance disrupts interpersonal distrust, historical amnesia, and inaccurate personal stories and distorted community narratives.	Cocreate and share products	Interpersonal	Exercise voice and choice, growth in relationship	Feeling heard, sense of growth as person and unit, making decisions
Remember		Critical community reflection		Fair sharing of obligations and privileges	Feeling valued and respected, not taken for granted, free of stereotypes
Decolonize					
Dimension III: Critical consciousness					
Empower	Storytelling promotes personal empowerment, collective organizing, and advocacy for community needs; while resistance helps reduce disempowering thought patterns, inertia, and systemic inequities.	New community narratives	Organizational	Opportunities to express opinions, exercise control, and to build and display strengths	Feeling that reward and effort are aligned, control and demands are aligned, satisfaction with competency level
Organize		Critical community action		Policies, procedures, and practices that respect all individuals equally, systems in place to promote fairness	Being treated with fairness and respect, perceiving collaborators as fair and equitable
Advocate					

Collective intervention examples and justice-informed outcomes. Testifying opportunities, like testimony therapy or "testimonio" invite survivors and community members to resist internalizing blame through first-person testimonio accounts. With the community bearing witness, first-person accounts include pre-trauma experiences that can provide emotional release, validate and document the storyteller's lived experience, and facilitate posttraumatic meaning making (Akinyela, 2005; Aron, 1992; Cienfuegos & Monelli, 1983). Testimonials in the form of collaborative poems that depicted trauma and memory cloths that connected recent history with personal tragedies enabled West African survivors of torture and civil war to step outside their pain and bear witness to an ethnopolitical phenomenon (Stepakoff et al., 2006). These public truth telling experiences contributed to reduced depression and traumatic stress, while it increased access to social bonding and social capital: objective indicators of well-being (Stepakoff et al., 2006). Testifying opportunities for war-affected Mayan children in Guatemala were designed as a creative workshop that encouraged participants to engage in cultural activities (e.g., making masks, weaving, and storytelling; Farwell & Cole, 2002). Subjective indicators of well-being were noted when the workshops not only helped children and their parents to better understand their collective trauma but also inspired their feelings of safety, acceptance, and respect in ways that allowed them to actively nurture their social bonds.

The revolutionary psychiatrist Frantz Fanon recognized the link between oppression and mental health among colonized communities in Africa. He advocated for the use of sociotherapy, a communal healing strategy, to support social bonding and rebuilding communities among patients in psychiatric institutions (Fanon, 2018). Sociotherapy is a facilitated group process that addresses mental health and well-being, and has been found to be particularly effective in the aftermath of war and political violence (Richters et al., 2008). Characterized as the "community acting as a doctor," sociotherapy groups are comprised of phases (e.g., safety, care, and respect) and guiding principles (e.g., democracy, nondirectivity, and a focus on reality) that inform core procedural rules (e.g., two-way communication, shared decision making, and collaborative leadership; Richters et al., 2008).

In 2005, sociotherapy groups were implemented in Rwanda to address ethnopolitical trauma. Groups included 10 to 12 individuals who lived in the same community and met for 2 to 3 hours weekly at a local venue for approximately 15 weeks, and each group was facilitated by trained group leaders, who were community residents (Richters et al., 2008). As social bonding and commitments to aid each other's well-being increased among participants, objective indicators of well-being were evident when participants gained greater access to social capital that could be leveraged for self and community needs. In a subsequent study, subjective indicators of well-being were

demonstrated. Selected from 10 sociotherapy groups, 100 Rwandan participants completed presurveys and postsurveys, in addition to an 8-month follow-up questionnaire, used to screen for common mental health disorders (Scholte et al., 2011). Compared with a demographically similar control group who did not participate in a sociotherapy intervention, experimental group participants reported better mental health; that is, greater perceived sense of control and higher levels of life satisfaction.

Dimension II: Collective memory. Collective memory, a group's shared understanding of the recent or distant past, is at the heart of psychological health (Zaromb et al., 2014). It aids in the healing process by unearthing the lived experiences of those whose histories have been hidden or erased from public record (Ainslie, 2013). Simultaneously, the exploration of a community's collective memory may limit the internalization of oppression by outlining how racial trauma is systemically embedded and institutionally perpetuated (Burkett, 2017; Grills et al., 2016; Myers et al., 2018).

To trust, remember, and decolonize minds help foster collective memory at the interpersonal sphere of life. Storytelling in a safe environment builds trust within group processes as community members resist interpersonal distrust that is tied to denigrating dominant cultural narratives (Case & Hunter, 2012; Farwell & Cole, 2002). With greater trust, opportunities to resist the perpetuation of historical amnesia can develop, allowing personal stories and community narratives that highlight traumas and triumphs to be actively remembered (Comas-Díaz, 2016; Rappaport, 2000). By helping community members interrogate their potentially inaccurate personal stories and distorted community narratives, storytelling and resistance may enhance their psychological decolonization process (Ainslie, 2013; Banks-Wallace, 1998; Comas-Díaz, 2016; Lawson-Te Aho, 2014). The goal is to promote movement from internalized oppression and self-blame to restoring self-worth, reestablishing a sense of competency, and grieving what has been lost due to historical trauma (Bulhan, 1985; David & Okazaki, 2006; Lawson-Te Aho, 2014). Thus, we propose that cocreating and sharing products such as digital stories (Rolón-Dow, 2011), memory cloths (Stepakoff et al., 2006), documentary films (Haaken et al., 2012), and dramatizations (Farwell & Cole, 2002), and using these products to aid critical community reflection, support the construction of a collective memory that may challenge dominant cultural narratives and give voice to pursuing justice-informed outcomes.

Collective intervention examples and justice-informed outcomes. Interventions that involve cocreating and sharing products, such as digital storytelling methods, are integral to reaching populations traditionally underserved in health research. With digital storytelling approaches, participants have

control over both the development and dissemination of their stories. They typically attend a group workshop to collaboratively tell a short story by learning how to produce a final (2- to 4-minute) digital product that incorporates multimedia (Briant et al., 2016). Briant et al. (2016), for example, interviewed Latinx cancer patients who created digital stories focused on cancer and found that their digital storytelling experience promoted the exercise of voice and choice, objective indicators of well-being (Prilleltensky, 2012). This exercise subsequently contributed to growth in their interpersonal relationships with family members who gained a deeper understanding of cancer as an illness. The digital storytellers also experienced subjective indicators of well-being such as, a sense of growth as a person and feeling heard regarding their illness. Tellers' heightened subjective well-being contributed to their ability to make more appropriate health-related decisions (e.g., eating healthier foods) with the support of their loved ones.

Opportunities for critical community reflection are important for naming, reengaging, and diminishing anger associated with historical trauma, and opening possibilities for developing a collective memory (Ainslie, 2013; Freire, 2000). An example of this can be found in relation to a long-standing historical trauma in a Texas community involving the "Sam Schwarz School," a segregated school for African American residents. The Sam Schwarz School was destroyed without the consent and despite the historical significance the school held for African American residents. Although the local school district had no official account of the school or its closing, decades later, a new building renamed the "Sam Schwarz Campus" was resurrected at the same site for students with academic/behavioral problems; and memories of positive community contributions were erased and became associated with deficiencies (Ainslie, 2013). Three interventions to promote community healing were developed: testimonial opportunities, a documentary film, and a public critical community reflection event. During the third intervention, African American alumni shared their educational successes and community narratives with all community members as witnesses. Several subjective indicators of well-being for the alumni emerged, such as feeling valued, not taken for granted, and disproving stereotypes. Important changes were also made by White school administrators that illustrated objective indicators of well-being, primarily, a fair sharing of obligations and privileges. For example, the academic/behavioral problems program was removed from the Sam Schwarz Campus, and a permanent display of African American alumni photographs and memorabilia were erected at the school district's office (Ainslie, 2013). Through critical community reflection, dominant cultural narratives were interrogated, which prompted actions to construct a more authentic collective memory that increased the visibility and significance of African American history in the community's collective memory.

Dimension III: Critical consciousness. Referring to the social, political, and economic forces shaping lived experiences and community well-being, critical consciousness is a process predicated on a person's belief in their ability to engage in actions that will produce change (i.e., political efficacy; Freire, 2000). Emerging data support key tenets of critical consciousness among Africana communities (Hope & Jagers, 2014). Specifically, among youth of African ancestry, data suggest that civic related actions contribute to both youth development (Sherrod et al., 2010) and the development of their communities (Watts & Flanagan, 2007). Data also suggest that an activism-oriented humanities curriculum that supports the development of particular character strengths (e.g., critical thinking about racial oppression as interpersonal, institutional, and internalized oppression) foster critical consciousness among youth to challenge oppressive systems (Seider et al., 2017). The crux of critical consciousness, thus, demands increasing the abilities of community members to address commonly identified concerns and taking action to challenge oppressive forces.

At the organizational sphere of life, vast opportunities for individuals to empower themselves, organize, and advocate for community needs through storytelling and collective acts of resistance are essential to critical consciousness. Telling counternarratives can empower storytellers because it creates occasions for them to name and debunk the larger dominant racial narrative, which is often hidden or denied. Additionally, storytellers are able to educate witnesses about an important social issue (Bell, 2016; Benmayor, 2008). Sharing stories using multimedia (e.g., flyers, web-videos, and blogs) may inform and galvanize others to organize. In the case of #BlackLivesMatter, people share video stories to stimulate critical awareness about long-standing state violence (e.g., police brutality) directed against people of African descent to encourage local communities to organize and demand changes (e.g., improve police-community relations, policies, and practices; Canella, 2017). Advocating for community needs can occur in multiple ways, whereby storytelling and resistance can reduce disempowering thought patterns, inertia, and systemic inequities that exclude oppressed communities (Hoffman & Mitchell, 2016; Kimball et al., 2016). Eleven-year-old student activist Naomi Walder (2018), for example, advocated for females of African descent who are omitted in dominant cultural narratives about gun violence in the United States. At *March for Our Lives* (a student antigun violence demonstration held in Washington, DC, on March 24, 2018), she issued a call to action: "I represent the African American girls [and women who are victims of gun violence but] whose stories don't make the front page of every national newspaper" because they "have been just numbers. . . . [H]elp me write the narrative for this world to understand so that these girls and women are never forgotten" (Walder, 2018). Because storytelling and acts of resistance reveal

injustices that have been silenced or ignored (Rappaport, 2000), we emphasize the role of liberatory practices, such as developing new community narratives and engaging in critical community action to develop critical consciousness (i.e., awareness, efficacy, and action).

Collective intervention examples and justice-informed outcomes. The community narratives and acts of resistance among Africana communities and other oppressed groups often get lost in dominant tropes of pathology (e.g., Black inferiority and criminality; Alexander, 2012; Grills et al., 2016). Hence, revealing the disempowering role of community narratives is a crucial step toward constructing liberatory narratives that cultivate community healing (Rappaport, 2000). Developing new community narratives played a pivotal role in the achievement of justice-informed outcomes for an oppressed group of non-English speaking Latinx immigrant parents who became grassroots organizers (Balcazar et al., 2012). A local nonprofit agency, the Hispanic Center (HC, a pseudonym provided by Balcazar et al., 2012), was tasked with serving the Latinx community's needs. Parents who have children with disabilities reported multiple challenges during interactions with HC. An ongoing challenge was that their requests for advanced American Sign Language classes were ignored; and when they persisted, HC representatives threatened to report parents' undocumented status to government officials. While grappling with these and other oppressive experiences, 10 to 15 parents were also participating in a community-university partnership, a facilitated group process that consisted of advocacy skills training (Balcazar et al., 2012). Once parents developed a new community narrative (e.g., critical awareness about their disadvantages, strengths, and actions that could transform their circumstances), they began advocating for themselves and created a grassroots organization that led to several objective indicators of well-being: expressing their opinions, exercising control, and displaying their strengths. Subjective indicators of well-being were also apparent: feeling that reward and efforts were aligned (e.g., receiving child care assistance when a family provided transportation); and experiencing a greater alignment between having control of resources and being able to meet demands (e.g., securing funding to offer American Sign Language classes and providing translation services). In stark contrast to their interactions with HC, parents' community narrative no longer depicted their community as victims of externally controlled circumstances, but rather increasingly competent change agents capable of addressing their families' needs and transforming their social realities.

Expanding possibilities for new community narratives that foster community healing is "impossible without a commitment to transform, and there is

no transformation without [critical community] action" (Freire, 2000, p. 87). As one example, 13 identified leaders narrated audio and video recorded stories about the evolution of *Movimiento Autonomo de Mujeres* (Autonomous Women's Movement; Grabe & Dutt, 2015). Despite women's active participation in the Nicaraguan Revolution as supporters, combatants, and appointees to high-ranking ministerial positions in the newly established *Frente Sandinsta de Liberación Nacional* (Sandinista National Liberation Front) government in 1979, women's gender counternarratives remained marginalized (Grabe & Dutt, 2015). Seeking political autonomy, women organized and constructed new community narratives that promoted inclusive attitudes toward human rights; their new narratives led to critical community action, such as the national "United in Diversity" meeting held in 1992 to establish the political platform of the newly formed *Movimiento Autonomo de Mujeres*. Comprising 150 independent women's groups representing 38 locations across Nicaragua, Movimiento was designed as a diverse multisector organization that implemented policies, procedures, and practices which respect all members equally (e.g., historically marginalized Afro-Nicaraguan communities), and enabled systems to be put in place that promoted fairness. These objective indicators of well-being were coupled with subjective indicators of well-being, such as feeling valued, as well as perceiving one's role as meaningful and collaborations as equitable. Over 20 years of critical community actions resulted in the passage of two important laws: the 1996 Law Against Domestic Violence and the 2012 Integral Law Against Violence Toward Women (Grabe & Dutt, 2015).

Summary of C-HeARTS Framework

Community healing is propelled by culturally syntonic processes coupled with liberatory practices that influence three psychological dimensions to promote justice-informed outcomes. Establishing connectedness involves storytelling to foster understanding, validate shared trauma, and nurture community bonds; while resistance diminishes psychological states of indifference, devaluation of the self and others, and ruptured community ties. At the personal sphere of life, testimonies have helped to make private pain a community issue anchored within a sociopolitical context; and through collaboration, a more comprehensive understanding of reality has been generated among testifying participants that served to validate their experiences (Farwell & Cole, 2002). Similarly, sociotherapy groups are beneficial and generate healing through the interplay of communal principles and practices that encourage group members to care for each other and resolve their challenges (Fanon, 2018; Richters et al., 2010).

Collective memory provides a cognitive map to reexamine (former) ways of being and behavioral patterns that can guide community healing (Stepakoff et al., 2006). At the interpersonal sphere of life, developing collective memory is enhanced when storytelling is used to promote trust in the group process, recall of historical traumas and triumphs, and psychological decolonization; while resistance disrupts interpersonal distrust, historical amnesia, and both inaccurate personal stories and distorted community narratives. Cocreating products enhances a sense of personal growth and a deeper understanding of shared journeys; and disseminating cocreated products is important for those who may feel their voices are ignored, undervalued, or simply denied (Briant et al., 2016). Furthermore, engaging in critical community reflection where cocreated products are used to interrogate dominant cultural narratives is a liberatory practice that may help authenticate collective memory (Ainslie, 2013).

Critical consciousness prepares community members to become civically engaged to address concerns directly affecting their communities (Watts et al., 2011). Fostering critical consciousness may be attained through storytelling to promote personal empowerment, collective organizing, and advocacy for community needs; while resistance helps to reduce disempowering thought patterns, inertia, and systemic inequities. At the organizational sphere of life, critical consciousness involves the development of new community narratives and partaking in critical community action. The importance of new community narratives are twofold: sources of racial trauma can be better understood, that is, more clearly connected to larger structural and historical issues (Bell, 2016); and the specific ways in which communities map out paths of resistance can be articulated. Meanwhile, progressing from discussing to envisioning and then implementing transformation requires critical community action to bring justice-informed outcomes into fruition (Bell, 2010).

Next Steps in the C-HeARTS Framework

Through the integration and review of multidisciplinary theory, research, and practice, we developed the C-HeARTS framework to advance an understanding of community healing. The theoretical underpinnings have been explicated and empirical research is now required to test the sequence of the proposed processes. As currently conceptualized, C-HeARTS has a number of limitations. The framework delineates multiple processes that contribute to community healing. However, the framework does not include an exhaustive review of all processes that potentially contribute to community healing nor does it outline how these processes operate beyond the personal,

interpersonal, and organizational spheres of life (Bronfenbrenner & Morris, 2006; Prilleltensky, 2012). Numerous scholars have suggested that storytelling and resistance are culturally syntonic mechanisms, but how (or if) they work together to support movement through the psychological dimensions have not been explored. Case studies could assess the presence and perceived function of storytelling and resistance within healing groups. Within the C-HeARTS framework, within group differences in motivations for, engagement in, and outcomes of community healing were not explored. To date, the published literature includes examples of community healing when communities share identities (e.g., ethnicity) and trauma experiences (e.g., survivors of torture and war). Additional racial trauma research is needed to understand the intersection of within group differences (e.g., gender, religiosity, and worldview) and community healing. A further limitation is lack of clarity as to whether the proposed processes operate similarly depending on the characteristics of the community. A longitudinal study design and the use of mixed methods could assess (a) whether more or less psychological dimensions exist, (b) whether the sequencing of the proposed psychological dimensions occur in a particular direction, and (c) whether both the proposed psychological dimensions and the sequencing of dimensions are necessary to achieve justice-informed outcomes. It is important to note that community healing may not occur without costs, which are being conceptualized and explored in the extant literature as professional burnout, compassion fatigue, activism burnout, and vicarious trauma (Hernandez-Wolfe et al., 2015; Vaccaro & Mena, 2011). Additional research is necessary to understand the various challenges of the community healing process. Despite these limitations, the C-HeARTS framework may serve to guide how new and existing groups engaging in healing processes progress toward their goals; assess what outcomes are prevalent; and identify if objective and subjective indicators of well-being occur within the three spheres of life, while documenting the nature and quality of well-being indicators.

Enhancing transformative healing possibilities requires a framework that helps agents of change proactively shift their oppressed group's status from victims to victors by promoting justice-informed outcomes within three fundamental spheres of life. The solution to racial trauma is not to effectively integrate oppressed groups into oppressive systems that maintain them as "beings for others" rather than "beings for themselves" (Freire, 2000, p. 74). Of utmost importance is healing approaches should enable oppressed groups to transform oppressive systems. To this end, we offer the C-HeARTS framework as one approach for Africana communities and other oppressed groups to become beings for themselves that acknowledges historical trauma and the importance of sociocultural resources to facilitate community healing.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research and/or authorship of this article: The research for this article was supported by the Illinois Program for Research in the Humanities.

ORCID iDs

Nkechinyelum A. Chioneso https://orcid.org/0000-0003-4129-5469
Carla D. Hunter https://orcid.org/0000-0001-9660-2898
Shardé McNeil Smith https://orcid.org/0000-0002-9310-2369

References

Ainslie, R. C. (2013). Intervention strategies for addressing collective trauma: Healing communities ravaged by racial strife. *Psychoanalysis, Culture & Society*, *18*(2), 140-152. https://doi.org/10.1057/pcs.2013.3

Akbar, N., Saafir, R. K., & Granberry-Stewart, D. (1980). Readings for mental health and human service workers in the Black community. In The Community Clinical Psychology Project of the Southern Regional Educational Board (Ed.), *Community psychology and systems interventions* (pp. 97-147). Southern Regional Educational Board.

Akinyela, M. K. (2005). Testimony of hope: African centered praxis for therapeutic ends. *Journal of Systemic Therapies*, *24*(1), 5-18. https://doi.org/10.1521/jsyt.2005.24.1.5

Alexander, M. (2012). *The new Jim Crow: Mass incarceration in the age of color-blindness*. New Press.

Anderson, R. E., McKenny, M., Mitchell, A., Koku, L., & Stevenson, H. C. (2018). EMBRacing racial stress and trauma: Preliminary feasibility and coping responses of a racial socialization intervention. *Journal of Black Psychology*, *44*(1), 25-46. https://doi.org/10.1177/0095798417732930

Anderson, R. E., & Stevenson, H. C. (2019). RECASTing racial stress and trauma: Theorizing the healing potential of racial socialization in families. *American Psychologist*, *74*(1), 63-75. https://doi.org/10.1037/amp0000392

Armah, A. K. (2010). *Remembering the dismembered continent*. Per Ankh.

Aron, A. (1992). Testiminio, a bridge between psychotherapy and sociotherapy. *Women & Therapy*, *13*(3), 173-189. https://doi.org/10.1300/J015V13N03_01

Balcazar, F. E., Suarez-Balcazar, Y., Adames, S. B., Keys, C. B., García-Ramírez, M., & Paloma, V. (2012). A case study of liberation among Latino immigrant families who have children with disabilities. *American Journal of Community Psychology*, *49*(1-2), 283-293. https://doi.org/10.1007/s10464-011-9447-9

Banks-Wallace, J. (1998). Emancipatory potential of storytelling in a group. *Journal of Nursing Scholarship*, *30*(1), 17-21. https://doi.org/10.1111/j.1547-5069.1998.tb01230.x

Banks-Wallace, J. (2002). Talk that talk: Storytelling and analysis rooted in African American oral tradition. *Qualitative Health Research*, *12*(3), 410-426. https://doi.org/10.1177/104973202129119892

Bell, L. A. (2003). Telling tales: What stories can teach us about racism. *Race, Ethnicity and Education*, *6*(1), 3-28. https://doi.org/10.1080/1361332032000044567

Bell, L. A. (2010). *Storytelling for social justice: Connecting narrative and the arts in antiracist teaching*. Routledge.

Bell, L. A. (2016). Telling on racism: Developing a race-conscious agenda. In H. A. Neville, M. Gallardo, & D. W. Sue (Eds.), *The myth of racial color blindness: Manifestations, dynamics, and impact* (pp. 105-122). American Psychological Association.

Benmayor, R. (2008). Digital storytelling as a signature pedagogy for the new humanities. *Arts and Humanities in Higher Education*, *7*(2), 188-204. https://doi.org/10.1177/1474022208088648

Bradford, J. H. (2017). Selfies, subtweets, and suicide: Social media as mediator and agitator of mental health for Black women. In S. Y. Evans, K. Bell, & N. K. Burton (Eds.), *Black women's mental health: Balancing strength and vulnerability* (pp. 75-86). SUNY Press.

Brave Heart, M. Y. H. (2003). The historical trauma response among Natives and its relationship with substance abuse: A Lakota illustration. *Journal of Psychoactive Drugs*, *35*(1), 7-13. https://doi.org/10.1080/02791072.2003.10399988

Brave Heart, M. Y. H., & DeBruyn, L. (1998). The American Indian holocaust: Healing historical unresolved grief. *American Indian and Alaska Native Mental Health Research*, *8*(2), 60-82. https://doi.org/10.5820/aian.0802.1998.60

Briant, K. J., Halter, A., Marchello, N., Escareno, M., & Thompson, B. (2016). The power of digital storytelling as a culturally relevant health promotion tool. *Health Promotion Practice*, *17*(6), 773-801. https://doi.org/10.1037/1099-9809.12.1.1

Bronfenbrenner, U., & Morris, P. A. (2006). The bioecological model of human development. In W. Damon & R. M. Lerner (Eds.), *Handbook of child psychology: Vol. 1. Theoretical models of human development* (6th ed., pp. 793-828). John Wiley.

Bryant-Davis, T., & Ocampo, C. (2006). A therapeutic approach to the treatment of racist-incident-based trauma. *Journal of Emotional Abuse*, *6*(4), 1-22. https://doi.org/10.1300/J135v06n04_01

Bulhan, H. A. (1985). *Frantz Fanon and the psychology of oppression*. Plenum Press.

Burkett, C. A. (2017). Obstructed use: Reconceptualizing the mental health (help-seeking) experiences of Black Americans. *Journal of Black Psychology*, *43*(8), 813-835. https://doi.org/10.1177/0095798417691381

Canella, G. (2017). Social movement documentary practices: Digital storytelling, social media and organizing. *Digital Creativity*, *28*(1), 24-37. https://doi.org/10.1080/14626268.2017.1289227

Carter, R. T. (2007). Racism and psychological and emotional injury: Recognizing and assessing race-based traumatic stress. *The Counseling Psychologist*, *35*(1), 13-105. https://doi.org/10.1177/0011000006292033

Case, A. D., & Hunter, C. D. (2012). Counterspaces: A unit of analysis for understanding the role of settings in marginalized individuals' adaptive responses to

oppression. *American Journal of Community Psychology*, *50*(1-2), 257-270. https://doi.org/10.1007/s10464-012-9497-7

Chavez-Dueñas, N. Y., Adames, H. Y., Perez-Chavez, J. G., & Salas, S. P. (2019). Healing ethno-racial trauma in Latinx immigrant communities: Cultivating hope, resistance, and action. *American Psychologist*, *74*(1), 49-52. https://doi.org/10.1037/amp0000289

Checkoway, B. (1995). Six strategies of community change. *Community Development Journal*, *30*(1), 2-20. https://doi.org/10.1093/cdj/30.1.2

Cienfuegos, A. J., & Monelli, C. (1983). The testimony of political repression as a therapeutic instrument. *American Journal of Orthopsychiatry*, *53*(1), 43-51. https://doi.org/10.1111/j.1939-0025.1983.tb03348.x

Comas-Díaz, L. (2006). Latino healing: The integration of ethnic psychology into psychotherapy. *Psychotherapy: Theory, Research, Practice, Training*, *43*(4), 436-453. https://doi.org/10.1037/0033-3204.43.4.436

Comas-Díaz, L. (2007). Ethnopolitical psychology: Healing and transformation. In E. Aladrondo (Ed.), *Advancing social justice through clinical practice* (pp. 91-118). Lawrence Erlbaum.

Comas-Díaz, L. (2016). Racial trauma recovery: A race-informed therapeutic approach to racial wounds. In A. N. Alvarez, C. T. H. Liang, & H. A. Neville (Eds.), *The cost of racism to people of color: Contextualizing experiences of discrimination* (pp. 341-375). American Psychological Association.

Comas-Díaz, L., Hall, G. N., & Neville, H. A. (2019). Racial trauma: Theory, research, and healing: Introduction to the special issue. *American Psychologist*, *74*(1), 1-5. https://doi.org/10.1037/amp0000442

David, E. J. R., & Okazaki, S. (2006). Colonial mentality: A review and recommendations for Filipino American Psychology. *Cultural Diversity and Ethnic Minority Psychology*, *12*(1), 1-16. https://doi.org/10.1037/1099-9809.12.1.1

Denham, A. R. (2008). Rethinking historical trauma: Narratives of resilience. *Transcultural Psychiatry*, *45*(3), 391-414. https://doi.org/10.1177/1363461508094673

Duran, E., Firehammer, J., & Gonzalez, J. (2008). Liberation psychology as the path toward healing cultural soul wounds. *Journal of Counseling & Development*, *86*(3), 288-295. https://doi.org/10.1002/j.1556-6678.2008.tb00511.x

East, L., Jackson, D., O'Brien, L., & Peters, K. (2010). Storytelling: An approach that can help to develop resilience. *Nurse Researcher*, *17*(3), 17-25. https://doi.org/10.7748/nr2010.04.17.3.17.c7742

Egnew, T. R. (2005). The meaning of healing: Transcending suffering. *Annals of Family Medicine*, *3*(3), 255-262. https://doi.org/10.1370/afm.313

Fanon, F. (2018). *Alienation and freedom*. Bloomsbury Academic.

Farwell, N., & Cole, J. B. (2002). Community as a context of healing: Psychosocial recovery of children affected by war and political violence. *International Journal of Mental Health*, *30*(4), 19-41. https://doi.org/10.1080/00207411.2001.11449530

Freire, P. (2000). *Pedagogy of the oppressed* (30th anniversary ed.). Continuum.

French, B. H., Lewis, J. A., Mosley, D., Adames, H. Y., Chavez- Dueñas, N. Y., Chen, G. A., & Neville, H. A. (2019). Toward a psychological framework of radical healing in communities of color. *The Counseling Psychologist, 48*(1), 14-46. https://doi.org/10.1177/0011000019843506

Fu-Kiau, K. K. B. (1991). *Self-healing power and therapy: Old teachings from Africa.* Black Classic Press.

Gordon, E. W. (2004). Defiance: Variation on the theme of resilience. In R. L. Jones (Ed.), *Black psychology* (4th ed., pp. 117-127). Cobb & Henry.

Grabe, S., & Dutt, A. (2015). Counter narratives, the psychology of liberation, and the evolution of a women's social movement in Nicaragua. *Peace and Conflict: Journal of Peace Psychology, 21*(1), 89-105. https://doi.org/10.1037/pac0000080

Graham, J. R., West, L. M., Martinez, J., & Roemer, L. (2016). The mediating role of internalized racism in the relationship between racist experiences and anxiety symptoms in a Black American sample. *Cultural Diversity and Ethnic Minority Psychology, 22*(3), 369-376. https://doi.org/10.1037/cdp0000073

Grills, C., Aird, E., & Rowe, D. (2016). Breathe, baby, breathe: Clearing the way for the emotional emancipation of Black people. *Cultural Studies Critical Methodologies, 16*(3), 333-343. https://doi.org/10.1177/1532708616634839

Grills, C., Nobles, W., & Hill, C. (2018). African, Black, neither or both? Models and strategies developed and implemented by the Association of Black Psychologists. *Journal of Black Psychology, 44*(8), 791-826. https://doi.org/10.1177/0095798418813660

Grills, C., & Rowe, D. (1998). African traditional medicine: Implications for African-centered approaches to healing. In R. L. Jones (Ed.), *African American mental health: Theory, research, and intervention* (pp. 71-100). Cobb & Henry.

Haaken, J., Wallin-Ruschman, J., & Patange, S. (2012). Global hip-hop identities: Black youth, psychoanalytic action research, and the *Moving to the Beat* project. *Journal of Community & Applied Social Psychology, 22*(1), 63-74. https://doi.org/10.1002/casp.1097

Hagerty, B., Lynch-Sauer, J., Patusky, K., & Bouwsema, M. (1993). An emerging theory of human relatedness. *Journal of Nursing Scholarship, 25*(4), 291-296. https://doi.org/10.1111/j.1547-5069.1993.tb00262.x

Harrell, S. P. (2015). Culture, wellness, and world "PEaCE": An introduction to person-environment-and-culture-emergence theory. *Community Psychology in Global Perspective, 1*(1), 16-49. https://doi.org/10.1285/i24212113v1i1p16

Harris, A., & Amutah-Onukagha, N. (2019). Under the radar: Strategies used by Black mothers to prepare their sons for potential police interactions. *Journal of Black Psychology, 45*(6-7), 439-453. https://doi.org/10.1177/0095798419887069

Hartmann, W. E., Wendt, D. C., Burrage, R. L., Pomerville, A., & Gone, J. P. (2019). American Indian historical trauma: Anticolonial prescriptions for healing, resilience, and survivance. *American Psychologist, 74*(1), 6-19. https://doi.org/10.1037/amp0000326

Helms, J. E., Nicolas, G., & Green, C. E. (2010). Racism and ethnoviolence as trauma: Enhancing professional training. *Traumatology, 16*(1), 53-62. https://doi.org/10.1177/1534765610389595

Hernandez-Wolfe, P., Killian, K., Engstrom, D., & Gangsei, D. (2015). Vicarious resilience, vicarious trauma, and awareness of equity in trauma work. *Journal of Humanistic Psychology*, *55*(2), 153-172. https://doi.org/10.1177/0022167814534322

Hill, D. L. (2006). Sense of belonging as connectedness, American Indian worldview, and mental health. *Archives of Psychiatric Nursing*, *20*(5), 210-216. https://doi.org/10.1016/j.apnu.2006.04.003

Hoffman, G. D., & Mitchell, T. D. (2016). Making diversity "everyone's business": A discourse analysis of institutional responses to student activism for equity and inclusion. *Journal of Diversity in Higher Education*, *9*(3), 277-289. https://doi.org/10.1037/dhe0000037

Hope, E. C., & Jagers, R. J. (2014). The role of sociopolitical attitudes and civic education in the civic engagement of Black youth. *Journal of Research on Adolescence*, *24*(3), 460-470. https://doi.org/10.1111/jora.12117

Jackson-Lowman, H. (2004). Perspectives on Afrikan American mental health: Lessons from Afrikan systems. In R. L. Jones (Ed.), *Black psychology* (4th ed., pp. 599-628). Cobb & Henry.

Jernigan, M. M., & Daniel, J. H. (2011). Racial trauma in the lives of Black children and adolescents: Challenges and clinical implications. *Journal of Child & Adolescent Trauma*, *4*(2), 123-141. https://doi.org/10.1080/19361521.2011.574678

Kaholokula, J. K. A. (2016). Racism and physical health disparities. In A. N. Alvarez, C. T. H. Liang, & H. A. Neville (Eds.), *The cost of racism for people of color: Contextualizing experiences of discrimination* (pp. 163-188). American Psychological Association.

Kambon, K. K. K. (1992). *The African personality in America: An African-centered framework*. Nubian Nation.

Karenga, M. (2004). *Maat, The moral ideal in ancient Egypt: A study in classical African ethics*. Routledge.

Karlsen, S., Nazroo, J. Y., McKenzie, K., Bhui, K., & Weich, S. (2005). Racism, psychosis and common mental disorder among ethnic minority groups in England. *Psychological Medicine*, *35*(12), 1795-1803. https://doi.org/10.1017/S0033291705005830

Kendall-Tackett, K. (2009). Psychological trauma and physical health: A psychoneuroimmunology approach to etiology of negative health effects and possible interventions. *Psychological Trauma: Research, Practice, and Policy*, *1*(1), 35-48. https://doi.org/10.1037/a0015128

Kimball, E. W., Moore, A., Vaccaro, A., Troiana, P. F., & Newman, B. M. (2016). College students with disabilities redefine activism: Self-advocacy, storytelling, and collective action. *Journal of Diversity in Higher Education*, *9*(3), 245-260. https://doi.org/10.1037/dhe0000031

Kloos, B., Hill, J., Thomas, E., Wandersman, A., Elias, M., & Dalton, J. (2012). *Community psychology: Linking individuals and communities*. Cengage Learning.

Kowanko, I., Stewart, T., Power, C., Fraser, R., Love, I., & Bromley, T. (2009). An aboriginal family and community healing program in metropolitan Adelaide: Description and evaluation. *Australian Indigenous Health Bulletin*, *9*(4), 1-12. http://hdl.handle.net/2328/26334

100

Lawson-Te Aho, K. (2014). The healing is in the pain: Revisiting and re-narrating trauma histories as a starting point for healing. *Psychology and Developing Societies*, *26*(2), 181-212. https://doi.org/10.1177/0971333614549139

Malcolme, M. L. D., Fedock, G., Garthe, R. C., Golder, S., Higgins, G., & Logan, T. K. (2019). Weathering probation and parole: The protective role of social support on Black women's recent stressful events and depressive symptoms. *Journal of Black Psychology*, *45*(8), 661-688. https://doi:10.1177/0095798419889755

Mankowski, E. S., & Rappaport, J. (2000). Narrative concepts and analysis in spiritually-based communities. *Journal of Community Psychology*, *28*(5), 479-493. https://doi.org/10.1002/1520-6629

Mariette, G. C. (2013). International healing and collaboration structures. *Journal of Black Psychology, 39*(3), 261-268. https://doi.org/10.1177/0095798413478077

McCaslin, W. (2005). *Justice as healing: Indigenous ways*. Living Justice Press.

McMillan, D. W., & Chavis, D. M. (1986). Sense of community: A definition and theory. *Journal of Community Psychology*, *14*(1), 6-23. https://doi.org/10.1002/1520-6629(198601)14:1%3C6::AID-JCOP2290140103%3E3.0.CO;2-I

Monteiro, N. M., & Wall, D. J. (2011). African dance as healing modality throughout the diaspora: The use of ritual and movement to work through trauma. *Journal of Pan African Studies*, *4*(6), 234-252.

Myers, L. J. (1993). *Understanding an Afrocentric world view: Introduction to an optimal psychology* (2nd ed.). Kendall/Hunt.

Myers, L. J. (2013). Restoration of spirit: An African-centered communal health model. *Journal of Black Psychology*, *39*(3), 257-260. https://doi.org/10.1177/0095798413478080

Myers, L. J., Anderson, M., Lodge, T., Speight, S., & Queener, J. E. (2018). Optimal theory's contributions to understanding and surmounting global challenges to humanity. *Journal of Black Psychology*, *44*(8), 747-771. https://doi.org/10.1177/0095798418813240

Myers, L. J., & Speight, S. (2010). Reframing mental health and psychological well-being among persons of African descent: Africana/Black psychology meeting the challenges of fractured social and cultural realities. *Journal of Pan African Studies*, *3*(8), 66-82.

Nadal, K. L. (2018). Racial microaggressions and trauma. In K. L Nadal (Ed.), *Concise guides on trauma care series: Microaggressions and traumatic stress: Theory, research, and clinical treatment* (pp. 53-70). American Psychological Association. https://doi.org/10.1037/0000073-004

Nobles, W. (1991). Extended self: Rethinking the so-called Negro self-concept. In R. Jones (Ed.), *Black psychology* (3rd ed., pp. 295-305). Cobb & Henry.

Omonzejele, P. (2008). African concepts of health, disease, and treatment: An ethical inquiry. *Explore*, *4*(2), 120-126. https://doi.org/10.1016/j.explore.2007.12.001

Opoku, K. A. (1978). *West African traditional religion*. FEP International.

Parks., F. M. (2007). Working with narratives: Coping strategies in African American folk beliefs and traditional healing practices. *Journal of Human Behavior in the Social Environment*, *15*(1), 135-147. https://doi.org/10.1300/J137v15n01_07

Pieterse, A. L., Carter, R. T., Evans, S. A., & Walter, R. (2010). An exploratory examination of the associations among racial and ethnic discrimination, racial climate, and trauma-related symptoms in a college student population. *Journal of Counseling Psychology*, *57*(3), 255-263. https://doi.org/10.1037/a0020040

Pieterse, A. L., Todd, N. R., Neville, H. A., & Carter, R. T. (2012). Perceived racism and mental health among Black American adults: A meta-analytic review. *Journal of Counseling Psychology*, *59*(1), 1-9. https://doi.org/10.1037/a0026208

Polanco-Roman, L., Danies, A., & Anglin, D. M. (2016). Racial discrimination as race-based trauma, coping strategies, and dissociative symptoms among emerging adults. *Psychological Trauma: Theory, Research, Practice, and Policy*, *8*(5), 609-617. http://dx.doi.org/10.1037/tra0000125

Prilleltensky, I. (2012). Wellness as fairness. *American Journal of Community Psychology*, *49*(1-2), 1-21. https://doi.org/10.1007/s10464-011-9448-8

Puvimanasinghe, T. S., & Price, I. R. (2016). Healing through giving testimony: An empirical study with Sri Lankan torture survivors. *Transcultural Psychiatry*, *53*(5), 531-550. https://doi.org/10.1177/1363461516651361

Rappaport, J. (2000). Community narratives: Tales of terror and joy. *American Journal of Community Psychology*, *28*(1), 1-24. https://doi.org/10.1023/A:1005161528817

Reitz, J., & Banerjee, R. (2007). Racial inequality, social cohesion and policy issues in Canada. In K. Banting, T. Courchene, & F. Seidle (Eds.), *Belonging? Diversity, recognition and shared citizenship in Canada* (pp. 489-545). McGill-Queen's University Press.

Richters, A., Dekker, C., & Scholte, W. F. (2008). Community based sociotherapy in Byumba, Rwanda. *Intervention*, *6*(2), 100-116. https://doi.org/10.1097/WTF.0b013e328307ed33

Richters, A., Rutayisire, T., Sewimfura, T., & Ngendahayo, E. (2010). Psychotrauma, healing and reconciliation in Rwanda: The contribution of community-based sociotherapy. *African Journal of Traumatic Stress*, *1*(2), 55-63.

Riina, E. M., Martin, A., Gardner, M., & Brooks-Gunn, J. (2013). Context matters: Links between neighborhood discrimination, neighborhood cohesion and African American adolescents' adjustment. *Journal of Youth and Adolescence*, *42*(1), 136-146. https://doi.org/10.1007/s10964-012-9804-5

Rolón-Dow, R. (2011). Race(ing) stories: Digital storytelling as a tool for critical race scholarship. *Race Ethnicity and Education*, *14*(2), 159-173. https://doi.org/10.1080/13613324.2010.519975

Schiele, J. H. (1996). Afrocentricity: An emerging paradigm in social work practice. *Social Work*, *41*(3), 284-294. https://doi.org/10.1093/sw/41.3.284

Scholte, W. F., Verduin, F., Kamperman, A. M., Rutayisire, T., Zwinderman, A. H., & Stronks, K. (2011). The effect on mental health of a large scale psychosocial intervention for survivors of mass violence: A quasi-experimental study in Rwanda. *PLOS ONE*, *6*(8), Article e21819. https://doi.org/10.1371/journal.pone.0021819

Schultz, K., Cattaneo, L. B., Sabina, C., Brunner, L., Jackson, S., & Serrata, J. V. (2016). Key roles of community connectedness in healing from trauma. *Psychology of Violence*, *6*(1), 42-48. https://doi.org/10.1037/vio0000025

Seider, S., Tamerat, J., Clark, S., & Soutter, M. (2017). Investigating adolescents' critical consciousness development through a character framework. *Journal of Youth and Adolescence, 46*(6), 1162-1178. https://doi.org/10.1007/s10964-017-0641-4

Sherrod, L. R., Torney-Purta, J., & Flanagan, C. A. (2010). *Handbook of research on civic engagement in youth*. John Wiley.

Somé, M. P. (1993). *Ritual: Power, healing, and community*. Penguin Group.

Stepakoff, S., Hubbard, J., Katoh, M., Falk, E., Mikulu, J.-B., Nkhoma, P., & Omagwa, Y. (2006). Trauma healing in refugee camps in Guinea: A psychosocial program for Liberian and Sierra Leonean survivors of torture and war. *American Psychologist, 61*(8), 921-932. https://doi.org/10.1037/0003-066X.61.8.921

Sunwolf. (2005). R_x storysharing, prn: Stories as medicine. *Storytelling Self Society, 1*(2), 1-10. https://doi.org/10.1080/15505340509490262

Vaccaro, A., & Mena, J. A. (2011). It's not burnout, it's more: Queer college activists of color and mental health. *Journal of Gay, & Lesbian Mental Health, 15*(4), 339-367. https://doi.org/10.1080/19359705.2011.600656

Walder, N. (2018, March 24). *Speech at march for our lives*. https://www.youtube.com/watch?v=KiQaIaI9xmk

Warry, W. (1998). *Unfinished dreams: Community healing and the reality of Aboriginal self-government*. University of Toronto Press.

Washington, K. (2010). Zulu traditional healing, Afrikan worldview and the practice of Ubuntu: Deep thought for Afrikan/Black Psychology. *Journal of Pan African Studies, 3*(8), 24-39.

Watts, R. J., Diemer, M. A., & Voight, A. M. (2011). Critical consciousness: Current status and future directions. *New Directions for Child and Adolescent Development, 2011*(134), 43-57. https://doi.org/10.1002/cd.310

Watts, R. J., & Flanagan, C. (2007). Pushing the envelope on youth civic engagement: A developmental and liberation psychology perspective. *Journal of Community Psychology, 35*(6), 779-792. https://doi.org/10.1002/jcop.20178

West, C. (2014, February, 24). *Cornel West talks to David Shuster: Al Jazeera America*. http://america.aljazeera.com/watch/shows/talk-to-al-jazeera/interviews-and-more/2014/2/24/cornel-west-talkstodavidshuster.html

Williams, M. T., Metzger, I. W., Leins, C., & DeLapp, C. (2018). Assessing racial trauma within a DSM-5 framework: The UConn racial/ethnic stress and trauma survey. *Practice Innovations, 3*(3), 242-260. https://doi:10.1037/pri0000076

Woods, V. D. (2009). African American health initiative planning project: A social ecological approach utilizing community-based participatory research methods. *Journal of Black Psychology, 35*(2), 247-270. https://doi.org/10.1177/0095798409333589

Zaromb, F., Butler, A. C., Agarwal, P. K., & Roediger, H. L. (2014). Collective memories of three wars in United States history in younger and older adults. *Memory & Cognition, 42*(3), 383-399. https://doi.org/10.3758/s13421-013-0369-7

CHAMPAIGN COUNTY

EXPENDITURE APPROVAL LIST

6/05/20 PAGE 1

VENDOR NO	VENDOR NAME	TRN DTE	B N	TR CD	TRANS NO	PO NO	CHECK NUMBER	CHECK DATE	ACCOUNT NUMBER	ACCOUNT DESCRIPTION	ITEM DESCRIPTION	EXPENDITURE AMOUNT
*** FUND NO. 090 MENTAL HEALTH												
*** DEPT NO. 053 MENTAL HEALTH BOARD												
41	CHAMPAIGN COUNTY TREASURER								HEALTH INSUR FND 620			
		5/13/20	01	VR 620-	70		607895	5/15/20	090-053-513.06-00	EMPLOYEE HEALTH/LIFE INS	MAY HI, LI & ADMIN	3,951.15
		6/03/20	04	VR 620-	80		608323	6/05/20	090-053-513.06-00	EMPLOYEE HEALTH/LIFE INS	JUN-AUG LIFEWORKS	29.70
											VENDOR TOTAL	3,980.85 *
88	CHAMPAIGN COUNTY TREASURER								I.M.R.F. FUND 088			
		5/13/20	01	VR 88-	15		607899	5/15/20	090-053-513.02-00	IMRF - EMPLOYER COST	IMRF 5/8 PR	1,148.05
		5/28/20	01	VR 88-	16		608226	5/29/20	090-053-513.02-00	IMRF - EMPLOYER COST	IMRF 5/22 PR	1,148.05
											VENDOR TOTAL	2,296.10 *
96	CHAMPAIGN COUNTY TREASURER								T & A ADVANCES			
		5/26/20	01	VR 53-	159		608227	5/29/20	090-053-533.07-00	PROFESSIONAL SERVICES	TD 3464 MCMANUS 4/2	500.00
											VENDOR TOTAL	500.00 *
176	CHAMPAIGN COUNTY TREASURER								SELF-FUND INS FND476			
		5/28/20	01	VR 119-	29		608229	5/29/20	090-053-513.04-00	WORKERS' COMPENSATION INS	W/C 5/1, 8, 22 PR	210.54
											VENDOR TOTAL	210.54 *
188	CHAMPAIGN COUNTY TREASURER								SOCIAL SECUR FUND188			
		5/13/20	01	VR 188-	33		607903	5/15/20	090-053-513.01-00	SOCIAL SECURITY-EMPLOYER	FICA 5/8 PR	1,201.44
		5/28/20	01	VR 188-	36		608231	5/29/20	090-053-513.01-00	SOCIAL SECURITY-EMPLOYER	FICA 5/22 PR	1,201.47
											VENDOR TOTAL	2,402.91 *
18430	CONSOLIDATED COMMUNICATIONS											
		5/19/20	05	VR 28-	40		608080	5/22/20	090-053-533.33-00	TELEPHONE SERVICE	21738437760 5/1	28.98
											VENDOR TOTAL	28.98 *
27970	FREDERICK & HAGLE											
		5/19/20	05	VR 53-	166		608096	5/22/20	090-053-533.07-00	PROFESSIONAL SERVICES	2HR APR 5/4	440.00
											VENDOR TOTAL	440.00 *

CHAMPAIGN COUNTY

EXPENDITURE APPROVAL LIST

6/05/20 PAGE 2

VENDOR NO	VENDOR NAME	TRN DTE	B N	TR CD	TRANS NO	PO NO	CHECK NUMBER	CHECK DATE	ACCOUNT NUMBER	ACCOUNT DESCRIPTION	ITEM DESCRIPTION	EXPENDITURE AMOUNT
*** FUND NO. 090 MENTAL HEALTH												
78888	VISA CARDMEMBER SERVICE - MENTAL HEALTH AC#4798510049573930											
		5/28/20	05 VR	53-	167		608288	5/29/20	090-053-533.29-00	COMPUTER/INF TCH SERVICES	3930 ADOBE 4/9	11.24-
		5/28/20	05 VR	53-	167		608288	5/29/20	090-053-533.98-00	DISABILITY EXPO	3930 EZ LOCK 4/9	2,040.00
		5/28/20	05 VR	53-	167		608288	5/29/20	090-053-533.93-00	DUES AND LICENSES	3930 ARC OF IL 4/15	51.69
											VENDOR TOTAL	2,080.45 *
81610	XEROX CORPORATION											
		5/28/20	05 VR	53-	169		608297	5/29/20	090-053-533.85-00	PHOTOCOPY SERVICES	INV 230218511 2/8	285.89
											VENDOR TOTAL	285.89 *
604568	CANFIELD, LYNN									MENTAL HEALTH BOARD		
		5/28/20	05 VR	53-	168		608301	5/29/20	090-053-533.12-00	JOB-REQUIRED TRAVEL EXP	25 MILE 5/12-16	14.38
		5/28/20	05 VR	53-	168		608301	5/29/20	090-053-522.02-00	OFFICE SUPPLIES	REIM MASKS 5/16	50.00
											VENDOR TOTAL	64.38 *
										MENTAL HEALTH BOARD	DEPARTMENT TOTAL	12,290.10 *
										MENTAL HEALTH	FUND TOTAL	12,290.10 *