Community Visions for Public Mental Health Services in Chicago: Findings from Citywide Listening Sessions & Survey
## Contents

Executive Summary .................................................. 3
Introduction .................................................................. 5
Literature Review ....................................................... 6

### Study Methodology ................................................ 9
  - Listening Sessions .............................................. 9
  - Community Survey ........................................... 11

### Key Findings ....................................................... 13
  - Promoting Service Accessibility ............................. 14
  - Establishing Inclusive, Culturally Affirming, and Community-Centered Spaces .................................................. 18
  - Hiring Staff Who Can Address Holistic Needs, Who are Trauma-Informed, and Who Understand the Lived Experiences of the Community Members Who They Serve ............................................ 22
  - Creating Systems that Provide a Continuum of Preventative and Crisis Response Care Through a Trauma-Informed Lens .................................................. 28
  - Implementing Accountability Mechanisms for Ensuring High-Quality Service Delivery .............................................. 32

### Recommendations & Timeline ................................ 33
  - Our Long-Term Demands ..................................... 35
  - A Reiteration of our Key Findings/Themes ............... 36
  - Priority Elements within Community Wellness Centers ........................................................................................................... 37
    - Incremental Service Needs & Considerations ........ 38
    - Space Needs & Considerations ........................... 40
    - Incremental Staff Needs & Considerations .......... 41
  - Priority Elements within Crisis Response ............... 43
  - Timeline .............................................................. 45
    - Goals for Current Year ...................................... 45
    - Goals for This Administrative Term .................. 46
    - The Following Administrative Term .................. 48
  - Implementation Needs & Considerations ................ 49

Notes ............................................................................ 51
Chicago suffers from high rates of concentrated poverty, unemployment, violence, incarceration, overdose, and health inequality exacerbated by the progressive withdrawal of public support systems over the last three decades. These intersecting problems disproportionately affect Black and Latinx neighborhoods, many of which suffer from especially poor access to mental health care and supportive social services.

Since the beginning of the Johnson administration, the City of Chicago has made a public commitment to reinvesting in a public infrastructure of care – one that prioritizes the re-opening of barrier-free, publicly-funded and publicly-operated mental health centers, as well as the creation and scaling of a fully non-police crisis response for behavioral crises that occur. At the close of 2023, the administration created a Working Group that brought together city officials and key community stakeholders to perform research and build out the implementation plan of Treatment Not Trauma (TNT). TNT is a plan that seeks to break the cycle of trauma, violence, and poverty with a public health model for community mental health and shared safety that invests in a community care worker corps backed by City-run mental health centers integrated with both mental health crisis call lines and non-police crisis response teams. The TNT Campaign spent Q1 of 2024 holding listening sessions throughout the city to gather a community-driven perspective of what needed to be considered for the further opening of mental health centers and services in the city, as well as the ways in which we should scale our non-police crisis response.
The biggest themes that we found over the course of six in-person and one virtual listening session, as well as a citywide survey, was 5-fold:

1. Ensuring that we’re centering service awareness & accessibility
2. Creating centers that are inclusive, culturally affirming, and community-centered
3. Staffing our centers and services with individuals that have lived experiences and can relate to the day-to-day challenges of community members
4. Integrating preventative care through the centers with interventive care through crisis response
5. Empowering local systems of accountability to adapt and make changes needed to our local communities.

Not only is the reopening of our centers and scaling of the non-police crisis teams incredibly urgent, but it is paramount that it’s done so in partnership with our diverse communities across this city. We have an opportunity to build the model for Community Care – one that centers the needs of those most vulnerable, one that is focused on creating infrastructure that cares rather than criminalizes, and one that can be a model for cities around the country. Our goal is that this report gives a clear view of the needs and demands of our communities in partnership with Mayor Brandon Johnson’s administration, who is committed to co-governance, as we look to work collaboratively to create and invest in what a public infrastructure of care truly looks like.
Recognizing how decades of disinvestment in public mental health services has severely limited mental health service access for individuals across Chicago, Mayor Brandon Johnson committed in his 2024 budget to rebuilding public mental health infrastructure. More specifically, he allocated $43.1 million to continue funding the five mental health centers currently operated through the Chicago Department of Public Health (CDPH) and to support opening two additional centers. Furthermore, $15.9 million will be invested in doubling the number of staff on CDPH’s CARE 911 alternate response team, which responds to 911 mental health-related calls by sending a Chicago Fire Department community paramedic and a CDPH mental health clinician to provide crisis intervention and de-escalation support, while phasing out the co-response teams involving police officers. With the Johnson administration’s commitment to expanding public mental health services, there is a unique opportunity to ensure that both preventative and crisis response services are built out in a way that is aligned with community needs and without the involvement of police. To help ensure that community perspectives are at the forefront of the planning process, the Collaborative for Community Wellness (CCW) hosted a series of listening sessions and implemented a community survey to hear directly from community members about their vision for services offered through the CDPH mental health centers and their vision for an expanded mental health crisis response system.
A synthesis of past research highlights the severe limitations in mental health service access through Chicago’s privatized, non-profit providers and points to some preliminary recommendations for building out preventative and crisis response services in the public sector. The Collaborative for Community Wellness (CCW) conducted a study between July and September 2023 to understand current mental health service accessibility among 32 city-funded, privatized providers that comprised the Trauma-Informed Centers of Care (TICC) network. In this study, the survey response themes demonstrated multiple barriers within the TICC network. Service access barriers included difficulty connecting with providers (42% of the sample), challenges navigating phone systems, waitlists for services (56% of the sample reported a wait of one month or longer), documentation status (63% of the sample did not offer services to undocumented individuals), insurance status, and cost. These barriers severely limit the extent to which Chicagoans can access mental health support in their moment of need, in spite of significant investment of federal COVID relief funding in this sector.

In recognizing the challenges with accessing mental health services through the private sector, CCW released a white paper in 2023 outlining a vision for expanding Chicago’s public mental health infrastructure to deliver preventative and crisis response services. The vision centered around expanding infrastructure in the areas of staffing and space to ensure that all Chicagoans can access emotional support in their moment of need. In the area of staffing, the white
paper outlined a vision for building a community care worker corps comprised of community residents and paraprofessionals who live in the areas served by each center, who can provide person-centered, culturally affirming services grounded in an understanding of the lived experiences of community members seeking services. In the area of space, the white paper highlighted the importance of both investing in the expansion of the five existing CDPH mental health centers and reopening the 14 centers that were closed under previous mayoral administrations.

Drawing on the living room model, the CCW recommended that at least three of the CDPH centers operate as 24-hour integrated service facilities that offer crisis intervention support. Living room models serve as an alternative for crisis response, supporting community members with de-escalation without the need for unnecessary hospitalization or incarceration. There currently are several living room spaces operated through private providers in Chicago where community members who are experiencing mental health crises can receive support on a walk-in basis. These living room spaces are generally 23-24 hour walk-in/drop-off spaces for individuals in crisis that are used as a diversion for psychiatric hospitalization. These spaces are most successful when staffed with individuals with lived experiences - generally as peer support specialists, that are supported by licensed workers. At the national level, the city of Denver, Colorado has established living room spaces that have capacity to serve as drop-off centers for first responders who encounter a community member who is actively in crisis, so that community members can receive crisis stabilization services within the living room space rather than being dropped off at a hospital emergency room. As highlighted in the CCW white paper, the integration of living room spaces within the CDPH mental health centers thus offers an opportunity to provide a continuum of preventative and crisis intervention services within a
single space to prevent involuntary hospitalization and other carceral responses. Similar to the recommendations around staffing models of the living room, CCW also recommended the employment of Community Care Workers as a part of both the clinical teams as well as the CARE (non-police crisis response) teams. As we see in models like Albuquerque’s Public Safety Department - there is ample opportunity for us to bring community workers into the crisis teams.

While the CCW white paper initiates a preliminary conversation regarding the expansion of public mental health infrastructure in the city of Chicago, we recognize that rebuilding Chicago’s public mental health infrastructure must be a community-engaged process. Outlined in the subsequent sections are a discussion of the methodology that we utilized to solicit community feedback on how the city of Chicago should expand public mental health services, the key findings that emerged, and recommendations for rebuilding the city’s public mental health infrastructure in a way that is aligned with community needs.
Study Methodology

Listening Sessions

Between February 15 and March 18, 2024, representatives from the Collaborative for Community Wellness (CCW) hosted a series of seven listening sessions across the city of Chicago. The aim of the listening sessions was to facilitate small group conversations where community members could share past experiences with public mental health services, if applicable, and their vision for public mental health services in the future. Four listening sessions were held at or in the vicinity of each of the currently operating CDPH mental health centers; a fifth and sixth session were held on the city’s southeast and northwest sides respectively; and a seventh session was conducted virtually via Zoom. All listening sessions were open to community members who had never received services at a public mental health center, former and current public mental health center program participants, and public mental health center service providers.
There were a total of 208 attendees across the 7 listening sessions, with the attendance at each session ranging from 10 to 75. At each listening session, individuals were assigned to small breakout groups ranging from 5 to 13 individuals per group. Each group had one facilitator and one note taker. Where groups had a mix of Spanish and English speakers, the City of Chicago provided an interpreter for live translation. Additionally, while most groups were conducted in English, a few were conducted in Spanish. Facilitators followed a focus group guide developed by representatives from the CCW with expertise in community-based and qualitative research. Each breakout group was assigned to focus on one of three subsets of questions organized according to themes, including outreach and accessibility, vision for centers and services, and mental health crisis response. Notes were compiled across all listening sessions and breakout groups. Four CCW representatives with expertise in qualitative research conducted a content analysis to identify salient themes.
To supplement the data collected through the listening sessions, representatives from the CCW with expertise in community-based research and survey design created an electronic survey consisting of closed and open-ended questions asking respondents to share their vision on how public mental health services can best meet community needs. The survey additionally included questions specifically for public mental health service providers and public mental health center program participants on their experiences working at or receiving services through the public mental health centers. The survey was intended for both listening session participants who wanted to share written feedback and for individuals who were unable to attend a listening session who wanted to share their recommendations for building out public mental health services. The survey was made available in both English and Spanish. It was distributed widely via an electronic link, and a phone number was also provided for prospective respondents who wished to speak with a CCW representative to complete the survey verbally. While there were a total of 223 surveys completed, eight of the responses indicated neither a Chicago Ward nor community area, so we had no evidence to say the respondent actually lived in Chicago. For example, one of the eight indicated living in a suburb. Consequently, the final sample was 215 surveys completed across 45 of Chicago’s 50 wards between January 27, 2024 and April 1, 2024.
Survey Demographics:

- Of the 215 respondents, 8 did not report their race/ethnicity, and 9 indicated they preferred not to say. Of the remaining 198, 25% reported Black or African American, 6% reported Asian, 26% reported Latino/a/e, 52% reported white; 2% reported Middle Eastern/North African, and less than 1% reported Native American or another race not listed. Respondents could choose more than one race/ethnicity, which is why totals added up to more than 100%.
- For gender, 5 respondents did not report a gender, and 1 said they preferred not to say. Of the remaining 209 respondents, 65% were women; 28% were men; 10% were transgender, non-binary, or gender diverse; and 1% reported a different identity. Again, respondents could pick more than one gender, which is why the totals are greater than 100%.
- The mean age was 39, while the median age was 36.
- The majority of respondents (94%) had never received services at the public mental health centers and did not work there. Staff at the centers made up 2% of respondents, while current or past users made up 3% of respondents.
- The majority of surveys were completed in English (98%), while 2% were completed in Spanish. While it would have been ideal to offer the survey in additional languages, given the linguistic diversity of the city, limited capacity meant this was not possible.
A central theme that emerged across listening sessions was the importance of ensuring that services offered through the public mental health centers are high quality. Listening session participants consistently recounted negative past experiences with mental health services, primarily through non-profit providers and hospitals, where they could not access services in their moment of need, where their needs and experiences were invalidated, where their autonomy was not respected, and where they were treated as subhuman. Participants specifically called out racism’s role: for example, they described how services were not available to people of color on Medicaid until they were in crisis. They also described how the majority of therapists were white men and women, creating a barrier to truly understanding their situation and providing culturally concordant care. While the majority of listening session participants had limited experience with the CDPH mental health centers, they noted that there is a general assumption that services offered through the public sector are inherently low quality. Listening session participants emphasized the importance of challenging this assumption and shifting this paradigm. For that reason, the expectation of high-quality services is at the core of all recommendations for expanding the services offered through the CDPH mental health centers. Outlined below are four key themes pertaining to service accessibility, space, staff, and systems of preventative and crisis response care that emerged as central to ensuring high-quality service delivery.
Promoting Service Accessibility

Through analysis of the focus group data, it is apparent that community members generally had limited knowledge of the CDPH mental health centers. The survey findings support this: of the 203 people who were not staff or service users, a small majority (51%) answered no to the question, “Do you know that the Chicago Department of Public Health currently operates five mental health centers where Chicagoans can access free mental health services?” Additionally, listening session participants had experienced multiple barriers to accessing services through the private sectors.

Achieving high-quality service delivery through the CDPH mental health centers first requires ensuring that community members can easily access these services. Included below are recommendations for promoting service accessibility by increasing awareness of the CDPH mental health centers and addressing access barriers that are commonly encountered through the private non-profit sector.

Culturally tailored outreach & information sharing. The vast majority of listening session participants were unaware of the services that are currently offered through the CDPH mental health centers. They noted that first and foremost, facilitating service access requires more intensive outreach and culturally tailored information dissemination to ensure that community members are aware of the services that are available. Outreach should encompass a range of strategies including promotion through social
media, flyers posted in well-traveled public spaces, advertisements through the television, radio, and newspaper, and door-to-door canvassing and mailers. Listening session participants additionally discussed that beyond sharing written materials, a comprehensive outreach strategy requires establishing relationships with local organizations and institutions in the surrounding community. More specifically, staff at CDPH mental health centers can collaborate with local public schools, libraries, park district locations, healthcare providers, non-profit organizations, religious institutions, and local businesses to offer presentations on public mental health services and establish referral partnerships. Survey results support these efforts: of the non-staff and non-participants who were aware of the services available at the CDPH mental health centers, 34% had learned about the services at a community presentation or event, 27% had learned about them from a friend or family member, and 22% had learned about them from another service provider. Similarly, when all non-staff and non-participants were asked to prioritize outreach strategies, 30% said outreach workers should engage the community, and 24% said CDPH should host community events. Another 24% said the priority should be outreach via social media, 12% said flyers/brochures, 8% said traditional media ads such as radio and TV, while 4% wrote in their own ideas. Hosting events that encourage interaction and engagement with the broader community, including pop-up events with food and family-centered activities and trainings on mental health related topics such as mental health first aid or self care, provide an additional opportunity to promote awareness about public mental health services in a way that is aligned with the specific community context in which each center is located. Lastly, outreach efforts should be inclusive of all age groups, with special consideration for identifying community partners who serve youth and older adult populations.
Addressing common access barriers. Listening session participants discussed that in Chicago’s current mental health service landscape, they consistently faced obstacles to accessing services through the private non-profit sector in their moment of need due to barriers including long waiting lists, service cost, insurance status, and limited services in close proximity. As such, another important component of promoting service accessibility is ensuring that services are free and without service caps, regardless of insurance status and immigration status, for all individuals at the time that they seek support, without requiring that they are placed on a waiting list. Furthermore, recognizing that transportation can pose a barrier particularly when services are not in the immediate vicinity of where an individual lives, listening session participants recommended that the CDPH mental health centers offer transportation assistance in accordance with an individual’s needs. Transportation assistance may include CTA passes and rideshare or other door-to-door transportation options when mobility or safety concerns prevent program participants from accessing public transportation. Survey respondents echoed these recommendations, with 81% saying centers should be close to an L or bus stop, 73% endorsing free CTA passes to get to appointments, 72% supporting free parking, and 58% saying free rideshare (Uber/Lyft) rides should be offered. Similarly, listening session participants recommended that virtual and in-home services be offered as an option when it is not possible for program participants to travel to the public mental health centers.

"IT'S IMPORTANT TO MAKE SURE THESE SERVICES ARE TRULY OBTAINABLE. OFTEN TIMES IT TAKES SO LONG TO REALLY GET COMMUNITY MEMBERS CONNECTED THAT THEY LOSE INTEREST OR HAVE AN EPISODE THAT REQUIRES MORE MEDICAL ATTENTION."

-COMMUNITY SURVEY RESPONDENT
Additional recommendations for addressing logistical barriers to service access included offering on-site childcare, in-home childcare, offering extended evening hours, and limiting the documents that are required to initiate services. The majority of survey respondents supported these measures (84% endorsed evening appointments, 80% backed telehealth options, and 76% supported free childcare; the survey did not ask about documentation). Lastly, recognizing that individuals may be deterred from initiating services when the process for scheduling an appointment is overly complex or cumbersome, listening session participants recommended that community members be given multiple options for scheduling an intake appointment, including the options to schedule in-person, over the phone, or online. The majority of survey participants backed the idea of being able to schedule online (81%), via a centralized intake hub (71%), and in-person (69%); the only option with less than majority support was scheduling via calling each center independently (41%).

Listening session participants additionally emphasized that phones should be answered directly by staff in order to prevent the challenge of navigating an automated phone system. With regard to the option of scheduling online, one specific recommendation that emerged was to have a centralized scheduling system where community members could select their preferred center location based on factors including proximity to their home and appointment availability.
Establishing Inclusive, Culturally Affirming, & Community-Centered Spaces

After ensuring that services are easily accessible, the second element of promoting high-quality service delivery centers around establishing spaces that are inclusive to and affirming of all community members who seek services within that space. Pivotal to these recommendations is a framing of the CDPH mental health centers as community hubs, which would best integrate the centers into the networks of support that Chicagoans already depend upon. Outlined below is an explanation of how to achieve this orientation to the community, as well as recommendations for establishing spaces that reflect a welcoming service environment and address the holistic needs of community members.

Public mental health centers can serve as community hubs.

In order to truly promote healing and holistic well-being, CDPH mental health centers must extend beyond alleviating mental health symptoms and addressing resource needs at the individual level. We heard repeatedly across listening sessions that individual wellness is integrally connected with community wellness.

Recognizing the interconnection between thriving individuals and thriving communities, public mental health centers should be viewed as community hubs that promote a sense of social connection and belonging. Listening session participants specifically discussed the importance of integrating public mental health centers within the broader community. Well-established relationships between the CDPH mental health centers and other institutions and organizations in the
surrounding community can help to ensure that the mental health centers become a space to promote connections with a larger network of community supports. CDPH mental health centers can serve this role by inviting local community entities into their space to offer classes, hold events, and post flyers. Similarly, two-thirds of survey respondents agreed that centers should offer art and recreational activities. CDPH mental health centers can also host events where they invite representatives from local community entities to participate alongside community members, including gallery events where they showcase the work of local artists. Listening session participants additionally recommended hosting events that allow for intergenerational exchange between youth and older adult community members, thus allowing unique opportunities to build community and learn from individuals at different developmental stages. Through these efforts to build spaces that are inclusive of and affirming to individuals and entities across the broader community in which each mental health center is located, CDPH mental health centers can facilitate opportunities to promote social connection and belonging that in turn promote emotional wellness at both the individual and community levels.

_Cultivating a welcoming service environment where people feel at ease accessing services._ Listening session participants consistently noted that ensuring high-quality service delivery requires establishing a space where individuals of all cultural identities and lived experiences feel safe walking through the door and participating in services. In turn, establishing an inclusive and culturally-affirming space requires creating a service environment where all individuals “feel at home.”
Listening session participants described the following two core components as being integral to the process of cultivating a welcoming service environment:

**Physical space:**
Recognizing that the process of participating in mental health services requires sharing deeply personal and often painful experiences, it is critical that the physical surroundings convey a sense of warmth and comfort. As such, listening session participants recommended painting the reception area and office spaces with warm and gentle colors, using soft and non-fluorescent lighting, having comfortable furniture and plants, and ensuring that both the exterior and interior of the building are clean and well-maintained. The design of the physical space should also be informed by the community context in which the center is located, with exterior and interior artwork and decorating that is reflective of the cultural backgrounds of community members in the area where the center is located. Listening session participants recommended integrating murals and artwork by local artists as part of these efforts to cultivate a welcoming physical space.

**Interactions between service providers & program participants:**
Listening session participants noted that just as an individual’s physical surroundings can help them to “feel at home” within an unfamiliar space, so too can their interactions in the reception area. From the moment that a community member opens the door and sets foot within the CDPH mental health center, they should be greeted warmly, offered water or a snack, provided with clear instructions on what to expect, and have their questions answered respectfully. Participants noted that where security personnel are necessary, their presence should be calming and helpful, not intimidating. Listening session participants additionally identified that if service providers are unable to communicate with a community member in their preferred language, efforts must be taken to provide interpretation services. All of these efforts to cultivate a welcoming service environment are instrumental to facilitating meaningful participation in service delivery.
Creating multi-service spaces that address holistic resource needs. Across listening sessions, participants consistently discussed the interconnection between emotional, material, medical, and social needs. Therefore, effectively supporting individuals in their healing journey requires that public mental health centers integrate a range of services within their space that promote holistic well-being. Survey respondents agreed, with solid majorities agreeing that the centers should provide each of the 14 services listed, ranging from family therapy to substance use services to grief support. Listening session participants recommended that the public mental health centers offer the following services:

- Individual, couples, and family mental health therapy, ensuring that providers are culturally affirming and well versed in a range of modalities, including art and music therapy.
- Specialized mental health services, including psychiatry and medication management, substance use services, violence recovery, and grief support.
- Health care and health education, including nutrition education.
- Case management services that use an accompaniment approach to assist community members with addressing the range of material resource needs that impact mental health, including food assistance, housing, financial assistance, public benefits enrollment, and employment support.
- A range of group services that promote opportunities for establishing social connections and expanding social support networks. Group services can include both mental health group therapy facilitated by mental health therapists and support groups facilitated by peer support specialists, who have similar lived experiences to community members who are seeking services. Peer support specialists could also work with volunteers to facilitate group enrichment activities, including art classes, recreation activities, or computer classes. Specific group offerings should be informed by feedback from community members. Lastly, in addition to these formal group offerings, listening session participants recommended that there be informal drop-in socialization spaces for adults and youth to build community in a fun, safe, and supportive environment.
- When asked to prioritize service offerings, 37% of survey respondents chose individual therapy, 15% chose psychiatric services, and 13% chose case management. The remaining 35% were split among an array of service choices, reinforcing the notion that multiple service options should be available.
Hiring Staff Who Can Address Holistic Needs, Who are Trauma-Informed, & Who Understand the Lived Experiences of the Community Members Who They Serve

"WE NEED TO THINK ABOUT MENTAL HEALTH AND TRAUMA SUPPORT MORE EXPANSIVELY AND GET AWAY FROM A MEDICAL MODEL APPROACH...WE NEED TRAUMA-INFORMED, ANTIRACIST, HEALTH EQUITY-FOCUSED SYSTEMS AND APPROACHES TO MAKE THESE CLINICS AS SUCCESSFUL AND EFFECTIVE AS POSSIBLE."
- COMMUNITY SURVEY RESPONDENT

In addition to promoting service accessibility and establishing spaces that are inclusive of and affirming to the broader community, another critical element to achieving high-quality service delivery is ensuring that staff at the CDPH mental health centers can address the needs of community members in a way that is trauma-informed and affirming of their lived experiences. Listening session participants offered recommendations to guide CDPH mental health center staff in providing effective support for community members in their healing journey. This feedback is clustered around engaging with the holistic needs of participants, using trauma-informed approaches, and fostering understanding of community members’ lived experiences. In addition to these staff capacities, listening session participants stressed the importance of safeguarding the emotional wellness of CDPH mental health center staff.
**Addressing the holistic needs of program participants.**

In accordance with the recommendation that the CDPH mental health centers operate as multi-service spaces that address a range of interconnected holistic resource needs that impact mental health, the staff working at the CDPH mental health centers should in turn encompass the range of roles necessary to address these holistic needs. Listening session participants recommended that staff at the CDPH mental health centers be inclusive of the following roles:

- Case managers
- Medical providers
- Psychiatrists/psychiatric nurse practitioners
- Mental health therapists, including clinicians trained in a range of modalities and with expertise to provide specialty services in the areas of substance use counseling, violence recovery support, and grief support.
- Peer support specialists who are from the surrounding community and have shared live experiences with community members receiving services. Peer support specialists should be paid living wages and should receive the support and accommodations that are necessary for them to thrive in their role, recognizing that mental health challenges may be an element of their shared lived experience. Listening session participants also recommended that there be employment opportunities for youth peer support specialists who are interested in taking on a mentorship role with their peers.
- A majority of survey respondents supported each type of staff position working at the centers. When asked which staff position category should be prioritized for expansion, 53% said mental health therapists, 16% said case managers, 9% said psychiatrists/psychiatric nurse practitioners, 8% said peer support workers, and 6% said substance use counselors. The remaining 8% were split among other position types, including ones they wrote in, such as licensed clinical social workers and youth workers for queer youth.
"CREATE OPPORTUNITIES FOR PEER & COMMUNITY SUPPORT AS MUCH AS POSSIBLE SO THAT WE ARE INVESTED IN EACH OTHER RATHER THAN ASSUMING SOMEONE OR SOMETHING ELSE WILL HAVE US COVERED."
- COMMUNITY SURVEY RESPONDENT

Utilizing a trauma-informed approach to service delivery. While listening session participants did not always use the words “trauma-informed” when describing their vision for high-quality interactions between service providers and program participants, they did consistently describe the importance of these interactions being person-centered, affirming of an individual’s humanity, and focused on establishing trust. Listening session participants discussed that experiences of trauma stemming from structural inequities and past interactions with the mental health system are prevalent among underserved communities in Chicago. As such, establishing a trusting, reparative relationship is critical to promoting healing. In this context, the relationship between the service provider and program participant becomes the vehicle for promoting positive mental health outcomes.
Listening session participants viewed the following approaches as being instrumental in the process of establishing a trusting and reparative relationship:

A person-centered approach that recognizes the individual’s humanity & inherent strengths:
Listening session participants described that all too often, they have been treated as a number on a caseload in their past interactions with mental health providers. Establishing trust requires clearly demonstrating that service providers respect the program participant and prioritize their autonomy; that they listen without judgment; and that they collaborate with the program participant based on the program participant’s own needs and desires, rather than the service provider assuming that they know what is in the best interest of the program participant.

Addressing power dynamics:
Care should be taken throughout the therapeutic process to ensure that service providers and program participants are working together as equal partners to do what will best support the program participant’s healing and to collaboratively develop treatment goals. In accordance with this approach, service providers should avoid placing themselves in the role of “expert” and program participants in the role of “learner.” Instead, it should be clearly communicated that both program participants and service providers have a set of expertise that they are contributing throughout the process of service delivery.

Consistency & reliability:
Listening session participants noted that service providers can establish a trusting relationship with program participants by conveying that they are a stable presence within the program participant’s social support network. While service providers may not be immediately available outside of scheduled appointments, timely response when a program participant reaches out is important in demonstrating that the service provider cares about the program participant and values the relationship. In a similar vein, service caps that terminate support before treatment goals have been met are antithetical to trauma-informed service delivery.
Understanding the lived experiences of community members who seek services. Listening session participants consistently noted that staff at the CDPH mental health centers should have an understanding of the community members who they are serving, including an understanding of an individual’s cultural values, the community context in which they live, and the structural factors that impact their mental health. In order to achieve this aim, care should be taken to hire staff who live within the community and whose cultural and linguistic backgrounds are reflective of the populations who live in the vicinity of each mental health center. Hiring from within the communities served not only allows for more culturally affirming care, but it also moves the centers one step closer to being anti-racist community spaces. When it is not possible to hire staff from within the community, listening session participants recommended that the City hire staff who approach their work from a social justice lens and who are open to learning about the lived experiences of program participants and the broader community in which the mental health center is located. Listening session participants additionally recommended hiring staff who are diverse with regard to age and gender identity.

"ENSURE THE SERVICE TEAM/TREATMENT PROVIDERS ARE CULTURALLY INFORMED AND REFLECT THE COMMUNITY(PEOPLE) IN WHICH THEY SERVE!!"
- COMMUNITY SURVEY RESPONDENT

Lastly, individuals at several listening sessions emphasized that it should not be assumed that a prospective participant wants to work with a service provider of a specific cultural background, gender identity, or age. Instead, at the time that they initiate services, each program participant should have the opportunity to share their preference. Listening session participants identified that all of these measures will help to promote empathy and affirmation throughout the process of service delivery, which in turn is critical to delivering high-quality services.
Promoting emotional wellness among staff. Recognizing that staff at the CDPH mental health centers are engaging in emotionally draining work, it is of utmost importance to ensure that there is the necessary support infrastructure in place to promote emotional wellness among staff. Across listening sessions, it was frequently noted that emotional wellness among staff is essential to high-quality service delivery. Listening session participants identified that administrators can support the emotional well-being of their frontline workers by ensuring that each center is adequately staffed, caseloads are realistic, administrative tasks are not overly burdensome, and workers are fairly compensated with a living wage and benefits. It would also be beneficial to create a culture that encourages opportunities for community building among colleagues and that promotes shared decision-making between administrators and frontline workers. Lastly, administrators should ensure adequate time and space for high-quality clinical supervision and ongoing training in the areas of trauma-informed care, cultural sensitivity, and other modalities and interventions aligned with staff interests and community needs. Such measures will ensure that staff have the capacity that they need to effectively support program participants.

"PEOPLE WHO ARE DRAWN TO COMMUNITY WORK OFTEN BURN OUT DUE TO HIGH COGNITIVE LOAD, FRUSTRATION WITH SYSTEMS NOT WORKING, AND BEING UNDER-VALUED. IF THERE ARE ENOUGH STAFF WHO ARE PAID WELL, THE COMMUNITY WILL BE SERVED AND HEALTHIER!" - COMMUNITY SURVEY RESPONDENT
Creating Systems that Provide a Continuum of Preventative and Crisis Response Care Through a Trauma-Informed Lens

The last key theme that emerged as being critical to promoting high-quality service delivery pertains to the need for a coordinated system of preventative and crisis response care. We consistently heard across listening sessions that the current limited availability of preventative mental health services allows mental health needs to go unaddressed until they reach a point of crisis. In turn, after an individual experiences a mental health crisis, it is challenging to connect with long-term follow-up services. Furthermore, a crisis response system that relies on police, emergency room settings, and involuntary hospitalization is physically and emotionally traumatizing. Outlined below are recommendations for establishing a coordinated system of preventative and crisis response services through the CDPH mental health centers and expanding crisis response services in a way that is trauma-informed.

Establishing a single, coordinated system of preventative & crisis response services. Listening session participants consistently noted that in the current social service landscape, the capacity of mental health providers to deliver preventative services cannot keep pace with the demand. In this context, individuals in communities with predominantly African American and Latinx populations who are impacted by structural inequities and historic disinvestment often cannot access
mental health support until their needs reach a point of crisis. Not only did listening session participants describe the responses that they received when they were in crisis as being traumatizing and violent, but they also reported that there was typically no connection to long-term follow-up care. In the absence of long-term, consistent services, individuals often cycle in and out of emergency departments and involuntary hospital stays. Based on these experiences, listening session participants identified that there must be a clear connection between preventative and crisis response services, with the ultimate aim of preventing crises and ensuring that individuals are connected to follow-up services that promote long-term well-being in the event that a crisis does occur. Situating CDPH mental health centers as the home bases for crisis intervention support thus establishes a coordinated system between preventative and crisis intervention services. CDPH mental health centers can become home bases for crisis intervention support through the following approaches:

Create living rooms/triage centers at the CDPH mental health centers:
While listening session participants typically did not explicitly say “living rooms” or “triage centers”, their descriptions of the crisis intervention support that they envisioned at the CDPH mental health centers were closely aligned with the living room and triage center model. In particular, listening session participants identified that when community members are experiencing mental health symptoms or a challenging problem that is overwhelming their ability to cope, there should be a safe space available 24 hours per day, seven days per week, “where they can just go and sit” and speak with a mental health therapist or a peer support specialist. Housing living rooms or triage centers at the CDPH mental health centers, with their own private entrance and reception area to protect privacy, would allow community members to receive both immediate de-escalation support to address the crisis at hand and allow a more seamless connection to the range of long-term supports available through the centers. Listening session participants noted that this model could effectively divert individuals from emergency room settings and prevent involuntary hospitalizations.
House mobile crisis teams through the CDPH mental health centers:

In addition to having a safe space where community members can come in a moment of crisis, listening session participants also noted that mobile crisis teams should respond to calls requesting crisis intervention support at people’s homes or other community locations. Ensuring that mobile crisis teams are housed at the CDPH mental health centers again ensures a more seamless connection between the community-based crisis intervention support that the mobile teams provide and the range of follow-up services that are necessary to promote long-term emotional well-being.

Survey respondents were asked about four options for crisis response: having a drop-in center open 24 hours a day, seven days a week where people can receive support; having mobile crisis response teams based at the centers; offering after-hours phone support; and offering mental health first aid training. A solid majority of respondents endorsed each idea. However, when asked to prioritize, most chose the first two: 40% chose having mobile crisis response teams based at the centers, and 38% chose the all-hours drop-in centers.

Trauma-informed crisis response interventions are inherently non-police interventions. In response to the question of how they envisioned the delivery of crisis intervention support through mobile teams, listening session participants unequivocally identified that police should not be involved. Listening session participants consistently noted that when police are present in mental health crisis response interventions, there is an unequal power dynamic that escalates the situation, ultimately leading to physical and emotional harm. An empathetic and person-centered approach to crisis intervention that affirms the individual’s humanity and respects their autonomy is therefore an approach that inherently does not involve police. Instead, mobile crisis response teams should be composed of a mental health therapist, a medical provider, and a peer support specialist who can relate to the individual’s lived experiences.
In describing the invaluable role of peer support specialists on a mobile crisis response team, one listening session participant noted that oftentimes it is more comforting to hear that “things will be okay” from someone with a shared lived experience who has made it through a similar struggle. Listening session participants discussed that individuals experiencing crises should be treated as equal partners in the process of making a decision regarding what supports they need to help them stabilize in the moment, with an emphasis on providing immediate de-escalation support, helping them connect with others in their social support network as desired, and facilitating access to long-term supportive services. Additional recommendations included ensuring that crisis response teams have the necessary training to support youth, adults, and families who are in crisis; that services are culturally and linguistically appropriate, utilizing trauma-informed interpreters when needed; and that they work collaboratively with families to identify alternatives to child welfare system involvement in cases where a child’s parent or guardian is experiencing a mental health crisis that prevents them from caring for their child. Lastly, listening session participants emphasized the importance of ensuring that services are scaled and staffed appropriately to respond to crises across Chicago 24 hours per day, seven days per week. Taken together, these recommendations are critical for implementing a model of crisis response that promotes healing from the immediate crisis and long-term healing through connections to supportive resources.

“CDPH SHOULD NOT INCLUDE POLICE OFFICERS IN ANY OF THEIR WORK. IT IS UNSAFE, DANGEROUS, AND UNNECESSARY.”
COMMUNITY SURVEY RESPONDENT
Implementing Accountability Mechanisms for Ensuring High-Quality Service Delivery

As highlighted in our findings, the Chicago Department of Public Health can ensure high-quality service delivery through the CDPH mental health centers by promoting service accessibility; establishing inclusive, culturally affirming, and community-centered spaces; hiring staff who can address holistic needs, who are trauma-informed, and who understand the lived experiences of community members seeking services; and creating a coordinated system of preventative and crisis response care. Listening session participants described that in order for this model to be successful, there must be formal accountability mechanisms to ensure that these efforts are undertaken as intended and systematic review in place to assess whether interventions have the anticipated outcome. More specifically, the Chicago Department of Public Health should establish and post formal processes for both program participants and service providers to submit feedback on service delivery and quality assurance concerns. The Community Mental Health Board can also serve to discuss feedback that is submitted and collaborate with the administration to develop a plan for addressing any quality assurance concerns that arise. There should also be open community meetings where data on service outputs and outcomes are regularly shared, with a breakdown of aggregate client outputs and outcomes by race and ethnicity to ensure equity in service access and quality. Lastly, throughout the process of expanding public mental health services, community members should receive regular updates progress with implementing services and hiring staff. These accountability mechanisms will ensure that public mental health services are being expanded and delivered in accordance with community recommendations.
Recommendations & Timeline

The key findings ascertained through this quantitative and qualitative research process has yielded three primary results for our campaign which we will elucidate on further below. It has:

1. Reaffirmed and refined our long-term goals
2. Expanded both our language & vision for this public infrastructure of care
3. Given us clarity and detail of key requirements for the scaling of both the centers and the non-police crisis response
This process has also reinforced the importance of engaging and receiving guidance from those community members for whom these services are to serve throughout the implementation process, all the way from ideation, to scaling, to continuous accountability and iteration. Being a campaign borne out of a decades-long struggle to invest in an infrastructure of care, it has been core to our work to be led by, built by, and supported by those most directly impacted, and those with deep community and technical expertise. We look forward to ensuring that this community engagement process becomes an integral part of holding these systems accountable and continuously shaping them to our communities’ evolving needs. In the most recent election, there was a clear mandate set by the people that Treatment Not Trauma was a requirement for any mayor and administration that came to power. TNT was supported by almost every mayoral candidate and promised as a key priority for supporting our communities. This report reflects that same mandate directly from our community, and pushes the administration to fulfill that promise with greater urgency.
Our Long-Term Demands

As outlined above, this process reaffirmed and refined our long-term goals, while both expanding our language and vision for this infrastructure and giving us further detail for what our communities envision this to be:

1. Universal, barrier-free access to mental healthcare and community wellness programming with high-quality services for both continuous and crisis care.
2. Comprehensive behavioral health services at all facilities, as a baseline, with multi-service offerings based on the local community needs – expanding the scope of these centers and services to provide holistic community wellness. The expanded scope of work should be reflected in a rebranding of CDPH mental health centers to CDPH community wellness centers.
3. Citywide non-police crisis response teams as first responders, integrated with CDPH community wellness centers - ensuring people get immediate care, treatment, and resources in crisis, alongside post-care infrastructure to support longer-term healing and support.
4. A fully-staffed, unionized public Community Care Worker Corps across both crisis and continuous care that enables a diverse set of peers and community members to be a part of the healing process, and creates a hyper-localized care infrastructure.
5. A localized community wellness center board to expand and localize the current Community Mental Health Board which would allow neighbors, patients, and individuals within the community to understand the quality of care being offered, through an accessible database, as well as to raise issues, concerns, and opportunities with agency and power to make changes to improve quality of, and access to, care.
A reiteration of our key findings/themes

As we outline the community needs within the expansion of CDPH Mental Health Centers, (rebranded as Community Wellness Centers) as well as our Crisis Response, you’ll see that they are a further elucidation of the key findings from the report:

- Promoting service accessibility and coordination across both crisis response and wellness centers
- Establishing inclusive, culturally affirming, and community-centered spaces
- Hiring staff who can address holistic needs, who are trauma-informed and who understand the lived experiences of the communities that they serve – stressing the importance of establishing a community care worker corps
- Creating systems that provide a continuum of preventative and crisis response through a trauma-informed lens
- Implementing accountability and transparency mechanisms to ensure high quality service delivery
As reflected in our findings, quality of care and services is the utmost priority for community members. We are not able to achieve that without addressing the past harms that have occurred in spaces - be it public or private care (non-profit) services. Given access barriers, and overburdened providers in times past, there are community members that hold trauma from historical experiences that need to be recognized and addressed in order to ensure that these services are accessible to everyone moving forward.

Similarly, this requires that central to our centers is a culture and practice of being trauma-informed and anti-racist. That includes everything from the lighting in the space, to the intake process, to how we train service providers to enter a room and sit with a patient. Building trust will be crucial to how we scale these services, and ensuring that our clinicians, community care workers, and office administration team members are moving at the speed of trust, allowing folks agency over their care, and recognizing that high-quality care is based in collaboration and honors someone’s autonomy.
**Incremental Service Needs & Considerations**

The below are a consolidated set of needs expressed by community members to ensure that the service offering is holistic of their needs. It is not exhaustive, but a recommendation that should be seen as all spaces being inclusive of:

**Living Room.** A living room space / triage space that is available 24/7 for de-escalation, with opportunity for acute care services. These spaces must be staffed with a therapist and peer support specialists (Community Care Workers) to give individuals a place to sit, as well as a place for crisis teams to bring individuals that need a space. The living room spaces must be dedicated in focus and should not regularly be dual-use as, for example, the waiting room for clinical appointments.

**Basic Needs.** Laundry services, snacks and beverages, a shower, menstrual products, transportation services to and from the space. These services are helpful to ensuring we’re meeting individuals’ material and sanitary needs as we work to also offer support for their emotional and social needs.

**No Wrong Door.** The ability to link individuals to the city services that can help support material, health, or social needs that they may have that cannot be directly serviced from the community wellness center – that may be housing, medical services, workforce development, etc..

**Multiple Modalities.** Inclusive of modalities of care such as art and music therapy, as well as any other culturally competent modalities of care. Availability of in-person and virtual services.

**Childcare.** In order to improve accessibility, we need to ensure that we have the space for caretakers, offering childcare for anyone that is using the space, and being available for children from infancy to teens.

**Multiple Population Types.** Youth, Relationships, Group Support, and Family Therapy at these locations to ensure that we are, once again, being cognizant of the patient and community population.
Substance Use Services. The community wellness centers should offer a range of substance use services aligned with community needs, including early intervention, outpatient services, and triage support.

- Sobering Center. Creating a 24/7 alternate destination facility for individuals to recover from acute substance intoxication in the City of Chicago remains a critical priority for the City. Recognizing that the City has been unable to identify a private provider to operate a sobering center to date after an RFP was issued supported with ARPA funding, we are recommending that the City operate a public sobering center as a 24/7 facility that provides triage support to individuals as part of these efforts to offer comprehensive substance use services.

Home Visits. The ability for home visits to be possible for those patients that are unable to come to the Wellness Centers. Availability of child-care support for in-home visits, as needed.

Localized needs assessments. In the process of expanding services at locations, or evaluating service quality, we should be undergoing a hyperlocal needs assessment to understand what services are needed by the communities it's serving, over and above the baseline service needs that have been outlined.

Group services that allow for social connectedness. Group therapy, peer support groups, enrichment activities (such as digital literacy, art classes, etc.).

Training services. Within each center, we should be holding training services for community care workers and community members, to expand the capacities of our communities, and to engage folks in active worker development at the localized level.

Engagement with our school and senior center spaces. Though our schools and senior centers are separate spaces, we need to have programming in conjunction with them to ensure we're engaging those populations with a human-centered approach to wellness.

We also must increase both the amount and the quality of outreach on our Community Wellness Centers. More than 75% of those individuals that attended a listening session stated that they did not know that these services existed within our public infrastructure. As we continue to scale our investment, we also need to scale our outreach.
Space Needs & Considerations

Just as our services need to be trauma-informed, our spaces need to be as well. A repeated comment throughout each of the sessions was ensuring that the physical space was laid out in a way that was inviting with design, art, and lighting that reflected both that intention and the community.

- **Lighting and art.** Ensuring that the space has art both within the space as well as outside the space that is reflective of the community that it serves. Lighting must be soft, warm, and non-fluorescent.
- **Rest Spaces.** Spaces where individuals can have quiet time, as well as spaces where they can lay down for a few hours.
- **Individual Spaces.** Similarly, having spaces where individuals can be on their own with privacy - whether that’s used for prayer, for feeding, for meditation, etc.
- **Group session spaces.** Knowing that we need to be holding a more diverse set of modalities in serving community members, we should have spaces that are meant to hold groups for group sessions or peer support sessions.
- **Socializing space / community space.** Especially with both our younger and older populations, we should have space where people can be active and engaging with each other.
- **Private office spaces.** For individual therapy sessions, or 1:1 sessions.
- **Kitchen / Food Prep.** Given these are wellness centers, and we’re hoping to be able to host groups here, we should have an active kitchen or food prep space.
- **Learning space.** There should be spaces within the center that are specifically designed for learning.
Quality staffing - by both licensed professionals as well as peer support staff (also named Community Care Workers), with proper training, support, and reasonable caseloads were of the utmost importance in our Listening Session discussions. There was also an importance stressed around ensuring that every individual - no matter if they were a service provider, or administrative staff, engaged in the space in a way that was welcoming, trauma-informed, and trained in anti-racism. Below are a list of roles, as well as concepts that were expressed as a need in each of our Wellness Centers.

Similarly, it is imperative that we create a career pathway through training and mentorship for those individuals that are entering this work as a peer support specialist or community care worker.

- **Community Workers.** Peer Support Specialists, Youth Peer Support Specialists, Substance Use Specialist, Re-Entry Support. These should be individuals that have lived experiences or are from the immediate community that are providing care.
- **Holistic Service Connectors.** We know that individuals that are coming to our centers for care often have adjacent needs - we should have individuals at our centers who are focused on connecting our patients and community members with other city services that help meet those other needs - be it housing, food, education, etc.
- **Mental Health Professionals.** Psychiatrists, Psychiatric Nurses, Mental Health Clinicians with expertise to provide specialty services in the areas of substance use counseling, violence recovery support, grief support, re-entry support.
- **Training.** These staff members should have training in both racial and cultural competencies, as well as around trauma-informed, anti-racist, and anti-oppressive care and power dynamics. We should have robust standards of care around patient engagement, case-load quantity, and triage processes.
- **Taking Care of our Providers.** The wellbeing of front-line workers is paramount – ensuring that pay is fair, caseloads and tasks are reasonable to allow them to be present in space and remain committed to the work, and to reduce churn.
  - The direct service providers should be able to engage in decision making between them and administration in how these centers and their roles evolve.
- **Welcoming Staff.** We should have staff that are welcoming individuals in, guiding them through how to engage with the space.
- **Community Nurse.** To be able to engage in preliminary level medical care, as well as to provide community based training & coaching: nutrition coaching, Narcan training, gunshot wound triage training, etc.

Across all three areas of need (Services, Staff, and Space), there was an underlying theme of awareness that must be tackled as well. The vast majority of participants in the listening sessions were unaware that the City of Chicago had free mental health services, and publicly-run clinics across the city. In order to outreach to a diverse set of neighbors, we need to employ a diverse set of tactics. That means, as we see with the police budget, having a true outreach and marketing budget allows us to both advertise the centers and their services, as well as advertising the employment opportunities within them. If we want to increase engagement, we need to increase awareness - both organically and inorganically across this city.
Crisis response must be deeply integrated with the Community Wellness Centers in order to offer a full cycle of care and support to patients and community members. One of the largest drivers to moments of acute crisis is the lack of access to support resources pre-crisis, and not being connected to continuous care for follow-up services. This connection is crucial for individuals to feel safe and supported when calling for crisis response. Similarly, community members need to know that a non-police crisis response is available to them – repeatedly we heard from community members that they didn’t know that this existed, nor that it was being scaled citywide.

Echoed in these listening sessions was also a reinforcement that crisis response that engages with the police, emergency rooms, and involuntary hospitalization is deeply traumatizing - both physically and emotionally, not only for the patient, but also for connected family and community members. It is because of this that we need to ensure that 988 and non-police crisis response does not engage with the police. Further, staff should engage in procedures designed to support de-escalation and emotional regulation, that take full advantage of Wellness Center capacities, to reduce reliance on involuntary hospitalization.
Below is a non-exhaustive view of elements that need to be addressed as we scale our non-police crisis response:

- **Wellness centers as crisis team hubs.** Our wellness centers need to be the home bases for our crisis intervention teams. This also allows for engaging at nearby schools, and faster dispatch to homes in our neighborhoods, and ensures continuity of access and familiarity of service and service providers, given trust is a challenge.

- **Living room or Triage centers.** As outlined above, these should be crossover between wellness centers and crisis response - a space that is open 24/7 staffed with a mental health therapist and peer support specialist at every wellness center.

- **Non-police.** This crisis response cannot involve the police - the presence of police immediately shifts the power dynamic, escalates, and leads to at best emotional harm, at worst both emotional and physical harm. Given these responses need to be trauma-informed, it must be person-centered and affirm the autonomy of the individual.

- **Diverse set of first responders.** The crisis / CARE teams should be made up of a collection of – EMT, therapist or crisis counselor, peer support specialist or community care worker, with the option for crisis-response to be fully staffed by community care team members if we find the quality of crisis care to be matching. In conversations with Violence Interruption and Prevention (VIP) organizations, we also recognize the importance of exploring the involvement of a publicly-operated VIP service to be wrapped into these crisis response.

- **Training for diverse populations.** We need to ensure that these crisis teams are trained in differing approaches to crisis response - ensuring that we have appropriate responses for young folks, family crises, individuals that speak different languages, and have differing relationships with the state.

- **Citywide, 24/7.** We need to ensure that we have enough staff to be able to serve all of our neighborhoods 24/7.

- **Community training programming.** Similar to what we’ve seen for police and fire, our non-police crisis response, we need to have a training program that allows community members to learn the skills to become CARE crisis team members.
Timeline

As we conclude this report, we will be outlining the set of recommendations around the expansion of our centers and non-police crisis response for the Administration and the Chicago Department of Public Health (CDPH) along three timelines: (1) by the close of 2024, (2) by the close of this administrative term (April 2027), (3) the mandate for the next administrative term.

Goals for Current Year

Community Wellness Centers

**New Centers.** At a minimum, the opening of 2 additional mental health centers or integration of CDPH mental health staff (Community Wellness Staff) to provide services in other city spaces and facilitate access to mental health services in new areas of the city
- With the locations set for expansions - using a community-centered approach for opening these centers - that means engagement sessions, local career fair (outlined further below)
- Locations and process of opening new spaces has been outlined and approved for 2024 with a proper corresponding budget.

**Existing Centers.**
- Fully realized / achieved staffing per the budget outlined for 2024
- Creation of Peer Support Specialists positions within CDPH beginning the formation of the Community Care Worker Corps
- Experimenting with new intake procedures to ensure individuals that are calling for services are talking with a CDPH staff member
- Expanding to evening and weekend hours at each of the centers
- Refreshing existing CDPH mental health center spaces to ensure that they are welcoming, per the recommendations above

**A staffing plan** to outline how we will properly hire and scale to the personnel needs of 2025 and an assessment plan to outline how we will determine the location of new spaces in 2025
Crisis Response

- The creation of at least one living room center, used as a base for a CARE team, as well as the blueprint to scale living room centers to every location within the following year
- Expansion of geographic coverage working towards a full city access to non-police crisis response as a way of increasing awareness and access to more parts of the city to non-police crisis response, this year scaling up from from 4 police districts up to 13 police districts
- Developing a staffing plan for expanding to a minimum of 2-24/7 non-police crisis response teams as a start in 2025, with full staffing of teams during standard hours from 6a - 10p

Goals for this Administrative Term

Community Wellness Centers

- Rebranding CDPH Mental Health centers as Community Wellness Centers, and expanding the types of services to be holistic to community wellness - using all of the recommendations outlined above
- All 12 closed CDPH Mental Health Centers should be opened (for a total of 19 CDPH Community Wellness Centers), operate through the weekend as well as evening hours, and have some form of triage or living room center that is serviced 24/7
- A publicly operated sobering center, available 24 hours per day and 7 days per week, should be established to address the need for triage support for individuals experiencing acute substance intoxication. A space should be identified and staff should be hired in 2024 and early 2025, so that the center can be fully operational by the end of 2025.
There is full staffing of a Community Care Corps with a robust pathway towards career advancement, as well as a pathway for community members to be trained and on-boarded as a community care worker. Each location should be governed by a local community mental health board, that has power to make changes at the center itself, with a representative citywide community mental health board. The creation of a blueprint for what a successful CDPH Community Wellness Center looks, feels, and operates like, with the vision to scale the model across additional locations/neighborhoods across the city.

**Crisis Response/ CARE Teams**

- There is 24/7 access to non-police crisis teams and they are fully integrated in with OEMC + 911 + 988
  - All behavioral calls / non-’violent’ calls are routed through the CARE teams
  - Change in 911 call-in procedure to ask if it’s fire, police, EMS, or mental health services
- These CARE teams are fully integrated into our Community Wellness Centers (CWC), with CARE teams being based out of each CWC
- We have a robust first response training center that recruits and trains non-police care workers to administer care to those in need
  - The level of care we’re able to provide with a non-police team includes Category 4 crisis calls
- We’re integrated into the local Community Violence Interrupter programs as well as local city services to be able to provide not only those in crisis, but their families and loved ones, continuous care post-crisis
- Virtual crisis care is fully live, and integrated in with providing follow up support either through the mobile crisis response teams or through the CWCs
The next administrative term will be entering in with a mandate for an expansion of the vision of these Community Wellness Centers, and continuing to scale them to every neighborhood in this city.

- **These will be spaces where our communities can care for one another** :: where they can receive their mental health care, get nutrition care, where they can sign up for social housing, or get access to mediation.
- **These will be spaces where communities can learn** :: where our community orgs can do teach-ins about local work, where our young folks can get tutoring, where community members can be trained in how to be a Community Care worker or an EMT, where local schools and universities can hold fellowships, where neighbors can learn about practices of restorative justice.
- **These will be spaces where our communities can come together** :: where we’re able to hold social events that celebrate the unique communities that make up our neighborhoods, where we can bring together our youth and elders, where we can welcome new neighbors.

We know that investing in community wellness is key to a prosperous, healthy, and safe city. We’re building the foundation for what can be a **Community Wellness Center in every neighborhood**. Our vision is for people in this city to always be in proximity to a hub where they can be cared for, find safety, and be in relationship with those in their community.
Implementation Needs & Considerations

When implementing a new center, we need to ensure that we have a community-led process. This means:

- Building up the local community mental health board to help guide the implementation
- Implementing regular community meetings and listening sessions to better drive the local service needs and the enrichment activities with the community
- Including local artists in helping design the art both inside and outside of the center
- Having local career fairs to ensure that we are properly advertising the services, as well as the new jobs that will be brought into that community

We also need to ensure that we have a transparent and democratic process of accountability within these centers, as well as an ability to consistently evolve the needs of the center based on the evolving needs of the population. This means fully implementing the Local Community Mental Health Boards across each location, as well as the citywide Community Mental Health Board.

We also need to ensure that we have a transparent and democratic process of accountability within these centers, as well as an ability to consistently evolve the needs of the center based on the evolving needs of the population. This means fully implementing the Local Community Mental Health Boards across each location, as well as the citywide Community Mental Health Board.
We recognize that as we scale out these centers and our crisis response, there will be roadblocks raised around budgeting and the hiring process. But we also know that the budget is a moral document, and that if we have the political will to fund preventative services and crisis response services that care for our people, we will find the budget. We also know that our hiring processes have been expanded to be able to hire police at a rapid rate, and with the right political will, we can find and improve our methods of hiring to be able to do the same for our CARE clinicians and our Community Wellness Centers, alongside us expanding the pool of those eligible by creating training programs for community members to become Community Care Workers, and removing our restrictions around barring those who have been criminalized from being in positions of care.

We know that we have the resources to be able to build and scale the type of public infrastructure that we all deserve – one that puts care over criminalization, and we’re finally in a place where we have allies within the administration to be able to actualize the demands of community.
Notes


About the Collaborative for Community Wellness

The Collaborative for Community Wellness is a collaborative that brings together mental health professionals, community-based organizations, and community residents to address the lack of mental health access and to redefine mental health to match the needs of the community.

For more information contact:
Arturo Carrillo, PhD, LCSW acarrillo@bpcnchicago.org
www.collaborativeforcommunitywellness.org
Follow us on Facebook, Twitter, Instagram @CCWChicago