

# Treatment Not Trauma

A Community Care Infrastructure for  
Crisis Response, Mental Health, and  
Shared Safety



Collaborative for Community Wellness  
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## **Treatment Not Trauma**

### **A Community Care Infrastructure for Crisis Response, Mental Health, and Shared Safety**

*Prepared by the Collaborative for Community Wellness<sup>1</sup>*

#### ***Summary***

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. This results in frequent mental health and behavioral crises to which police officers are currently required to respond, despite inadequate training and low levels of community trust in policing systems. The Chicago Police Department reports that, in 2019, its officers responded to more than 40,000 calls with a mental health component, generating widespread frustration among officers who feel that they are required to respond to social and medical problems for which they are not trained and that mental health systems should be managing instead. But existing community mental health infrastructure is grossly inadequate to respond to such needs, leading to unnecessary police contact and associated incidents of violence, arrest, and incarceration that reproduce cycles of trauma, violence, and poverty.

Treatment Not Trauma (TNT) is a plan that seeks to break this cycle 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. TNT begins from the recognition that crisis response works best, and is needed least, when it is interwoven with sustained crisis prevention systems based on supportive interpersonal relationships with people living at high risk of behavioral and mental health crises. TNT is thus designed around hiring both trained nonprofessional and professional mental health workers to 1) provide non-police crisis response and 2) prevent crises by providing supportive everyday care to those who are at greatest risk of mental health crises, police contact, violence, and hospitalization. To house and facilitate this work, TNT includes reopening 14 City-run mental health centers, bringing the total number of such centers to 19. Several of these centers will operate as 24-hour walk-in integrated service facilities for mobile crisis team dispatch, crisis reception and resolution, and stabilization and home bases for community outreach care worker teams. This is anticipated to reduce current inappropriate, harmful, and costly dependence on overburdened police, hospital emergency departments, and inpatient psychiatric beds, and to ultimately yield substantial savings to current spending on Chicago's hospital, emergency medical service, jail, and policing systems.

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### ***Historical Background***

Until 1950s and 60s, the dominant model for mental health care was hospitalization in large state institutions, which provided an inconsistent level of care, frequently featured abuse, and were often used as a tool for confining marginalized, disabled, and racialized individuals—including at times as a means of state repression of dissent. As more patients organized to demand an end to psychiatric institutionalization and mistreatment, and more medications were produced that could manage symptoms in an outpatient setting, more state mental hospitals began to close. In conjunction with the closure of these asylums in the 1950s and 60s in the United States, mental health professionals, patient advocates, and lawmakers called for the creation of a new model for community-based mental health systems. Many demonstration projects focused on both treatment and prevention ensued, including several effective initiatives that prioritized nonprofessional community care workers, neighborhood mental health service centers, and supplemental support from mental health professionals as needed, with a focus on urban neighborhoods with highest levels of unmet economic and health needs. These included the first Chicago Department of Public Health (CDPH) community mental health center, the Mid-South Center in Bronzeville, which opened in 1959 and was followed by the opening of several more such CDPH-run centers over the subsequent years.

By the late 1960s, however, public investment in such programs (eg, via the Economic Opportunity Act of 1964 as part of the short-lived “War on Poverty”) began to fade. New federal grants, such as the Mental Health Center Staffing Grant, required conformity to traditional medical models of care delivery that prioritized professional services for which health insurers, including newly established Medicare and Medicaid, could be billed. Federal qualified health centers (FQHCs)—private non-profit centers meant to provide care to underserved populations—were also rolled out during this period and were subject to similar funding pressures, often leading to exclusion of individuals without insurance or other means of payment or whose needs exceeded the ability of available psychiatric treatments to address. This severely limited the development of robust community mental health infrastructures equipped to go beyond reactive medical models in order to focus on community-based peer support, housing, employment and financial support, conflict resolution, elder care, and additional social determinants of mental health. As a result, medical treatment and reactive response—after mental health needs had already worsened to the point of crisis—rather than continuous social support and crisis prevention were prioritized, short-circuiting the promise of community mental health before it even had a chance to be built and leading to its “programmed failure.”

In the years that followed, matters became considerably worse as the “War on Poverty” was replaced by a “War on Crime” and “War on Drugs.” This has led to an ongoing national practice of responding to overlapping problems of poverty, addiction, serious mental illness, and homelessness primarily through criminalization rather than support. In the absence of strong systems for community care, policing and incarceration have become the de facto centerpieces of

mental health crisis response and treatment. Given that evidence shows incarceration can actually *increase* crime at state and local levels, this reality contributes to remarkably poor both public health and public safety outcomes relative to peer wealthy nations by fueling the United States' globally unparalleled incarceration rate—now approximately seven times that of other wealthy countries.

Today, due to the overlapping criminalization of poverty and mental illness, jails and prisons are the largest providers of mental health services—albeit profoundly deficient services—in the United States, including for Chicago's residents, and police function as the main mental health crisis responders. Rather than improving mental health, this leads to a repeating feedback loop that worsens mental health and exacerbates racial inequalities—all in a historical context in which Black, Brown, and Indigenous communities are already subjected to disproportionate rates of poverty and policing. This is partly because healthcare in jails and prisons, which feature widespread abuse and violence, is of notoriously poor quality, often altogether unavailable, and severely under-regulated. Moreover, medical treatment alone—no matter how good its quality—cannot address the root causes of most mental health afflictions that leave individuals vulnerable to criminalization and repeated incarceration. As a result, reliance on policing and incarceration as substitutes for supportive and preventative community-based care perpetuates cycles of trauma, poverty, violence, addiction, and homelessness that profoundly undercut national public health, safety, and trust in government, particularly in racialized communities subjected to highest rates of policing and incarceration.

In the absence of investments in public health approaches to mental health crisis response, continued reliance on police response increases risk of traumatic encounters with long-term psychological as well as acute escalation and physical violence, leading to the high number of killings by police both in Chicago and nationwide. Approximately one quarter of all people killed by U.S. police officers since 2015 were suffering—or were perceived to be suffering—from a mental health crisis, and people with unmet mental health needs are 16 times more likely to be killed by police. Furthermore, recent research showed killings by police have gone unreported in official statistics in over half of all cases between 1980 and 2019, suggesting that the scale of harm inflicted by policy decisions to invest primarily in police-led crisis response is far greater than currently documented.

### ***Integration with 988 & Federal and State Support***

In light of the well-known deficiencies and harms of relying exclusively on police for responding to crises, 988 has recently been rolled out as an easily accessible, 3-digit emergency calling code for mental health and substance-use related crises. Similar to 911, this number is free to access and available 24 hours a day, 7 days a week, 365 days a year, in all 50 states, American Territories, and Tribal Areas. The launch of 988 has been accompanied by significant federal investments (over 1 billion dollars thus far) in order to ensure that all Americans have access to

timely and effective mental health crisis support, as 988 is envisioned as both an intervention in itself, as well as a gateway to a continuum of care, similar to how one might access 911 in order to access emergency medical services. In addition to dedicated funding and block grants to states for non-police crisis services implementation, the federal government has further incentivized states and localities to implement non-police crisis response teams by increasing Medicaid reimbursements for services provided by such mobile teams.



*Image courtesy of National Association of Counties*

It is important to note that a phone line alone cannot adequately respond to all crises, and that both mobile response teams and community-based crisis centers are required to fully support individuals in crisis without relying on currently existing infrastructure such as hospitals, emergency rooms, and jails. Data collected in peer cities demonstrates that doing so improves outcomes while decreasing costs. To date, however, Chicago has not taken advantage of available resources to build the necessary mental health crisis response infrastructure to allow 988 to fulfill its purpose, resulting in current calls to the emergency line frequently being routed to police and leading to unwanted police response.

Requesting police response to mental health crises via 911 calls remains the only option available to Chicago residents seeking in-person response, as 988 call centers serving Chicago are not equipped to deploy first responder or mobile crisis teams—and are also currently operated by a private nonprofit, C4, with minimal public accountability. This is in stark contrast to what residents are able to access in most major peer cities, including Atlanta, Albuquerque, New York City, Philadelphia, Seattle, Austin, Durham, Los Angeles, San Francisco, and San Diego, which have all implemented or begun to implement non-police mental health response services aligning with federal guidelines released by the the Substance Abuse and Mental Health Services Administration (SAMHSA). Chicago is in a prime position to begin to implement these services citywide as well, and take advantage of support offered by both the federal government

as well as the State of Illinois, where the Illinois Department of Human Services/Division of Mental Health is expanding investments and grant programs for implementation of non-police response teams and the crisis services continuum as outlined by SAMHSA.

### ***Models of Public Health Response to Mental Health and Behavioral Crises***

In Chicago, the killing by police of Quintonio Legrier and Bettie Jones in December 2015 exemplifies the devastating hazards of relying on police for mental health crisis response and the need for alternative systems. Quintonio was a 19-year-old college student home from college during winter break. On December 26, he called 911 three times to ask for help, pleading with the operator who dismissed his pleas and hung up. Quintonio's father later called, stating his son had "freaked out" and was holding a baseball bat. As Quintonio's mental health crisis worsened and the family sought help, police arrived. Bettie Jones, a neighbor and mother who had come to assist, opened the door to find police with guns drawn. Within minutes, they shot Bettie once and Quintonio six times, killing both and making no attempt to revive them.

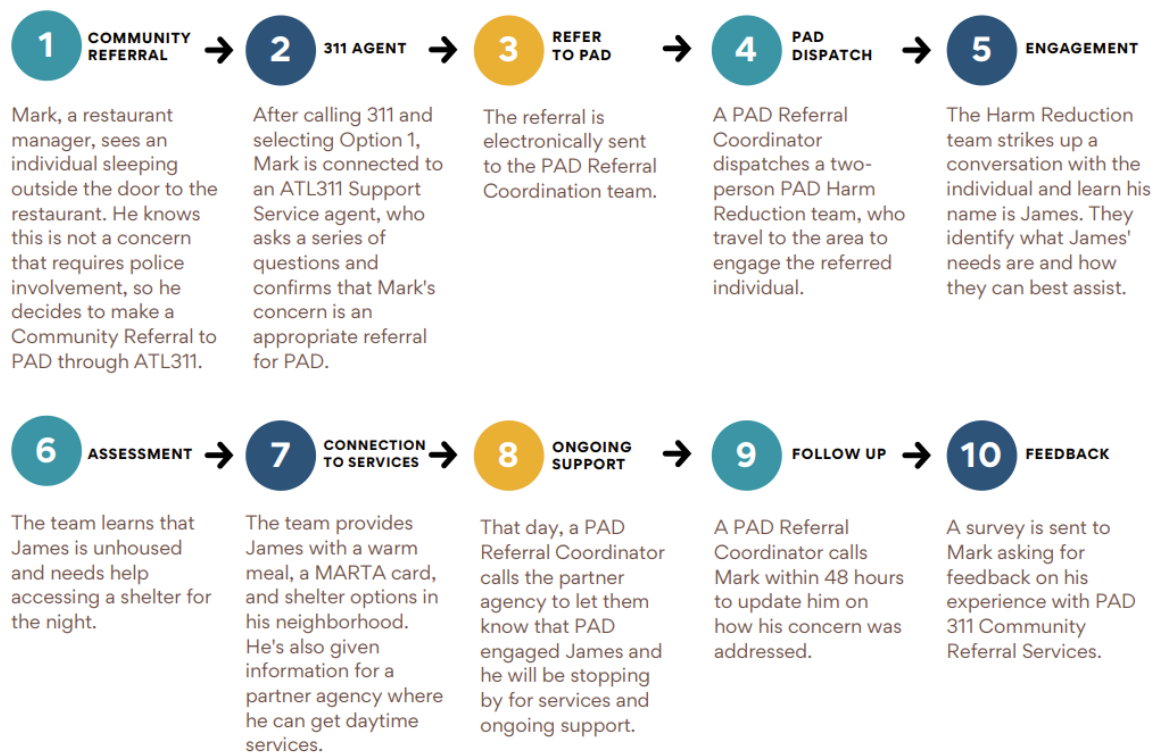
In response to such repeated, preventable killings by police and other unnecessarily violent encounters, most major U.S. cities have recently launched or expanded programs to send mental health responders rather than police to address emergency calls related to mental health. In 2022, in Portland, Oregon, Street Response Teams expanded citywide and responded to 19% of unwanted persons calls and non-emergency welfare checks; 96% of responses did not lead to involvement of police. In San Francisco, Street Crisis Response Teams also expanded citywide in 2022 and responded to 58% of all mental health-related calls; 97% of responses did not lead to police involvement.

In Denver, the STAR program also expanded citywide and responded to 48% of welfare check, trespassing, and unwanted persons calls flagged by dispatchers; 100% of responses did not lead to police involvement. According to a 2022 study, during its first six months in operation, STAR reduced low-level crimes (for example, trespassing and public disorder) by 34% and prevented almost 1,400 criminal offenses. Furthermore, shifting to a civilian responder model did not result in an increase in more serious crime, demonstrating that more tailored response to mental and behavioral health crises yields substantial individual and population-level safety benefits. The study also found that "the direct costs of having police as the first responders to individuals in mental health and substance abuse crises are over four times as large as those associated with a community response model." And, notably, those savings do not include additional savings gained from reduced healthcare utilization associated with diverting individuals from costly emergency room visits and hospitalizations.

Another example of a highly successful program is the Policing Alternatives and Diversion (PAD) initiative in Atlanta, which is supported by both the City of Atlanta and Fulton County, as well as a number of community groups. PAD provides immediate crisis support for a variety of

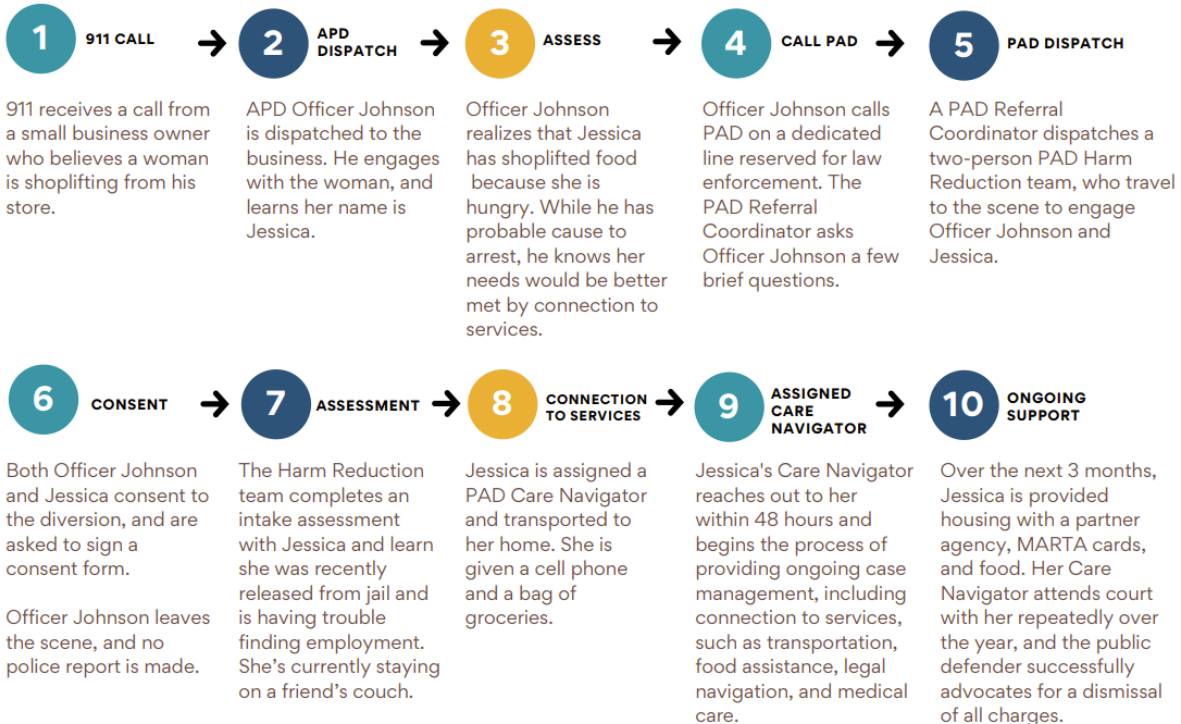
needs including mental health. Importantly, these non-police response services are directly accessible by residents and are also able to reduce burden on law enforcement by diverting calls from 911 and other emergency numbers that are more appropriately responded to by other means. The Atlanta PAD program has been featured by the US Department of Health and Human Services, US Department of Justice, Council of State Governments, University of Chicago Health Lab's Transform 911 Initiative, Urban League, and Vera Institute of Justice.

## 311 PAD Community Referral Services Flow Chart





## Pre-Arrest Diversion Flow Chart



These programs join others, such as the Crisis Assistance Helping Out On The Streets (CAHOOTS) program started in Eugene, Oregon in 1989, that have long demonstrated that a large proportion of mental health emergency calls can be responded to safely, more effectively, and more efficiently without police involvement. In 2019, CAHOOTS teams responded to about 24,000 calls, or approximately 17% of all 911-dispatch calls; they requested police backup in less than 1% of cases. The teams provide not only 24/7 mobile crisis intervention and first aid but also assist with “conflict resolution and mediation, grief and loss, substance use disorders (including acute intoxication and linkage to ongoing treatment), housing crises, connection to social services and treatment referrals, and transportation to services. CAHOOTS teams include a licensed mental health clinician paired with a nurse or emergency medical technician.” The program saves an average of \$8.5 million (about 12% of the total police budget) in police and hospital emergency department expenditures annually, and has earned broad popular support. Several cities have rolled out small-scale programs based on the CAHOOTS model that dispatches non-police mental health workers first and then utilizes police backup as needed, but expansion has been severely limited by lack of funding.



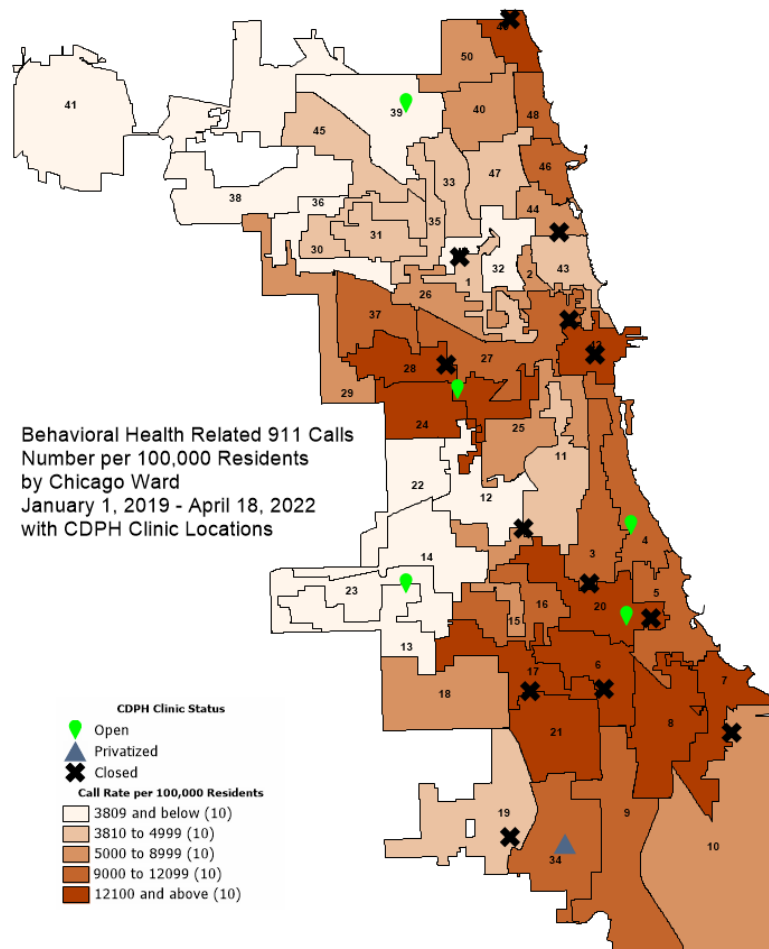
In addition to lack of public funds to scale up such programs backed by evidence, common sense, and popular opinion, three major obstacles exist to moving away from police-based crisis response to more effective public health models for crisis response and prevention: staff, space, and support systems. There does not currently exist a workforce adequate to staff necessary crisis response and prevention infrastructures. There also does not exist adequate physical spaces designed for 24/7 mental health emergency response, de-escalation, stabilization, and subsequent ongoing community care provision. Last, Chicago lacks systems to support the operation of non-police crisis response, such as an option upon calling 911 for callers to request mental health teams without police presence, a 988 system capable of dispatching non-police mobile crisis teams, and the equipment required for scaling up a public health model for crisis response.

### ***Chicago's Defunded Mental Health Infrastructure***

In Chicago, despite growing unmet community mental health needs, essential infrastructure has been progressively closed rather than reinforced and expanded over the last three decades. Despite the difficulty in obtaining adequate funding, CDPH-run mental health centers continued to operate throughout the 1960s, 70s, and 80s, providing vital services, particularly in poor, racially segregated neighborhoods where access to private providers was scarce and cost-prohibitive. In 1989, the City maintained 19 mental health centers and was the largest provider of outpatient care services in Chicago. By the time Rahm Emmanuel became Mayor in 2011, however, only 12 were left. “Welfare reform” in the 1990s led to widespread privatization of essential services and a shift away from public responsibility to care for dispossessed neighborhoods toward allocating grants given to FQHCs to provide services on a private, charitable basis rather than a rights-oriented basis. This had led to a fractured system lacking in public accountability and featuring various perverse incentives to prioritize organizational reproduction over maximally effective and equitable care delivery, leading to severe lack of services in many of the highest-need neighborhoods in Chicago.

Upon entering office, Emmanuel nonetheless chose to further withdraw the City from providing mental health services to its residents. In 2012, he closed half of the remaining City mental health centers in notably low-income, high-arrest neighborhoods, ostensibly to save the City \$3 million at a time when the Chicago Police Department budget was \$1.3 billion. Today, as police response to mental health crises has only grown more frequent and the police budget has increased to nearly \$2 billion (not including the high cost of settlements for police abuse, officer overtime pay, nor police assets), which represents the second-highest per capita police spending among large U.S. cities, only five City mental health centers remain. None operate as 24/7 emergency mental health centers nor are any integrated with mobile crisis response teams. None feature community outreach teams for crisis prevention via ongoing supportive care. None incorporate violence prevention nor conflict resolution.

Analysis of publicly available 911 behavioral health call rates per 100,000 residents between January 1, 2019 and February 8, 2022 demonstrate that wards with high rates of behavioral health 911 calls tend to be concentrated in areas of the city where CDPH mental health centers have been closed. This is particularly evident on Chicago's South Side, where disinvestment has led to a swath of CDPH mental health center closures. South Side wards 6, 7, and 8 had the highest rates of behavioral health 911 calls in the city, with respective rates of 13,203, 17,668, and 22,012 per 100,000 residents. Nearby wards 17, 20, and 21 also had high rates of behavioral health calls, at 12,162, 12,369, and 11,827 per 100,000 residents. All of these are higher than the city average of 7,434 per 100,000 residents. Data also highlight the intersection between disinvestment from City mental health services and the needs of the unhoused population in Chicago. The 42nd ward, for example, which corresponds with much of Chicago's Loop and River North areas and features a high number of unsheltered individuals, also had a high rate of behavioral health-related 911 calls.



The scale of unmet need for mental health services in Chicago is enormous. A citywide survey on mental health needs in 2021 found that 94% of respondents would consider seeking emotional support by a professional (eg, counselor) as a way of dealing with their personal problems; 90%

of respondents stated they would use a city-run mental health clinic in their neighborhood that offered free services; and 73% of people (275) did not know that the City of Chicago operates any mental health centers that are available to residents regardless of ability to pay. This is particularly problematic given that approximately two-thirds (68%) of residents reported cost as a barrier to accessing mental health care and 29% of residents reported that they did not know where to go for services. 86% of surveyed residents stated they did not believe there are enough mental health services available in their neighborhood.

Access is highly variable between Chicago neighborhoods. A 2020 analysis of mental health providers throughout the city found that over three quarters (79%) of the city's population live in ZIP codes with an average of 0.197 therapists per 1,000 residents. Less than one quarter (21%) live in ZIP codes with an average of 4.284 therapists per 1,000 residents. Low-access areas feature more low-income residents and have fewer financial resources compared to the high-access areas (ie, ZIP codes with more than 1 licensed clinician per 1,000 residents). The mean household income in high-access areas (\$104,814) is twice that of low-access areas (\$57,084). Additionally, per-capita income is over 2.5 times greater in high-access areas (\$51,160) compared with low-access areas (\$19,475). ZIP codes with fewer than 0.2 licensed clinician per 1,000 residents are areas in which a high percentage of adults with psychological distress do not receive mental health treatment.

In the absence of universally accessible public mental health centers, CDPH has touted private providers, such as FQHCs and community-based organizations, as the key to expanding access to mental health services through the Trauma-Informed Centers of Care (TICC) network. Research from 2021 suggests severe deficiencies in this approach, including the fact that many organizations have long wait times and require payments that are burdensome for low-income residents. This assessment of private, non-profit providers who received City funds to deliver mental health services indicated that 17% of surveyed organizations did not serve undocumented residents and 25% did not serve those without insurance. While this assessment was conducted early in the implementation of the TICC program, the findings still raise serious concerns about mental health service accessibility through private providers.

Furthermore, although CDPH has publicly released data on the number of individuals served through their TICC network, there is no publicly available data indicating that the accessibility concerns identified in 2021 have since been addressed. For example, although CDPH has reported that 40,290 individuals have been served through the TICC network, there are no data available on the wait time to access services, service cost for individuals who are uninsured, and whether prospective clients have been turned away when requesting support and reasons why they may have been turned away. There additionally are no publicly available data regarding service duration, type of service received, or service outcomes. The data that are available on the number of individuals served through each TICC indicates that the numbers served through

outpatient clinical care range from 16 at one center to 4,375 at another in Fiscal Year 2022. Without any additional context for these data, it is unclear what percentage of these individuals received a one-time assessment and what percentage were enrolled in ongoing mental health services. By contrast, CDPH public mental health centers are open to all residents and offer free long-term mental health therapy services to all those that live within the city, regardless of ability to pay, documentation status, or insurance status.

Although she has previously opposed Treatment Not Trauma and the reopening of closed CDPH mental health centers, current Chicago Department of Public Health (CDPH) Commissioner Allison Arwady has nonetheless alluded to the limitations of privatization that leave the City dependent upon private organizations to recruit and employ necessary staff, observing that “Workforce challenges and a limited number of mental health professionals make it difficult to provide more mental health care across the city.” Separately, a recent report by the City Council Office of Financial Analysis flagged another substantial problem that arises from privatization of mental health services, stating that: “While providing resources towards mental health safety net is important, issues can arise when it comes to oversight and accountability of funds going to non-public providers of these services.” In contrast with public mental health centers, Chicago’s current private sector model of providing mental health services is not accountable to the public. In the context of a progressively dismantled and now severely deficient public safety net that has been ostensibly replaced by a network of private non-profit providers who cannot keep pace with the demand for services, mental health needs often go unaddressed until they reach a point of crisis, leading to police response, overutilization of hospital emergency departments, and inappropriate use of limited inpatient psychiatric beds in the absence of alternative resources.

The reality is that subcontracting short-term grant funds to existing private providers, which is CDPH’s current mode of operation with respect to its TICC model, does not effectively create new resources and reliable mental health centers at which residents can access services, particularly in areas with highest unmet need. By contrast, reopening fully-funded public mental health centers through guaranteed City corporate funding increases the City’s capacity to offer free mental health services, with targeted investment in areas of the city experiencing highest levels of need, under a sustainable public service model. Additionally, by funding these reopened centers via City resources rather than forcing them to rely largely upon reimbursement via medical billing, sustained funding from the corporate budget would allow CDPH mental health centers to operate via the most effective combination of nonprofessional social care services and professional mental health care delivery rather than being forced to replicate suboptimal medical models imposed by billing incentives. And, importantly, investing in CDPH mental health centers would allow for integration of these centers as an essential component of a non-police crisis response and stabilization infrastructure—a role that private, decentralized mental health clinics do not play and are not well-suited to fulfill.

It is clear that a shift in City funding priorities is required in order to ensure individuals throughout Chicago have access to preventative and reparative mental health services. For example, budget analysis has shown that for every dollar that is invested in the police, the City of Chicago currently invests less than one cent in public mental health services. The City cannot and will not interrupt cycles of trauma and violence if it continues to prioritize funding for police models of crisis response over building systems for community-building care, prevention, healing, and collective wellness. Sustained, long-term investment in public mental health services through reestablishing a robust public infrastructure is essential to promote thriving communities.

Although it lacks necessary scale and sustained funding plans and utilizes an ongoing police model of crisis response, in 2020, Mayor Lori Lightfoot introduced a police reform plan that among other things called for the creation of a co-responder approach to crisis response—that is, a modified police model of crisis response in which mental health workers are dispatched together with police officers. Recognizing the inherent potential for escalation for harm by having police as part of crisis response, that same year the Collaborative for Community Wellness introduced council order 2020-242 with lead sponsor Ald. Rossana Ramirez Sanchez. This council order called for the development of Chicago Crisis Response and Care System within Chicago Department of Public Health—a city-wide non-police crisis response system dispatched from a network of public community mental health centers. A hearing was never held after the introduction of the council order. But after public pressure against the police co-responder model of crisis response, negotiations with alders yielded an expansion of the existing police co-responder model pilot program from a two team pilot (one police co-responder team in two different police districts) with an addition of two non-police teams (one non-police team in two different police districts). The pilot, later rebranded as Crisis Assistance Response and Assistance (CARE), launched its police co-responder model teams in Lakeview/Uptown/North Center and Auburn Gresham/Chatham in September 2021. Nine months later, in June 2022, one fully non-police team was deployed in Gage Park, West Elsdon, West Lawn, Chicago Lawn, and West Englewood. Twenty-two months of data gathered by the pilot have demonstrated there has been no need for police involvement. Of the 967 calls responded to by the CARE teams to date, no calls have required the use of force and none have entailed arrests.

Continued concerns with the police co-responder model in other parts of the country have led to a shift away from pilots that involve police to non-police crisis response. Notably New York City experimented with a police co-response model and then scrapped the pilot, opting instead for a city-wide non-police crisis response after police brutalized a young man of color and arrested his mother who had called 911 and requested a non-police crisis response. A synthesis of local Chicago CARE teams data demonstrating that no crisis calls required police involvement, coupled with lessons learned from other municipalities that have shifted away from

police-involved crisis response, thus indicates that Chicago is overdue to phase out its police co-responder pilot and to substantially expand its investments in non-police crisis response infrastructure.

Finally, non-police crisis response has been demonstrated to be a popular policy among Chicagoans and City Council has previously expressed clear political will to reestablish public mental health centers within Chicago. In 2019 city council voted 48-0 in support of a resolution R2018-1398 calling for establishing a working group to examine where public mental health centers should be reopened. In 2022, 27 alders co-sponsored a budget amendment that sought to reappropriate \$10 million towards reopening public mental health centers. In November 2022, a referendum was introduced on the ballot in three wards asking residents, “Shall the City of Chicago reopen all of the closed Chicago Department of Public Health mental health centers in support of a city-wide crisis response program that dispatches mental health professionals and an EMT to mental health emergency calls instead of police officers?” In all three wards, the ballot measure passed with an average of 93% approval. In one precinct in the 6th ward, 100% of voters approved. Furthermore, a survey exploring community visions for mental health crisis response among 652 Chicagoans across all wards of the city found that over three quarters (77%) of survey respondents believed that police should not have a role in responding to mental health crises. Instead, survey respondents overwhelmingly reported that crisis response teams should be comprised of mental health professionals and peer support specialists who can both provide compassionate, empathetic, person-centered care and de-escalation support and connect individuals to the range of financial resources, medical care, and emotional supportive services necessary to promote both short- and long-term wellness.

In this context, backed by both evidence and popular opinion among Chicago voters, Treatment Not Trauma seeks to build on the lessons learned from the CARE pilot to address and publicly fund the currently missing, necessarily interlocking components—staff, space, and systems—of effective crisis response, community mental health, and shared safety.

### ***Treatment Not Trauma: Rebuilding Chicago’s Public Mental Health System***

Treatment Not Trauma consists of four core parts, each of which is necessary to optimize the success and value of the other three:

#### **1) Space: Reopening Chicago’s City-Run Mental Health Centers**

In addition to investing in expansion of the five existing CDPH mental health centers, Treatment Not Trauma will reopen 14 closed mental health centers. Drawing on the “Living Room” model of mental health centers, at least several of these centers will operate as 24-hour integrated service facilities for walk-in mental health services while also integrating conflict mediation and resolution, arts and culture-focused activities with neighborhood artist/maker fellowships, migrant welcome and transitional housing spaces,

community kitchens, embedded clinics for STI testing and gender-affirming care connection, contraceptive and centering-based prenatal support services, harm-reduction substance use disorder treatment services and connections, supportive transitional housing for people suffering from domestic violence and/or serious mental illness, navigator services that help refer community members to already available critical social services, and a service connection point for violence survivors who need help accessing critical non-carceral services. CDPH mental health centers will also double as the home bases for neighborhood community care worker outreach and mobile crisis response teams and in-community CDPH offices. (The lease for the current CDPH headquarters is expiring in 2024, providing an ideal opportunity for moving offices out of downtown and into closer interrelation with CDPH's priority target neighborhoods.)

These centers should have dedicated staff capacity for addressing the needs of particularly vulnerable groups, including youth, unhoused individuals, individuals with serious mental illness, gun violence survivors, and domestic violence survivors. Creating staff and non-carceral safety resources for both gun violence and domestic violence survivors would represent an enormous public health benefit to the Chicago community. Most domestic violence cases, for example, are never referred into the criminal system; according to the Bureau of Justice Statistics, nationally, an average of 582,000 nonfatal domestic violence victimizations are not reported to police each year. According to the National Domestic Violence Hotline, 80% of survivors are afraid to call the police and 24% who called the police in the past said that they would not call again in the future. Research from The Network: Advocating Against Domestic Violence and Mujeres Latinas en Acción indicates that domestic violence survivors commonly reported negative experiences with police, including being treated insensitively or feeling pressure to file a police report; being uninformed or misinformed of their rights; and not being connected to long-term supports. Both research reports recommended an alternate, non-police crisis response model that can provide immediate crisis stabilization support and connect survivors and their families to long-term supportive services. In addition, reluctance to speak to police following shootings has also been noted to be common in Chicago communities suffering high rates of gun violence. Given such realities, a large number of Chicago residents suffering gun and domestic violence have nowhere to turn—even though a broad range of programs from alternative crisis response and transitional housing to cash assistance, employment assistance, and safety planning have shown substantial progress at keeping survivors safe. CDPH community mental health centers could provide service connection points that would provide survivors with an alternative to the criminal-legal options, thereby keeping them, their families, and their communities safer.



Providing targeted youth mental health and wellness support would fill a similarly acute need. Other jurisdictions have achieved enormous success with youth violence prevention plans that holistically assess and address youth needs. In Minneapolis, for example, the Blueprint for Action to Prevent Youth Violence was associated with a 43% reduction in violent crime in its first two years. Given the efficacy of youth programming like sports and therapy programs, summer jobs, afterschool programming, and school-based violence prevention, it is unsurprising that this approach would see such results. By creating community mental health centers that assess and address youth mental health and safety needs while also collaborating with Chicago Public Schools, CDPH mental health centers have the potential to increase both youth safety in particular and the safety of communities in general.

Renovation of CDPH mental health centers should be led by communities with priority employment for local residents—including and especially those individuals who have one or multiple barriers to employment—and will proceed with temporary facilities placed outside each site to begin providing the services that the renovated spaces will eventually house. A participatory approach to the renovation work itself should be considered part of the community mental health center intervention and a key tool for local awareness and utilization of the centers.

In enacting this preference, the centers will both fill critical staffing needs and directly improve community safety by increasing employment. Youth workforce development and employment programs, such as summer jobs, have been shown to reduce youth violent crime arrests by as much as 45%; another study of a New Orleans-based job training program found that program participants were two-fifths as likely to be arrested as non-participants. Increasing employment through CDPH mental health centers may be particularly essential to keeping domestic violence survivors safe, as unemployment is among the most important demographic risk factors for intimate partner violence. This underlines that CDPH mental health centers can have positive effects on communities not only through the services they provide but also through the gainful, dignified, and strategically targeted employment they can bring to neighborhoods.

Transparency and local community control in collaboration with CDPH centralization for maximally effective, integrated operations will be critical to the reemergence of Chicago's City-run mental health centers. The Community Mental Health Board, which continues to provide oversight and hold public meetings with CDPH administration, is currently able to provide oversight and community input in relation to existing CDPH mental health centers in ways that are not presently possible with private-sector providers. Building on this existing framework, expanding Community Mental Health Boards could allow for reinstituting democratic participation by grounding each CDPH

mental health center in the communities served by it, facilitating community input and control over allocation of resources and program offerings at each center. Historically, each CDPH center had its own Community Mental Health Board and a number of locally selected members of the Board sat on a city-wide Community Mental Health Board. Treatment Not Trauma will seek to reinstitute this model of transparent, democratic, and participatory governance over Chicago's public mental health system.

To further facilitate this, CDPH mental health centers should be responsible for ensuring a consistent, thorough assessment of community care and safety gaps in communities so as to be able to respond to unaddressed needs. Every three years, these centers should conduct a "community care and safety needs assessment" modeled on the health needs assessments often required of hospitals and other health providers. These assessments should systematically assess what underlying, systemic drivers are impacting health and safety outcomes, then use participatory processes to create community-oriented action plans to address these needs. In this way, the centers will maintain an ongoing commitment not only to providing the services discussed here, but remaining attuned to new needs, ideas, and innovations that can best achieve optimal mental health, safety, and community wellness outcomes.

Staffing at the centers will consist primarily of community residents who live in the areas served by each center and who are paid living wages to be trained and to work as community care providers. They will oversee day-to-day operations at the centers. They will work in conjunction with on-site social workers, multidisciplinary therapists, nurses, and physicians, with the express goal of facilitating "scope creep"—ie, assisting lay care workers to assume responsibility over a growing range of services as they are progressively trained to do so by their professionally trained colleagues. Every effort will be made to recruit staff—professional and lay—from the neighborhood around each CDPH mental health center, with housing and relocation incentives as needed to recruit professional staff as part of a CDPH campaign to counter healthcare worker demoralization and reinvigoration of social mission through the offer of community-based employment in an integrated care model.

CDPH mental health centers will also collaborate with other City agencies to serve as coordinating centers for securing permanent housing for every Chicago resident.

a) Stages of CDPH Mental Health Center Expansion

- i) Year 1: Reinvest and expand the existing 5 mental health centers, making at least three of them into 24/7 walk-in centers and mobile crisis dispatch and reception facilities. Begin an assessment of possible properties to purchase and begin investment in facility improvements to upgrade

existing city-owned properties to be opened beginning in year 2; the City should also explore whether closed CPS schools could serve as effective sites for new CDPH mental health centers.

- ii) Purchase properties or repurpose existing City-owned buildings to avoid repeating wasteful spending under the previous CDPH operations where rental contracts far exceeded the value of properties rented for mental health centers:
  - (1) Open 3 new centers in year 2
  - (2) Open 5 new centers in year 3
  - (3) Open 6 new centers in year 4
- b) Fund these via increased allocations from City corporate budget as well as issuance of public health bonds by CDPH.

## 2) Staff: Hiring a Community Care Worker Corps

- a) As it reopens 19 CDPH mental health centers, TNT will hire a large-scale Community Care Worker corps as CDPH employees as the core of TNT and a revitalized model of public health that is focused on trust-building direct service delivery rather than simply technocratic functions alone. This model of community health that makes central use of nonprofessional mental health workers alongside professional providers is currently notably underutilized in the US, largely due to reimbursement structures and medical-industry lobbies that have provided perverse incentives to overemphasize professional mental health services at the expense of investments in nonprofessional care systems. But there is abundant evidence from international contexts of its effectiveness and importance, especially in the face of a profound dearth of existing services and professionals such as that seen in Chicago's highest-need neighborhoods.

This hiring, on-the-job training, and retention of Community Care Workers could be funded via a possible combination of reallocating current police vacancies (estimated in July 2022 to represent approximately 1,800 funded positions; CPD, which already has the second-highest number of officers per capita of any U.S. city, has had chronic difficulty filling these positions such that many have been vacant for several years) and/or, independently, increasing City corporate funds for CDPH to staff the mobile mental health crisis response teams, mental health centers, and Community Care Worker teams engaged in everyday preventive care in neighborhoods.

Community mental health and mobile crisis response work, which is no less demanding nor does it entail less personal risk relative to police work, should be valued by the City at least as highly as it values investments in policing. By

investing in Community Care Workers with wages and benefits comparable to those presently provided to police officers, TNT can also provide another major benefit—a leading social determinant of individual and collective mental health: dignified, gainful employment—to Chicago neighborhoods currently suffering high levels of overlapping unmet mental health, economic, and social needs.

- b) Alongside Community Care Workers who will comprise the staffing backbone of the CDPH mental health centers and will provide both in-center services and neighborhood outreach services, each center should also be staffed by what will be collaboratively determined with local community members and other relevant stakeholders to be the optimal number of the following professionals: psychiatrists, psychiatric nurse practitioners, social workers, and nurses.
  - c) Depending upon results obtained from TNT's initial implementation and from ongoing assessment of community needs and preferences, funding for additional Community Care Workers beyond the initially requested number may subsequently be sought from the City in order to facilitate expansion of community outreach services for preventative care via further capacity for home visits and intensive social care for individuals living with addiction, physical disabilities, and/or serious mental illness.
  - d) Mental health response teams
    - i) Eliminate the police co-responder model for crisis response
    - ii) Expand the public health model of non-police crisis response teams to make them available to all Chicago neighborhoods on a 24/7 basis, initially focusing resources on areas with the highest number of mental health-related 911 calls. Each CDPH mental health center should feature its own mobile crisis response team, which should consist of a minimum of two team members, although alternating cross-cover across neighboring centers to facilitate 24/7 operation may be considered based upon need and staffing levels. Mobile crisis response teams will initially consist of a nonprofessional care worker paired with a professional care worker, although purely nonprofessional mobile crisis response teams may be trialed and utilized if found to be similarly effective and safe.
    - iii) Conduct analysis of the neighborhoods with greatest need for crisis response teams and reception centers to inform optimal sites for opening new CDPH mental health centers to best meet Chicagoan's needs
- 3) Systems: Mobile Crisis Response Dispatch Infrastructure
- a) Changing the 911 call-in procedure to ask if it's fire, police, EMS, or mental health services (currently people cannot request a CARE team); integrating 988 to dispatch services for non-police mobile crisis response teams

- b) Procure mobile crisis response unit and mental health center equipment, such as cars, vans, and trucks as well as equipment (eg, computers and tablets, basic medical laboratory equipment, etc.) to allow CDPH mental health centers to function effectively as integrated service facilities
- 4) Sustained Funding: City of Chicago corporate budget allocations to CDPH must be substantially increased to launch and then sustain Treatment Not Trauma as central to CDPH's mission and integrate it with CDPH's broader community health and syndemic disease control programs.

### ***Measuring Treatment Not Trauma's Effects***

Governance is shaped by the metrics upon which the success of policies are judged. Alongside the care it provides, then, a key aspect of TNT consists of its application and dissemination of innovative, more holistic means of measuring community wellness and safety. This is important for helping the City of Chicago and its residents move beyond currently dominant—yet arbitrary and misleading—distinctions between “public safety” and “public health” that obstruct optimal policy design for addressing the shared root causes of both violence and poor health.

Reflecting the growing realization that public health, mental health, community wellness, and safety are intertwined phenomena that must be addressed in tandem, the target outcomes of TNT should include metrics that more accurately capture these overlapping areas and better represent them to lawmakers, media, and the public. These should include 1) traditional measures of mental health treatment and prevention, healthcare outcomes and costs, overdose rates and mortality, and all-cause mortality as well as 2) metrics for community safety, including rates of homelessness and eviction, unemployment and income insecurity, property and violent crime, incarceration, healthcare access, police violence, suicide, and life expectancy, as well as subjective measures of perceived safety, neighborhood trust, and pro-sociality. Such outcomes can be assessed using a combination of administrative, community-level, and self-reported data. TNT's core metrics and anticipated outcomes should thus include consideration of the following:

#### ***Health metrics***

1. **Improved population-level health outcomes**, including reductions in all-cause mortality, chronic and infectious diseases, maternal and infant mortality, and addiction and overdose, with the most notable gains expected among the currently poorest and most medically disenfranchised demographics. Other relevant metrics CDPH will collect include data on changes in rate of hospitalizations, emergency department visits, and adherence to outpatient care plans. Building on a [2018 study](#) that showed a community health worker program in Philadelphia reduced hospitalizations by 65% and doubled patient satisfaction with their primary care physicians, TNT is anticipated to yield significant health gains.

2. **Reduced healthcare costs** as a result of decreased emergency room visits and hospitalizations, and improved adherence to medications and utilization of preventative care services. A 2020 study of a community health worker intervention in Philadelphia showed that for every dollar invested, \$2.47 is saved by Medicaid payers. Additionally, mobile crisis response in particular has been found to be especially effective at reducing healthcare costs. A 1993 study, for example, found that mobile crisis intervention services reduced inpatient hospitalization costs by 79% over a six month period following each crisis episode. Another study, looking only at initial expenses, found a 23% cost savings generated by mobile crisis response services, as such services are effective at diverting people from psychiatric hospitalization and better than hospitals at linking people to outpatient services. For example, when Delaware adopted a crisis management system, it found that mobile crisis teams were able to divert 80-90% of people from hospitalization or contact with the criminal justice system.
3. **Improved mental health**, including reduced rates of anxiety, depression, and substance use disorders; reduced rates of mental health crises resulting in police contact, 911 and 988 calls, emergency department visits, involuntary hospitalization, and need for court-ordered medications. Recent studies of social support via telephone and virtual visits conducted by lay care providers with less training than proposed for TNT's Community Care Workers have demonstrated significant improvements in mental health via supportive social interactions. Benefits from in-person visits by TNT outreach workers are likely to be even greater, as substantial evidence from international contexts further reinforces the promise of the TNT model for improving individual and population-level mental health.
4. **Reduced adverse childhood experiences**, owing both to family contact with police and prison systems as well as to childhood exposure to violence, that are well-documented to be associated with long-term psychiatric, medical, social, and economic disadvantages as children grow up.

#### *Criminal-legal metrics*

1. **Improved community safety** via reduced rates of homelessness, DCFS cases, firearm violence, violent crime, property crime, police contact and abuse, arrest, and incarceration.
2. **Reduced gun violence rates** via enhancing general preventative community-level factors and by incorporating de-escalation, conflict resolution, and targeted youth employment and mentoring programs into the community care workers' outreach tasks
3. **Decreased reliance on law enforcement for non law-enforcement needs** as community care workers take on roles previously performed by police, such as

mental health crisis response and welfare checks, and also as increases in community-based care increasingly prevent crises and violence.

4. **Reduced rates of rearrest and reincarceration** by addressing key causes of rearrest: unemployment, homelessness, lack of mental health and medical care access, social isolation, addiction, and lack of community.
5. **Reduced arrest and incarceration rates** due to diversion from police contact of individuals with mental health, addiction, housing, and other needs who are now able to find such needs met through community care infrastructures.

#### *Community wellness metrics*

1. **Improved levels of mutual trust and trust in government** as a result of reduced police contact, more contact with publicly supported care services and with other community members, and increased subjective perception of safety within communities.
2. **Reduced unemployment and poverty** via direct provision of dignified jobs with living wages (>\$60,000 annually, with full benefits) for residents of neighborhoods currently suffering highest risk of violence and poor health outcomes, as well as spillover economic benefits for others.
3. **Improved elder care and quality of life** via provision of home-based services that allow for continued community-based living rather than nursing-home support.
4. **Improved child education achievement** due to reduced parental illness, unemployment, poverty, and incarceration—all of which have been shown to affect childhood learning.
5. **Increased voter participation rates** due to improved trust in public systems and decreased exposure to known deterrents to voting, such as police contact and incarceration.
6. **Improved childhood educational attainment** due to decreased exposure to parental incarceration, neighborhood and domestic violence, and school violence—all of which are associated with significant adverse childhood experiences and impaired school performance.
7. **Population well-being** due to the intersection of decreased burden of disease and increased emotional health, job satisfaction, and optimism regarding personal and neighborhood futures.

#### ***Anticipated Cost Savings from Investments in Treatment Not Trauma***

In general, investing in community-based health and safety infrastructure like TNT produces dramatic cost savings both to municipal emergency services (eg, police and fire departments), jails and prisons, and hospitals and medical payers—as well as improvements in core health and safety outcomes. As pertains to healthcare savings generated by mobile non-police crisis



response systems, one study found that mobile crisis intervention services reduced inpatient hospitalization costs by 79% over the six months following each crisis call. A related study, which evaluated only initial expenses, found a 23% savings. Evaluated more comprehensively, The Crisis Resource Need Calculator developed by RI International, for example, estimates that a program for non-police crisis response like Treatment Not Trauma would yield \$537 million in savings per year if implemented across Cook County, which translates to \$279 million in savings when restricted to the population of Chicago alone. Actual savings may be greater, as Treatment Not Trauma provides more infrastructure for ongoing preventative support than the model upon which this calculator is based. Of note, the RI International model also estimates that building an adequate mental health crisis response system for Chicago would require at least 19 mobile crisis response teams (assuming 40-hour work weeks), 148 crisis-receiving chairs at mental health centers, 126 short-term crisis beds, and 350 acute inpatient psychiatric beds.

In public health, evidence shows that the greatest increases in life expectancy have stemmed not from advances in medical services but improvements like improved hygiene and water quality regulation, reduced air pollution, and other investments in public health. By preventing health complications upstream, these preventative investments created better outcomes for less money—and that cost-benefit calculation has persisted over time. Today, data shows that each dollar invested in evidence-based prevention produces fourfold or fivefold returns. A 2017 systematic review found that every \$1 invested specifically in “health protection interventions” produced \$34 in cost savings. A 2016 analysis suggested that public health spending is likely to yield savings ranging from \$67 to \$88 per dollar invested. Because TNT is designed to prevent not only poor health outcomes and associated healthcare costs but also violence, crime, incarceration, and police activity in a City that spends a large proportion of its budget on law enforcement, savings to the City from investments in TNT’s preventative systems may be even higher than in the case of more traditional investments in public health.

From a criminal-legal perspective, the economics of crime prevention operates along similar lines to that of public health investments. Nearly every study evaluating preventative measures that target criminal behavior has found that benefits far outweigh costs. In one study, adding streetlights yielded \$121 for every \$1 invested. Investments into housing have a similar effect, with an ROI evaluation noting that the Housing Pathway Return program “can reduce a previously homeless client’s healthcare costs by several-fold while also generating cost savings for the public safety, criminal justice, and education systems.” And as noted by the law enforcement group Strong America, a federal preschool investment would return an estimated \$3 for every dollar spent, partly through reduced criminal-legal spending.

### ***Treatment Not Trauma and the Future of the Chicago Department of Public Health***

Public health, both in Chicago and nationwide, is at a pivotal historical juncture after Covid has proven the current technocratic, privatized model of US public health to be severely deficient

and in need of substantial reorganization and increased funding. Trust in government in general and public health in particular are at historic lows. Simply continuing with the status quo in public health will further weaken health and safety, deepen racial inequalities, and undermine democratic participation.

Treatment Not Trauma is intended to revitalize public health systems in Chicago by shifting CDPH toward a model of public health focused on direct service delivery, public jobs, and trust-building community care systems. It is rooted in a community care worker corps as part of a coordinated response to the overlapping problems of gun violence, mass incarceration, mental illness, homelessness, overdose, distrust, and growing racial health inequalities in Chicago, where the Black-white gap in life expectancy has widened to 10 years. Gun-related homicide is the second leading contributor to this racial gap in life expectancy, following only 1) chronic diseases (eg, heart disease and diabetes) and followed by 3) infant mortality, 4) infectious disease, and 5) opioid overdose. Gun violence and overdose prevention must thus be core immediate and long-term priorities for CDPH reorganization, and Treatment Not Trauma is intended as a key piece of CDPH's response to these overlapping crises.

Funding shortfalls, however, must be overcome to make this expansion of CDPH possible. At present, CDPH receives the vast majority of its funding from federal grants earmarked for specific purposes, with almost no funding from the State and only about 10% of its budget ensured by the City of Chicago. Among large city public health departments in the US, this reliance on restricted federal funds is unusual. It is also unsustainable and harmful to Chicago's residents, limiting CDPH's capacity to build necessary, innovative, sustainable programs and to respond to shifting community needs in a timely, effective manner. After a three-decade-long defunding process, CDPH is now by far the most understaffed and underfunded large city public health department in the country. As Chicago's notably poor health and safety outcomes reflect, residents are paying the price for this persistent underinvestment in public health systems.

For CDPH to be effective in addressing poor health and safety in Chicago's neighborhoods, it must secure a substantial increase in its annual budget from the City and bring its staffing levels to at least the level of peer large city departments. In order to motivate such an increase, CDPH must also design, promote, and implement programs to justify such funding in the public eye and before City Council. Treatment Not Trauma is thus meant to be paired with a capital campaign involving City, State, and federal sources to enable a generational expansion of CDPH in order to rebuild public care systems in Chicago. As part of this campaign, CDPH will build an innovative program for public health bonds as part of negotiated partnerships with healthcare payers (ie, public and private insurers), who—unlike hospitals and healthcare providers—have structural incentives to prioritize prevention and improve baseline health in order to reduce healthcare costs.

Given the above, Treatment Not Trauma operates on the following guiding principles for public health systems redesign:

1. Public health cannot succeed without public trust and sustained funding. To earn trust and political support for adequate levels of continuous funding, public health systems must meet people's needs via supportive interpersonal contact and bottom-up knowledge production that values lived experience. Public health, then, must be grounded in everyday direct service provision—with public, not private-sector jobs—that is visible and felt by residents all the time, not only biosurveillance, vaccination, biostatistics, nor behavioral regulation that goes unnoticed by the public except in periods of epidemic emergency.
2. Public health approaches to shared safety are vital for the success of either public health or public safety; we cannot have one without the other. City infrastructures for health and violence prevention must be integrated.
3. Crisis response works best, and is needed least, when it is interwoven with sustained crisis prevention systems based on supportive interpersonal relationships with people living at greatest risk of behavioral and mental health crises.
4. To deliver maximum benefit to the entire population, public health must prioritize intensive social care and prevention for the most excluded and at-risk individuals and groups. It must also simultaneously engage every segment of a population, including the most well-protected groups, to generate universal support for bottom-up investments.
5. Good-quality public health jobs in disinvested communities are essential to earn public trust and to build health and safety. Income via dignified, meaningful work is a key tool for enabling individual and collective well-being.
6. Public health is biosocial and networked such that no problem can be understood nor solved in isolation; integrated community-based care enables synergy to maximize outcomes.
7. Metrics shape policy. How we measure health and safety determines how they are perceived and the political responses then believed to be necessary and effective. Public health should take a more central role in the measurement of community safety.
8. Effective care is participatory, inclusive, and community-controlled. Public health succeeds when the whole population is enabled by public systems to participate in caring for itself and each community is empowered to set and realize its own priorities for itself.

9. Functional health systems depend primarily upon non-medical, lay care systems for preventive support; professionalized medical care should generally function as a secondary infrastructure that steps in when first-line prevention is inadequate. Public health systems and funding choices must reflect this.