June 13, 2019 Public Hearing on the Public Mental Health Service Expansion Resolution:
Results and Recommendations

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FINAL REPORT

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"I HAVE NOT BEEN ABLE TO FIND A MENTAL HEALTH CLINIC IN MY NEIGHBORHOOD OF BACK OF THE YARDS, AND WHERE THERE ARE CLINICS, THERE IS A LONG WAIT. AND THEY ARE NOT ACCESSIBLE BECAUSE THEY ARE EXPENSIVE. WE NEED BILINGUAL CLINICIANS. AND THERE ARE MANY PEOPLE LIKE ME WHO NEED THESE SERVICES. IT'S TIME THAT WE ARE HEARD, AND THAT WE MAKE A CHANGE IN OUR COMMUNITY. WITH HEALTHY MINDS, EVERYTHING WILL BE HEALTHIER IN OUR COMMUNITY AND IN OUR HOMES." – MARIA JULIA PEÑA

The city of Chicago has seen a pattern of continued disinvestment in public mental health services, as evidenced through reduced spending and clinic closures since 2004. Although proponents of the mental health clinic closures have argued that private providers can meet the demand for mental health services, recent research points to the structural inequities in service access within Chicago's mental health service landscape. Survey data from a sample of 2,859 adults on Chicago's southwest side indicated that despite an overwhelming demand for services, structural barriers including cost, lack of insurance coverage, and a lack of services in close geographic proximity posed the greatest challenges to mental health service access.[1] Data also demonstrate that there are marked disparities in service access throughout the city as a whole. A systematic search of licensed private practice clinicians across each zip code in Chicago indicated that zip codes with the highest ratios of licensed clinicians are predominantly concentrated in the city's low economic hardship communities.[2] Furthermore, although the Chicago Department of Public Health maintains that there are 253 private providers who can address community residents' mental health needs, a systematic assessment of these providers pointed to problems with accessibility, as only 59% (150) of these providers could be successfully reached via phone after a minimum of two outreach attempts. Of the providers who were successfully contacted, only 15% (19) reported that they offer free services and 30% (34) reported having a wait for services.[3] Recognizing the gaps in the current infrastructure, the Chicago City Council approved the Public Mental Health Service Expansion Resolution in order to develop recommendations for strengthening Chicago's public mental health system.

On June 13, 2019, a public hearing was convened at Malcolm X College from 6:00-9:00pm in order to initiate the public input process outlined in the Public Mental Health Service Expansion Resolution. Due to widespread efforts among community organizations and community leaders to disseminate information about the hearing, 30 community areas and 22 wards were represented among those in attendance. In addition to the oral and written testimonies that were provided at the hearing, a survey on experiences with mental health service access was also administered to gain additional insight on mental health service needs, access barriers, and recommendations for strengthening the current public mental health system. Data were synthesized across testimonies and survey responses.

Findings indicate the need for increased funding and investment in mental health services. Public mental health services play a critical role in addressing the mental health needs of the most vulnerable and are an important part of the safety net in a community. The number of public clinics has been reduced to five, leaving many community residents with unmet needs. As illustrated through these data, a robust public mental health system promotes individual healing by addressing holistic needs, offering consistent, long-term emotional support, and fostering a sense of community. Community residents' primary recommendation for interrupting cycles of harm within their communities was to address systemic disinvestment in public mental health services. Community-based, public mental health clinics are an important safety net that can provide the space and resources needed to promote healing from trauma and address mental health needs, particularly for vulnerable and low-income communities. In order to accomplish this goal, there is a need for diversification and increase in funding services. Over-reliance on block grant funding leaves public mental health services vulnerable to continued disinvestment and erosion. Public Mental Health Clinics would go a long way toward addressing barriers to access. Despite a high demand for services, barriers including lack of proximity, cost, lack of insurance or underinsurance, the impact of policies such as the Public Charge rules, and long wait times limit the ability of community residents to access services even during an acute crisis.

Existing and expanded services must also consider a vision for what type of services will be offered. Community residents indicated the need for access to psychotherapy, services that are trauma informed and can address complex traumas such as historical and intergenerational trauma. Thus, there is a need for time and space that offers the opportunity for the development of relationships that promote healing. Furthermore, these services must be holistic and culturally responsive, de-emphasizing a biomedical model, and instead provide a system that addresses a wide range of psychosocial needs, access to alternative and non-medical services, and opportunities for social support.

REPORT AUTHOR

Dr. Leticia Villarreal Sosa is a professor of social work at Dominican University. She earned her PhD from the School of Social Service Administration at the University of Chicago. She has a wide range of experience with Program Evaluation and Community Based Participatory Research, collaborating with community based organizations globally and locally. She has led various community-based research projects focused on social services in immigrant communities, school equity, mental health, and adult education.

Dr. Villarreal Sosa also has over 14 years of experience as a clinical social worker, working with children and families in a variety of settings. She is currently serving as a trauma therapist for asylum seekers, and conducts forensic evaluations. She is a Licensed Clinical Social Worker, holds a School Social Work Professional Educator License, and a Certificate in Addictions Counseling. She provides professional development for clinicians, school social workers, faculty, and other professionals in areas such trauma, ethics, truancy, cultural humility, and inclusive education. She also serves as a key expert for the International Foster Care Organization providing consultation services regarding the de-institutionalization and social inclusion of vulnerable or marginalized children. Her international work has included the development of the legal basis for the child welfare system in Azerbaijan, including overseeing and evaluating a pilot project to deinstitutionalize children. Currently she is working on several international projects focused on the development of social work and social work education in Azerbaijan and Ecuador. In Ecuador, she is directing the development and implementation of the first Master's degree program in the country. She has an upcoming project in Vietnam focused on the development of school based mental health services.

She continues to do research in the area of school social work, immigrant adaptation, trauma, international social work, adult education, mental health, and school equity. Recently, she published a book which was selected for the Book of the Year Award by SSWAA, *School Social Work: National Perspectives on Practice in Schools* that promotes school social work aligned with the national practice model developed by SSWAA and a focus on an intersectional approach to diversity. She is the Co-Editor in Chief of the International School Social Work Journal and the Editor in Chief of Children & Schools. In addition, she serves as a board member of the School Social Work Association of America. Her current book projects focus on the needs of Latinx students in the schools, oral histories of Mexican and Puerto Rican older adult women active in organizing in Chicago since the 1960's, and a book focused on the collection of Queer Latina narratives. She is the recent recipient of a Spencer Grant for a collaborative project that focuses on the experiences of immigrant youth in the schools and the role of school social work.

INTRODUCTION

Public mental health services play a critical role in addressing the mental health needs of the most vulnerable and are an important part of the safety net in a community. In the U.S., public dollars account for more than half of the money spent on mental health services.[4] Having adequate support for persons with mental illness can prevent a person from becoming trapped in homelessness, poverty, frequent hospitalization, or recurrent involvement in the criminal justice system.[5, 6] Despite this vital role of the public mental health system, the city of Chicago has seen a pattern of continued disinvestment in public mental health centers. This is evidenced by the clinic closures beginning in 2004, the continued precipitous decline in mental health spending since 2011, and the over reliance on federal block grants to fund these services. After clinic closures in the city of Chicago, the most vulnerable communities, ethnic and racial minorities living near or below the poverty line, were hardest hit, facing major barriers to accessing services.[7] For example, those without cars or funds to pay for lengthy journeys to other neighborhoods for services face major barriers to accessing services. In an effort to provide empirical evidence to answer some of the questions about how vulnerable communities have been impacted by clinic closures in Chicago, this report provides the results of a survey and analysis of public testimony gathered at a public hearing on Thursday, June 13, 2019 at Malcolm X College. Concluding the report, recommendations are offered based on these findings.

Attendees at the June 13, 2019 Public Hearing at Malcolm X College.

BACKGROUND

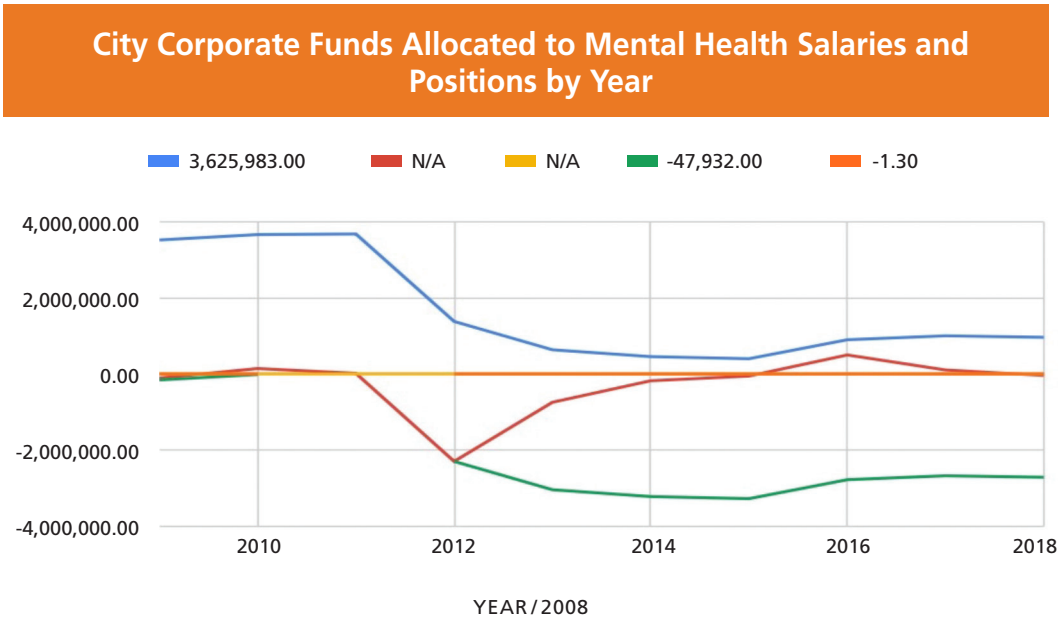
Decline in Spending

Between 2008 and 2011, prior to the cuts in mental health spending by the city, an average of $3,618,798.50 in city corporate funds was allocated to mental health salaries and positions per year. Since the cuts that began in 2012, city corporate funds have on average allocated only $817,730 to mental health salaries and positions. Comparing the pre and post cuts spending averages, the city since 2012 has allocated only 22.5% per year what it did between 2008 and 2011. In no year since 2011 has the city allocated more than 40% what it did in 2011, illustrating the comprehensive disinvestment by the city in mental health services, impacting some of Chicago's most vulnerable communities. If we compare the highest spending year between 2008 and 2011 and the lowest spending year since 2012, spending in 2011 was $3,673,915 while spending in 2015 was only $399,324. *Comparing those two years we observe spending in 2015 that is only 11% of what it was in 2011.* Even if we compare the lowest spending year between 2008 and 2011 and the highest spending year since 2012, spending in 2009 was $3,516,774 while spending in 2012 was only $1,377,638. Comparing those two years we observe spending in 2012 that is only 39% of what it was in 2009.[8]

TABLE 1: CITY CORPORATE FUND ALLOCATION TO MENTAL HEALTH SERVICES 2008-2018[9]

Year	City Corporate Funds Allocated to Mental Health Salaries and Positions	Change from Previous Year	Percent Change from Previous Year	Change from 2011	Percent Change from 2011
2008	3,625,983.00	N/A	N/A	-47,932.00	-1.30
2009	3,516,774.00	-109,209.00	-3.01	-157,141.00	-4.28
2010	3,658,522.00	141,748.00	4.03	-15,393.00	-0.42
2011	3,673,915.00	15,393.00	0.42	N/A	N/A
2012	1,377,638.00	-2,296,277.00	-62.50	-2,296,277.00	-62.50
2013	633,830.00	-743,808.00	-53.99	-3,040,085.00	-82.75
2014	454,472.00	-179,358.00	-28.30	-3,219,443.00	-87.63
2015	399,324.00	-55,148.00	-12.13	-3,274,591.00	-89.13
2016	897,108.00	497,784.00	124.66	-2,776,807.00	-75.58
2017	1,000,573.00	103,465.00	11.53	-2,673,342.00	-72.77
2018	961,165.00	-39,408.00	-3.94	-2,712,750.00	-73.84

FIGURE 1: CITY CORPORATE FUND ALLOCATION TO MENTAL HEALTH SERVICES BY YEAR[10]



Public Mental Health Clinic Closures and Service Access

While the city of Chicago had a network of 19 public mental health centers in the 1970's, this number has consistently decreased over the past several decades. As of 2004, seven of the 19 clinics had closed, following a series of budget cuts that began in the 1990's.[11] Further disinvestment occurred in the current decade, beginning with the passage of Chicago's 2012 city budget, which closed six clinics and privatized another.[12] The number of public mental health clinics operated through the Chicago Department of Public Health (CDPH) has been reduced to five in the present day.[13] Proponents of the clinic closures have argued that there is a network of private providers equipped to address the mental health needs of community residents across the city.

Although proponents of the CDPH mental health clinic closures have argued that private providers can meet the demand for mental health services, recent research points to the structural inequities in service access that exist within Chicago's mental health service landscape. In May of 2018, the Collaborative for Community Wellness, a coalition of community-based organizations, service providers, and community residents focused on facilitating mental health service access for underserved communities, released findings from its mental health needs assessment. Findings from this assessment, conducted across ten community areas on Chicago's southwest side, indicated that there was a high level of mental health need and an overwhelming demand for mental health services across the surveyed communities. In particular, among a sample of 2,859 adult community residents, slightly less than half reported experiencing depression (49%), over one-third reported experiencing anxiety (36%), and over one-fourth reported that they experienced trauma-related symptoms (27%). Furthermore, 80% of respondents reported "yes" or "probably yes" to the question of

whether they would seek professional support for their personal problems. Despite this high demand for mental health services, respondents reported that structural barriers, including cost (57%), lack of insurance coverage (38%), and a lack of services in close geographic proximity (34%) posed the primary barriers to service access. Qualitative data from individual interviews and community forums further indicated that because community residents are impacted by chronic trauma in the systemic and community contexts in which they live, long-term mental health services are necessary to promote healing.[14] Not only do the data from this mental health needs assessment point to structural inequities and a need for investment in free, long-term, trauma-focused mental health services on Chicago's southwest side, but several other research initiatives have also identified issues with disparate service access across the city of Chicago as a whole.

In September of 2018, the Collaborative for Community Wellness conducted a systematic search of licensed private practice clinicians across each zip code in the city of Chicago. Results from this search demonstrated that zip codes with the highest ratios of licensed clinicians are predominantly concentrated in low economic hardship areas in the north and central regions of Chicago. For example, the zip code 60602, which corresponds to affluent community areas in the center of the city, yielded the highest ratio in Chicago, with over 324 licensed clinicians per 1,000 individuals. In contrast, zip codes corresponding to high economic hardship community areas on Chicago's west, southwest, and south sides consistently yielded less than 0.1 licensed clinician per 1,000 residents.[15] Such data confirm that mental health services are not readily available within Chicago's high economic hardship communities.

Despite the marked disparities in service access highlighted through these data, CDPH has maintained that there are 253 private providers who are equipped to address the mental health needs of community residents throughout the city. To assess this claim, the Collaborative for Community Wellness conducted a systematic assessment of the accessibility of the listed 253 providers between December 28, 2018 and January 15, 2019. Phone calls were placed to each of the 253 providers in order to learn more about the type of mental health services provided and the organizational context informing service delivery. A script was developed to ask agencies: a) do you provide mental health services, b) if so, what type of services do you provide, and c) for each service provided, how long are the wait lists? Callers also inquired about organizational factors influencing accessibility, such as the cost of services and the number of part-time and full-time clinicians. A minimum of two outreach calls were placed to each agency in this time period. Results of these phone calls pointed to problems with accessibility of the listed providers, as callers were only able to connect with 59% (150) of the providers after at least two outreach attempts. Furthermore, of the providers with whom the Collaborative for Community Wellness was able to make contact, only 15% (19) reported that they offer services free of charge and 30% (34) reported having a wait for services.[16] Taken together, these data raise concerns regarding the accessibility and organizational capacity of the providers that the CDPH has identified as being equipped to meet the demand for mental health services within the city of Chicago.

The Impact of Changes in the Public Charge Rule

Immigration policy has historically had provisions for exclusion and removal designed to limit government spending on indigent non-Citizens. An individual can be denied entry or denied adjustment to lawful permanent resident status if they are deemed to be likely to become a "public charge." While there is no official definition of public charge in the Immigration and Nationality Act (INA), agencies have interpreted this definition as public cash assistance or long term institutionalized care at government expense.[17] However, new public charge rules for DHS and DOJ instruct consular officers to consider a wider range of public benefits when considering whether or not an immigrant is a public charge, including publicly funded health insurance. Under these new rules, an immigrant who applies for permanent legal status when they become of age could be barred due to having used medical coverage as a child, for example. It is important to point out that most immigrants, in fact, are not eligible for relevant public benefits programs. However, the examples of those who may receive benefits include: a) lawful permanent resident children can receive SNAP benefits in all states and Medicaid in most states, b) people granted asylum or refugee status are eligible for SNAP, Medicaid, and housing assistance, c) non-citizen veterans of the U.S. military and their surviving spouses are eligible for Medicaid and SNAP, d) lawful permanent residents are eligible for housing assistance in some states, and locally funded cash assistance or long-term care in some states.[18]

It is expected that these changes will have harmful health impacts on immigrant communities due to the disincentive to enroll in public health insurance programs for which they qualify due to fear of adverse immigration consequences.[19] Parents may elect to forgo enrollment even for U.S. citizen children in programs offering needed services such as vaccines, health care, safe housing, or nutrition.[20] The effect could be chilling for U.S. citizen children, as it is estimated that 10.3 million U.S. citizen children live with at least one non-citizen parent, constituting 13.2% of all U.S. children.[21] These changes create an even greater need for public health services in communities where residents could develop a sense of trust with providers; and services could be culturally responsive, understanding concerns that immigrant communities may have about accessing services. The social safety net that local, city funded public services could provide is imperative for the well-being of immigrant communities.

Over Reliance on Block Grants

The majority of funding for mental health services in the city of Chicago comes from Community Development Block Grants.[22] There are two challenges with this approach to funding public mental health services in this way. First, federal block grants are fixed grants. In comparison to entitlement programs, these grants cannot respond to changing needs in services. For example, with entitlement programs, anyone who is eligible for services can receive them, thus funding automatically increases in response to economic downturns, natural disasters, or higher than expected costs. Fixed funding creates a program structure unable to respond to changing needs. If needs increased, services would have to be rationed, such as cutting eligibility or creating long wait lists.[23] Second, block grants create disincentives for local investment in services in comparison to matching grants. When social services, particularly for the most vulnerable residents are funded through block grants, the initial funding level is almost never sustained and typically diminishes sharply over time.[24] For example, the Community Development Block Grants, used to fund housing and mental health services in the city of Chicago, have dropped 63% since its inception.[25] Second, if the city of Chicago is overly reliant on these funds for much needed mental health services, this will likely lead to continued disinvestment in mental health services as block grant funding tends to erode overtime,[26] or lead to a major crisis if funding was suddenly ended, rendering the public mental health clinics unable to operate.

PUBLIC MENTAL HEALTH SERVICE EXPANSION RESOLUTION

Based on the gaps that the aforementioned studies and funding context have identified in Chicago's mental health service infrastructure, in January of 2019 the Chicago City Council approved the *Public Mental Health Service Expansion Resolution*. The resolution called for the creation of a task force to oversee a public input process and independent study, with the goal of identifying the types of services needed and geographic areas most in need. The Task Force was also charged with identifying steps that should be taken to strengthen existing CDPH clinics and potentially re-open closed clinics. As part of this process, the Task Force is convening public hearings to solicit feedback from community residents on their experiences accessing mental health services and their recommendations for facilitating service access and improving the city's public mental health system. The first of these public hearings was convened on Thursday, June 13, 2019 at Malcolm X College. This report outlines the methodology that was undertaken to solicit feedback from community residents at the public hearing and summarizes the primary findings that emerged across the data that were collected. Finally, informed by the primary findings that emerged, this report offers recommendations to guide the Task Force in identifying action steps to strengthen and expand Chicago's public mental health service infrastructure.

Attendees at the June 13, 2019 Public Hearing at Malcolm X College.

METHODS

To initiate the public input process outlined in the Public Mental Health Service Expansion Resolution, the Task Force convened its first public hearing on June 13, 2019 at Malcolm X College from 6:00-9:00pm. Community organizations and community leaders played an instrumental role in disseminating information about the hearing across the city, thus ensuring that the individuals in attendance represented a range of wards and community areas. The hearing opened with an introduction from the Resolution sponsor, Alderwoman Sophia King (4th Ward) and the hearing facilitator, Dr. Leticia Villarreal Sosa, before proceeding with approximately an hour and a half of public testimony. There were 205 individuals in attendance at the hearing who signed in, but event coordinators estimate a total of 220-250 attendees, as not everyone officially signed in. Dr. Villarreal Sosa additionally oversaw all data collection and analysis activities undertaken in association with the hearing. Data were obtained through oral and written testimonies, as well as through surveys that were administered on the day of the hearing. Each of these activities will be described in greater depth below.

Oral and Written Testimonies

On the day of the hearing, all individuals in attendance were asked to register with the hearing conveners if they wished to deliver oral testimony regarding their experiences with mental health service delivery and/or their recommendations for improving Chicago's public mental health system during the hour and a half allocated for public testimony. Individuals providing testimony were asked to fill out a "testimony form" that included demographic data such as age, gender, and zip code, and asked them to focus their testimony in one of these areas: 1) strengths of the city-run mental health system, 2) recommendations for making existing city clinics more accessible and welcoming, and 3) gaps and barriers in the current mental health landscape.

Twenty-five individuals delivered oral testimony during this period. A maximum of three minutes was allotted for each oral testimony. Individuals had the option of testifying in either English or Spanish, and oral interpretation services were provided. Three designated note-takers were in attendance at the hearing to record detailed accounts of each oral testimony. Oral testimonies were additionally audio and video recorded, and select quotes were transcribed to supplement written notes. Hearing notes were compiled along with five supplemental written testimonies for subsequent analysis. A content analysis approach was utilized to identify salient themes across testimonies. Content analysis is an approach primarily used in analysis of records, reports, meeting minutes, transcripts, diaries, letters, etc. In this case, content analysis is used to analyze the written notes and transcripts of the testimonies. For the content analysis, a list of codes was developed through an inductive

process, based on the initial open coding of the data (See Appendix C). Systematic analysis of such documents can provide information about individual lives, important information about institutions, as well as social trends or patterns.[27] The coding process allows for units of meaning in the testimonies to be linked to themes and concepts used to organize the findings.

Mental Health Access in Chicago Community Survey

In order to gather more comprehensive data on experiences with mental health service delivery among all individuals present at the hearing, everyone in attendance was invited to complete a survey on mental health service access within Chicago. Dr. Villarreal Sosa oversaw the development of the survey. The survey consisted of a mix of 19 close-ended and open-ended questions that asked respondents to report on their personal experiences accessing mental health services, barriers they encountered in initiating care, knowledge of CDPH clinics, and their vision for city operated mental health services (See Appendix A). Surveys were completed anonymously, although respondents did have the option of providing their first name and telephone number if they wished to be contacted to share more information about their experiences with mental health service delivery. Surveys were made available in both English and Spanish. Hard copy surveys were distributed at the hearing, and a web link was also provided for all individuals who chose to complete the survey electronically. Hearing organizers had tablets available to facilitate electronic survey completion. While 84 questionnaires were completed, seven responses were eliminated because the respondent lived outside of Chicago (i.e., Oak Park, Plainfield), the respondent did not indicate whether or not they had received mental health services, or the respondent indicated both that they had and had not received mental health services. Thus, our final sample size was 77. Regarding language, 44 questionnaires were completed in English and 33 in Spanish. Closed-choice questions were compiled from the English and Spanish versions into one spreadsheet. This spreadsheet was uploaded into SPSS, where data were labeled and multiple response categories of variables were created. Descriptive statistics were calculated, including frequencies and crosstabs where applicable. Open-ended survey responses were analyzed using a content analysis approach to identify salient themes across responses, and are included in the qualitative results.

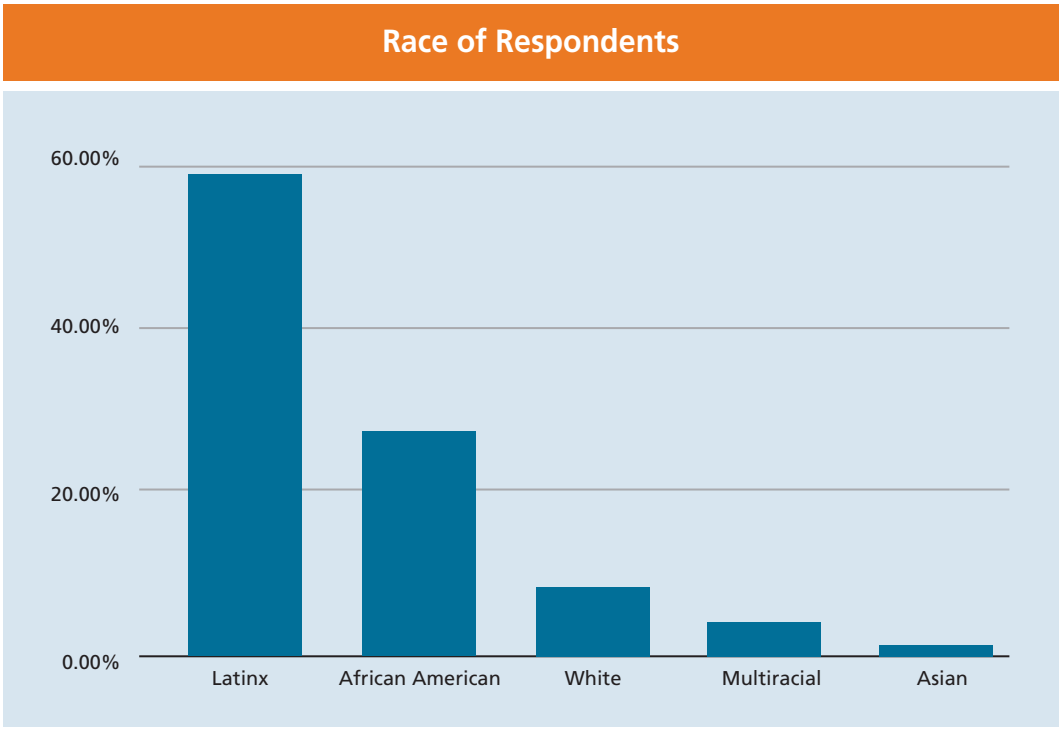
FINDINGS

Quantitative Findings

Respondent Demographics. Hearing attendees who completed surveys came from many areas of the city (n=75)[28]. Out of the 77 community areas, 30 (39.0%) were represented. The most common community areas were Brighton Park (23.6%) and Gage Park (12.5%). Among wards (n=66), 22 of the 50 (44.0%) were represented. The most common wards were the 12th Ward (22.7%) and the 15th Ward (12.1%).

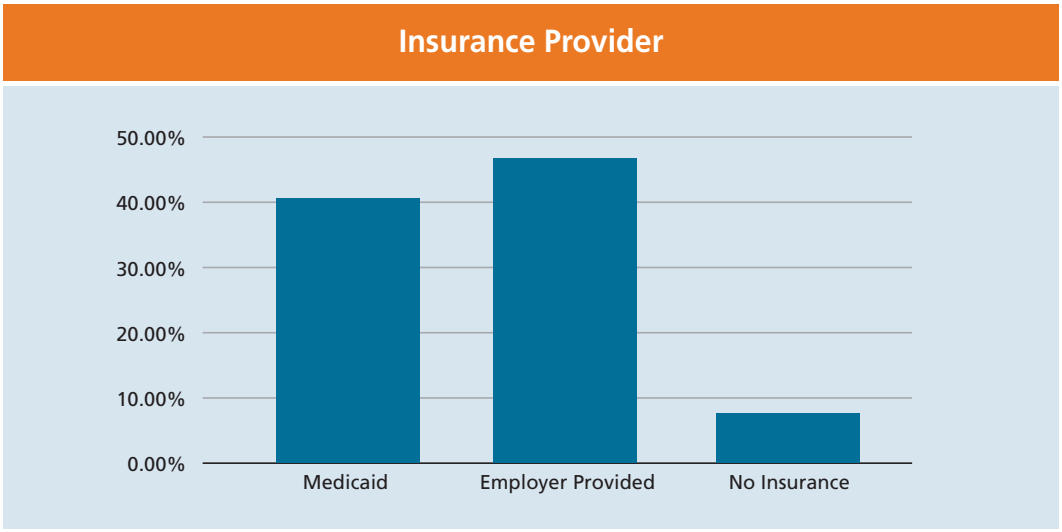
The majority of survey respondents (n=73) identified as either Latinx (58.9%) or African American (27.4%); 8.2% were white, 4.1% were multiracial, and 1.4% were Asian.

FIGURE 2: RESPONDENTS' RACIAL IDENTIFICATION



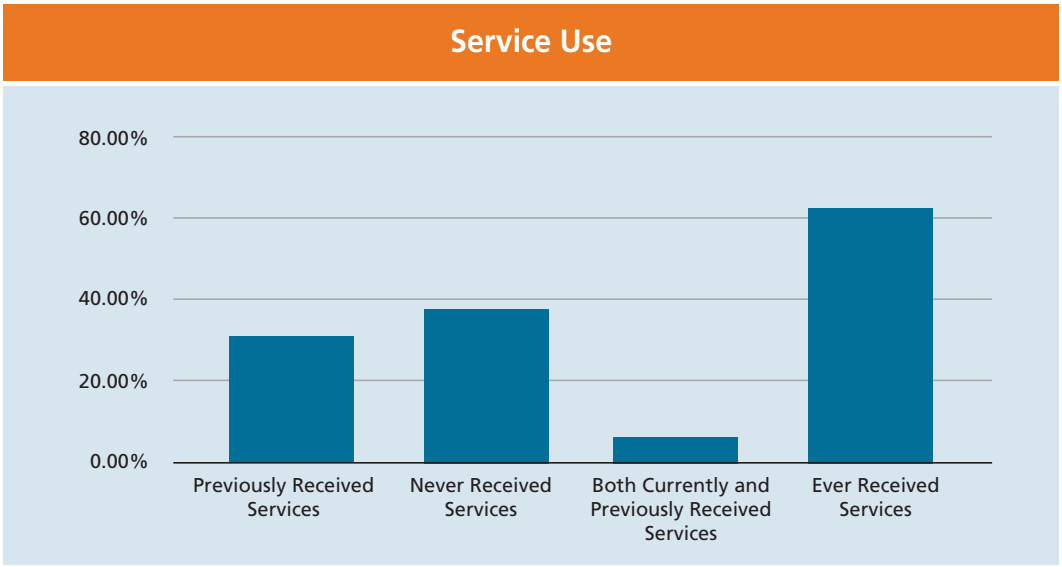
Most had insurance through their employer (46.9%) or Medicaid (40.6%); 8.2% had no insurance (n=73).

FIGURE 3: RESPONDENTS' HEALTH INSURANCE TYPE



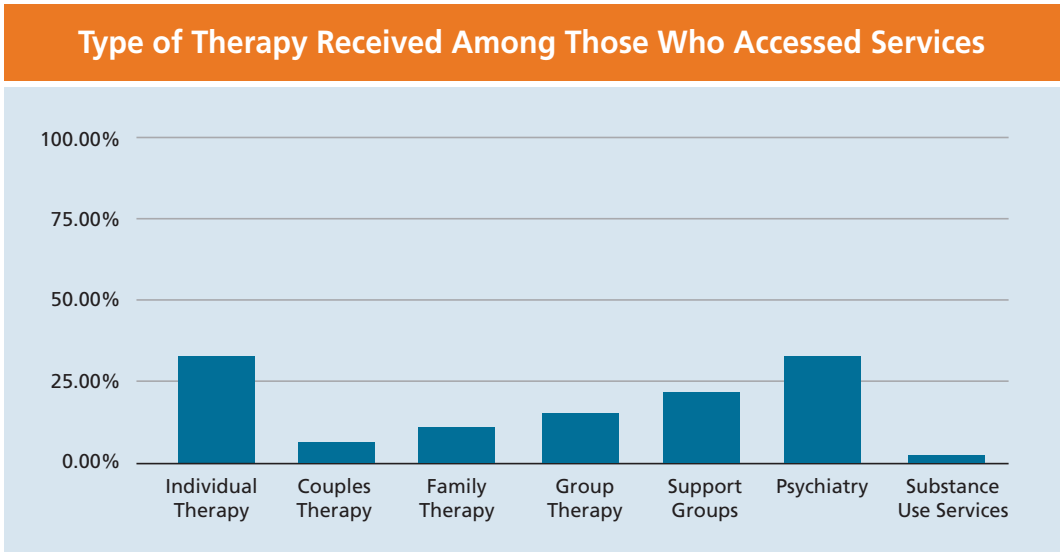
One of the survey questions asked respondents to identify whether they or someone in their family had ever received mental health services. For this question, 24 individuals indicated they were currently receiving services, 29 indicated they had previously received services, and 29 indicated they had never received services. There were five individuals who indicated they were currently receiving services and had previously received services. Thus, the total number of people with experiences receiving mental health services was 48, or 62.3% of the total sample (n=77), while 37.7% had never received any mental health services.

FIGURE 4: MENTAL HEALTH SERVICE USE



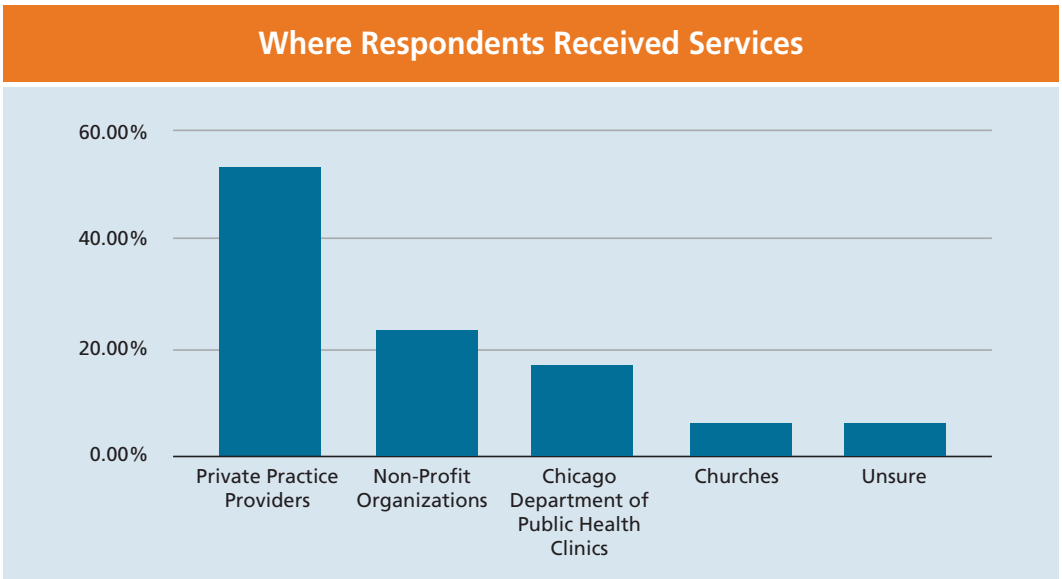
Experiences with Mental Health Service Delivery. Among the respondents who indicated a past or current experience receiving mental health services (n=46), the most common types of services they had received were individual therapy (80.4%),[29] psychiatry (47.8%), support groups (21.7%), group therapy (13.0%), and family therapy (10.9%). Less than 10% of respondents had received couples therapy or substance use services.

FIGURE 5: TYPE OF INTERVENTION/THERAPY RECEIVED



These services were accessed through clinics that also provided medical services (53.2% of 47 valid responses),[30] private practice providers (29.8%), non-profit organizations (23.4%), Chicago Department of Public Health mental health clinics (17.0%), and churches (6.4%). Additionally, 6.4% of respondents indicated they were unsure where they had received services.

FIGURE 6: LOCATION WHERE SERVICES WERE PROVIDED



Getting connected to services (n=41) most frequently occurred via a doctor's referral (70.7%).[31] Other connections include being referred by another organization (22.0%), referred by a friend (9.8%), or seeing an advertisement (2.4%). Wait times to receive services varied (n=45). While many respondents had no wait (28.9%)[32] or less than a one month wait (26.7%), a further 26.7% had to wait between one and three months. Longer waits were less common but still prevalent: 2.2% waited between three and six months, 2.2% waited between six and nine months, 4.4% waited nine to twelve months, and 11.1% waited over a year for services. When looking at wait times by provider type, CDPH clinics had the lowest wait times, with 50% of respondents reporting no wait time and 37.5% of respondents reporting a wait time of less than one month (See Table 2). No respondent who reported using services at the CDPH clinics reported wait times longer than three months.

TABLE 2: WAIT TIMES BY PROVIDER TYPE

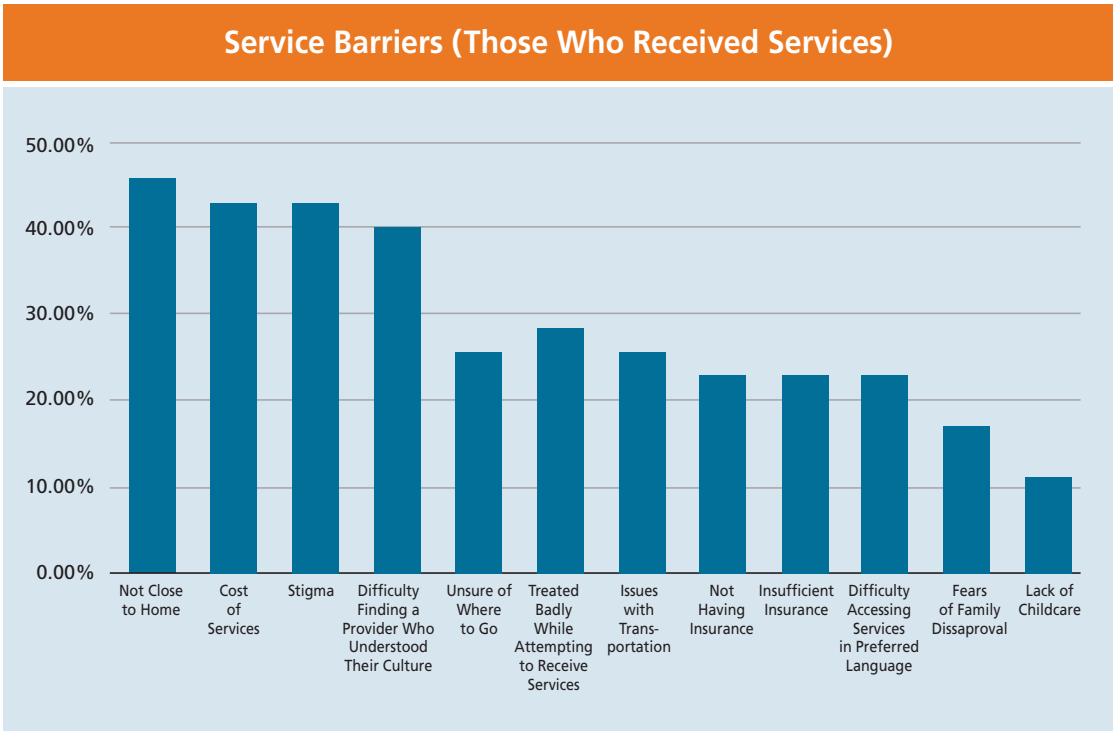
WAIT TIME	PROVIDER TYPE					
	Medical Clinic (n=25)	Non Profit (n=10)	CDPH Clinic (n=8)	Church (n=3)	Private Practice (n=13)	Unsure (n=3)
No wait time	6 (24%)	-	4 (50%)	-	2 (15.4%)	2 (66.7%)
Less than one month	6 (24%)	1 (10%)	3 (37.5%)	1 (33.3%)	5 (38.5%)	-
1-3 months	8 (32%)	6 (60%)	1 (12.5%)	2 (66.7%)	4 (30.7%)	-
3-6 months	-	1 (10%)	-	-	-	-
6-9 months	1 (4%)	1 (10%)	-	-	-	-
9-12 months	1 (4%)	1 (10%)	-	-	-	-
Longer than one year	3 (12%)	-	-	-	2 (15.4%)	1 (33.3%)

The question about the cost of services had 13 non-responses, and among the respondents, 15 indicated they were unsure of the cost. Thus, we were unable to get accurate cost information from 58.3% of respondents. Among those 20 respondents who did provide cost information, most (70%) were able to get free services, 15% indicated they paid between $1 and $10 for each session, and a further 15% indicated they paid more than $30 for each session.

Barriers to Service Delivery. Service barriers for those who received services had a large number (13) of non-responses. Those who did respond (n=35) indicated a range of barriers. The highest were that services were not close to their home (45.7%),[33] cost of services (42.9%), stigma (42.9%), and difficulty finding a provider that understood their culture (40.0%). Other barriers included having been treated badly while attempting to receive services (28.6%), being unsure of where to go (25.7%), issues with transportation (25.7%), not having insurance (22.9%) or insufficient insurance (22.9%), having difficulty accessing

services in their preferred language (22.9%), fears that their family would disapprove of them getting services (17.1%), and lack of childcare (11.4%). It is interesting to note that stigma was highly cited as a barrier, yet we note below, only 5% of those who had *not received* services cited it as a barrier. Thus, the role of stigma is not clear in service access. For example, does stigma increase or change once the individual has accessed services?

FIGURE 7A: BARRIERS TO SERVICE ACCESS



There was considerable variance in how respondents (n=44) rated the quality of services. While 25.0% experienced excellent quality services, 20.5% rated the services they received as very good, 22.7% rated them as good, 27.3% rated them as fair, and 4.5% rated them as poor.

Among the 29 respondents who indicated they *had not received* services, 27 answered the question about their desire for services. A majority (59.3%) had not wanted to receive services, but a sizable percentage (40.7%) had wanted to receive services. Among all of the respondents who had not received services, 25.0% identified difficulty finding a provider who understood their culture as an access barrier, while 20.0% identified cost, 20.0% identified being unsure where to go, 15.0% identified insufficient insurance, 10.0% identified difficulty finding services in their preferred language, 10.0% identified not having insurance, and 5.0% identified stigma as access barriers (See Figure 7B). Furthermore, among the subset of 10 respondents who identified service access barriers, 50.0% indicated difficulty finding a provider who understood their culture, 40.0% indicated cost of services, 40.0% indicated being unsure of where to go, 30.0% indicated having insufficient insurance, 20.0% indicated difficulty finding services in their preferred language, 20.0% indicated not having insurance, and 10.0% indicated stigma (See Figure 8).[34]

FIGURE 7B: BARRIERS TO SERVICE ACCESS

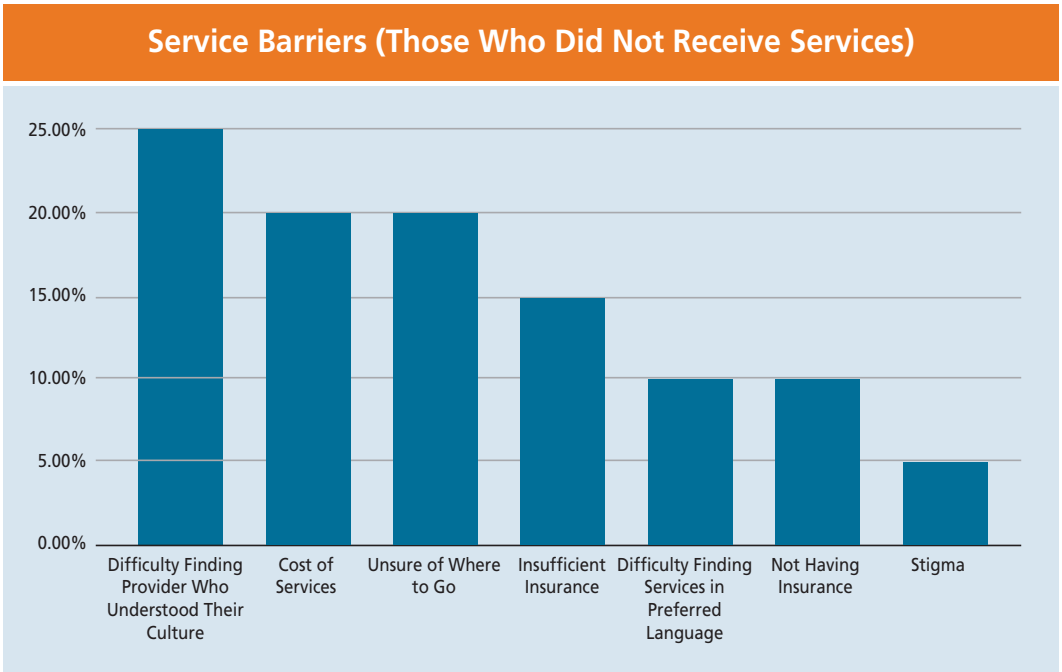
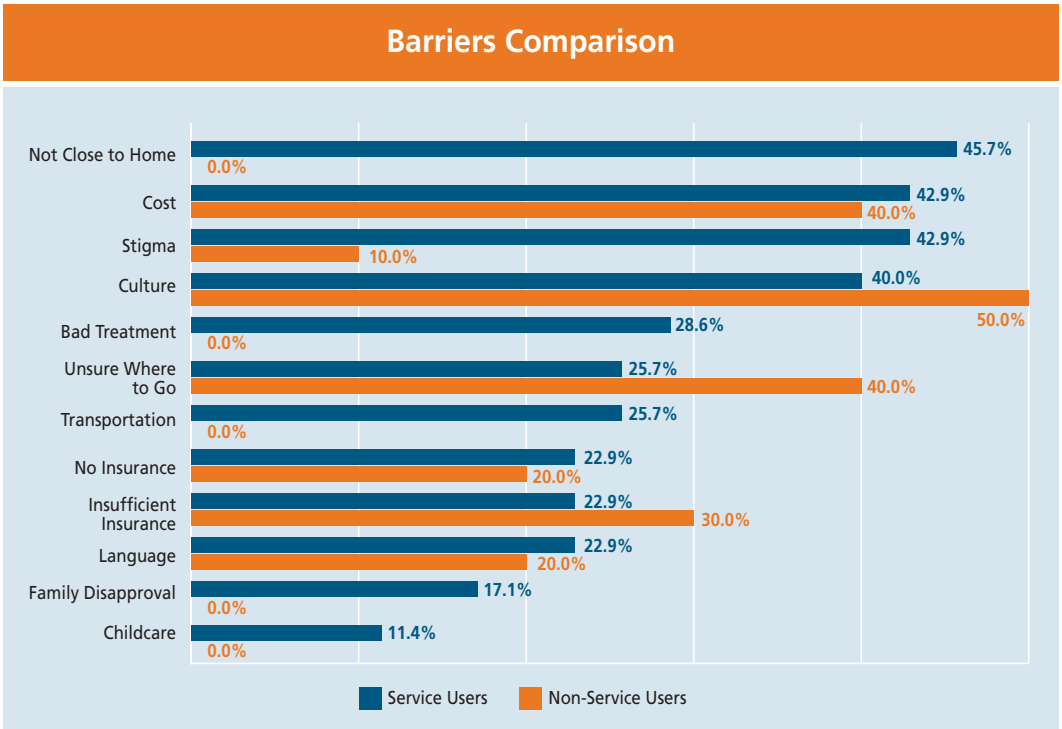


FIGURE 8: BARRIER COMPARISON BETWEEN SERVICE USERS AND NON-SERVICE USERS



When considering potential barriers based on insurance type, it is important to note that having employer insurance may not be sufficient to access affordable services. Within the category of those with employer insurance, 53.3% stated that cost was a barrier to services and 33.3% stated that insufficient insurance is a barrier. A barrier that was common for both those with employer insurance and those with Medicaid was the location of services, for 58.3% of those with Medicaid, and 53.3% of those with employer insurance, services "not close to home" remained a barrier.

TABLE 3: BARRIERS TO SERVICE BY TYPE OF INSURANCE

BARRIER[35]	INSURANCE TYPE		
	Medicaid	Employer Insurance	No Insurance
Cost	4 (33.3%)	8 (53.3%)	1 (100%)
No Insurance	3 (25%)	3 (20%)	1 (100%)
Insufficient Insurance	2 (16.7%)	5 (33.%)	1 (100%)
Unsure Where to Go	6 (50%)	3 (20%)	1 (100%)
Not Close to Home	7 (58.3%)	8 (53.3%)	1 (100%)
Language	2 (16.7%)	1 (6.7%)	1 (100%)
Culture	5 (41.7%)	7 (46.7%)	1 (100%)
Childcare	2 (16.7%)	1 (6.7%)	-
Transportation	5 (41.7%)	2 (13.3%)	1 (100%)
Stigma	4 (33.3%)	8 (53.3%)	-
Family Disapproval	3 (25%)	4 (26.7%)	-
Bad Treatment	4 (33.3%)	5 (33.3%)	1 (100%)

Access to Chicago Department of Public Health Clinics. All survey respondents were asked about the accessibility of Chicago Department of Public Health (CDPH) mental health clinics. Nearly all respondents (75 out of 77) answered the question about whether there was a CDPH clinic near them. Among these, 18.7% indicated there was a clinic they could access easily, 34.7% indicated there was not a clinic they could easily access, 29.3% indicated there had been a clinic near them that had closed, and 34.7% were unsure. When asked about how easy it was to access information about CDPH clinics, a small majority (53.0% of the 66 valid responses) indicated it was easy, while 47.0% indicated it was not easy to access the information.

Qualitative Findings

Data across open-ended survey responses and oral and written testimonies indicated that experiences of systemic harm and disinvestment underlie both community residents' mental health needs and their experiences accessing mental health services. Within Chicago's communities of color, trauma stems from structural racism and harm perpetrated through the criminal justice system. Furthermore, in a community context where there is limited investment in mental health services, violent crime emerges as a symptom. In turn, when individuals experience violent crime and mental health services are not available to support them in coping with trauma, their mental health needs go unmet and cycles of trauma, pain, and violence continue. Mental health needs that emerge in the context of systemic harm and disinvestment are thus integrally connected to the service access barriers that perpetuate cycles of harm. Community residents' primary recommendation for interrupting these cycles of harm was to address systemic disinvestment. More specifically, respondents repeatedly asked for increased investment in safety net services that promote healing from trauma. Each of these themes will be discussed in greater depth below.

Unmet Mental Health Needs and Systemic Harm. Across oral testimonies, individuals consistently referenced ways in which systemic harm leads to experiences of trauma and subsequent mental health challenges within Chicago's communities of color. For example, in her testimony Arewa Winters identified the impact of historical trauma and ongoing structural racism among the African American community, stating that African American community residents live with *"present traumatic stress and posttraumatic enslavement syndrome"* due to the enslavement of their ancestors and the ongoing subjugation of Eurocentric views on people of color. Several respondents highlighted how structural racism is manifested through interactions with the criminal justice system, specifically through experiences of police brutality and incarceration among individuals of color. Among these stories was that of Gregory Banks, who suffers from posttraumatic stress disorder as a result of torture that he experienced at the hands of the Chicago Police Department. Mark Clements also testified regarding the impact of the inhumane treatment while incarcerated. Mark Clements was incarcerated for 28 years and now lives with PTSD as a result of the trauma he experienced while in prison. Dorothy Holmes, a member of Black Lives Matter, stated that not only are communities of color impacted by police brutality, but that systemic disinvestment also limits the extent to which they can access services to heal from such experiences. After describing how her son was shot and killed by a Chicago Police Department detective, Ms. Holmes stated: *"I'm sure that the detective got the services that he needed after he killed my son. I'm asking that black and brown communities get the same services."*

Systemic Disinvestment. As illustrated in Ms. Holmes' quote above, community members identified how systemic harm is integrally connected to systemic disinvestment. Not only do communities of color cope with structural racism and its manifestations on a daily basis, but they also recognize that there is a lack of acknowledgement of the trauma that they experience and a lack of investment in providing the resources and supports necessary to heal from such traumatic experiences. Several individuals stated that they view this lack of investment as stemming from disinterest in their communities among local politicians. As Patricia Everett, a member of Southside Together Organizing for Power (STOP), stated: *"The politicians come to our neighborhood when they want our vote. But when they get your vote they don't*

do anything for the community." For community residents, it is important hear their stories. Mark Clements stated, *"[it] reflects a lack of investment when politicians do not listen to our stories and experiences, this conveys that they do not care about our well-being."* Community residents viewed this lack of political attention as manifesting through an erosion of safety net services. Community residents recognized that the CDPH public mental health clinics played an important role in offering emotional support to marginalized individuals whose options for accessing services were limited due to barriers such as cost and lack of insurance coverage. With the closure of CDPH clinics beginning in 2012, marginalized community residents were left with little to no options for accessing supportive services. One white male survey respondent highlighted the role of the CDPH clinics as safety net providers and pointed to the erosion of this social safety net with the clinic closures: *"I went to Chicago public health clinics when I didn't have medical coverage through my job. This was in the 1980s. Since then the clinic has been closed."*

Need for Trauma Informed Services. Community members also described how violence emerges as a symptom when mental health needs go unmet as a result of disinvestment in safety net providers and policies such as school closures. Ariel Atkins, a member of Black Lives Matter, described how unmet mental health needs can lead to an escalation in police violence. She shared the story of a young man experiencing a mental health crisis who was killed when the Chicago Police Department called in the SWAT team, thus highlighting the human consequences of asking police who do not have specialized training in mental health to take on the role of mental health professionals. An African American survey respondent residing in a neighborhood where a CDPH mental health clinic was closed similarly stated: *"I want a public mental health clinic that is accessible to ALL people that is fully resourced. Police should not be first responders. The mental health clinic should house trained first responders that will respond to people with mental health problems."*

Individuals providing oral testimony also highlighted how violent crime occurs when mental health needs go unmet; and how cycles of violence, pain, and trauma are then perpetuated when survivors of violent crime do not have access to services that promote healing from trauma. Among the stories of individuals who shared personal experiences of mental health challenges stemming from losing loved ones to homicide and surviving violent crimes such as shootings and armed robbery is that of Yanni Butler. Ms. Butler, a youth organizer with STOP, shared the long-lasting emotional consequences of coping with trauma in the absence of professional support:

For the last, I want to say three years, I have been struggling with anxiety very badly. I don't have medical insurance, so it has been very difficult for me to find clinics in my neighborhood that can help support me with my anxiety....I've been dealing with this because my fiancé, or my daughter's dad, was shot five times and during that time that he was shot, I was six months pregnant. He spent three months in the hospital, at which time neither one of us was offered any additional therapeutic services at the end of that. And we was [sic] not offered these services for multiple reasons, because we didn't have insurance, because of where we lived, and because they felt like because he was a gunshot victim, it was going to happen to him again. So during that time, that long span, we went through a lot of difficult things within our relationship that caused a lot of strain. And it made it very difficult to be in the same house with each other because we both were dealing with something. I was dealing with postpartum after having a baby and he was dealing with the aftershocks after

being shot multiple times. So with that being said, we do need more mental health clinics, we do need more access to mental health clinics. We need to support public mental health services. I am not the only person who has suffered through something like this or similar to this. It's a lot of people in our community that has dealt with people who have been shot and killed right in front of them and they have not had any adequate mental health services to help them with what they're dealing with.

As Ms. Butler emphasizes in her testimony, coping with the aftermath of traumatic experiences in the absence of professional support impacts both the individual and the family system, as feeling isolated and alone in one's pain puts a strain on family relationships. Veronica Smith, the Director of Clinical Services at Brighton Park Neighborhood Council, pointed to a similar trend in her oral testimony. In particular, she described how she and her staff observe the impacts of intergenerational trauma among the students and families whom they serve in a school setting. As she noted, when parents have unmet mental health needs, they face challenges in providing a stable home environment for their children, which in turn impacts the well-being of their children. Ms. Smith shared the example of an adolescent female who witnessed "drugs, sex, and violence" at home, which in turn led to feelings of hopelessness and defeat and poor academic performance. While this young woman's grades improved after three months of school-based services, Ms. Smith stated that "this is not enough," because intergenerational cycles of trauma in her home environment have not been addressed. Furthermore, untreated trauma has an impact on the community as a whole, as community members identified that individuals coping with the traumatic impact of violence may in turn perpetrate additional acts of violence within the community. Maribel Miranda, a community organizer with Brighton Park Neighborhood Council, highlighted this perpetual cycle of harm when she asked the audience at the hearing: "Who thinks that the violence in our communities is not due to mental health?" It is noteworthy that no one in the audience raised their hand in response to this question.

Barriers to Access due to Limited Services and Cost. Integrally connected to community members' mental health needs are the barriers that prevent individuals from accessing services within a context of systemic disinvestment. Among the barriers that community members cited were a lack of services in close geographic proximity, service cost, lack of insurance coverage, waiting lists, and limited services that were aligned with individuals' needs. Maria Julia Peña, a leader of POWER-PAC and a resident of the Back of the Yards community, pointed to several of these barriers in her oral testimony, where she described her experience of being robbed at gunpoint in her home and the challenges that she subsequently encountered in accessing mental health services:

En el 2008, fui víctima de violencia a mano armada en mi propia casa. Han pasado ya algunos años, y aún siguen los malos recuerdos en mi mente. No hay un solo día sin sentir este temor. El escuchar un ruido, escuchar que las puertas se abren o mirar que las cortinas se mueven. Pero lo que más me causa ese trauma es mirar las sombras de alguna persona, ya que me llega el recuerdo de los dos jóvenes, los cuales nos tenían encadenados. Escuchar el llanto de mis hijas fue lo que más me impactó. Es por eso que yo estoy pidiendo que nos reabran las clínicas de salud mental. Ya he buscado clínica de salud mental en el barrio de las Empaquetadoras, y donde hay tiene una larga espera. Y no son accesibles porque cobran muy caro. Necesitamos psicólogos bilingües. Y así como yo, hay muchas personas que necesitan de esos servicios. Ya es hora que seamos escuchados, y así hacer el cambio en nuestra comunidad. Con mentes sanas, todo será más sano en nuestra comunidad y hogares.

In 2008, I was a victim of violence, an armed robbery in my own home. Several years have passed, and I still am left with the bad memories. There is not a single day that goes by when I don't feel this fear. I am reminded when I hear a noise, when I hear the doors open, or when the curtains move. But what is most traumatic is seeing another person's shadows, as this reminds me of the two young people who held us hostage. Hearing the crying of my daughters was what impacted me the most. It is for this reason that I am asking that the mental health clinics be reopened. I have not been able to find a mental health clinic in my neighborhood of Back of the Yards, and where there are clinics, there is a long wait. And they are not accessible because they are expensive. We need bilingual clinicians. And there are many people like me who need these services. It's time that we are heard, and that we make a change in our community. With healthy minds, everything will be healthier in our community and in our homes. [Translation]

As Ms. Peña emphasized in her testimony, she has been unable to engage with mental health services to help her heal from this experience of trauma due to barriers including a lack of services close to her home, the cost of services, and the wait times at the organizations that do provide mental health services. Ms. Peña's testimony coincides with that of Ms. Butler, highlighted in the previous section, who spoke to the challenges she experienced in accessing affordable services since she does not have health insurance. In addition to these challenges with service affordability that span across Latinx and African American communities, the limited organizational capacity of non-profit providers to meet the demand for services poses an additional concern. Estela Diaz, a health promoter from Brighton Park Neighborhood Council who shared her personal struggles with mental health that resulted in a suicide attempt when her daughter was seven months old, discussed the difficulties she experienced in accessing services due to the length of program waiting lists. As she pointed out, when individuals are in the midst of a crisis situation, having to wait to receive emotional support could have dire consequences. Furthermore, limited organizational capacity undermines service quality. Julia Cannon, a member of Brighton Park Neighborhood Council and a program participant at Thresholds, a non-profit mental health provider, shared her concerns about the quality of service delivery when providers are overburdened. She recounted instances when her appointments have been canceled because there were no staff members available to meet with her, and an instance when she asked her therapist to call her and her therapist replied, "Can it wait until tomorrow?" As Ms. Cannon poignantly described, when community residents do not have another source of emotional or social support, their concerns cannot wait until the next day.

Barriers to Access due to the Lack of Culturally Responsive and Trauma Informed Services. Individuals also highlighted through their oral and written testimonies that it is not enough to simply offer mental health services, but that services also must align with community residents' needs. As Ms. Peña noted, limited availability of mental health services in her native language posed an additional barrier to service access. Similarly, in her written testimony, Lindsey Bailey, a mental health provider at Saint Anthony Hospital's Community Wellness Program, identified a lack of culturally and linguistically affirming services as posing an access barrier among her clients who sought out mental health services with other providers. Ms. Bailey went on to describe that providing affirming services is also connected to the length of time for which services are offered. Recognizing that healing from trauma is a long-term process, providers cannot truly address the service needs of community residents if they do not offer the necessary time and space to develop the trusting relationships that are a prerequisite for processing past traumatic experiences:

A staple of complex trauma is that due to the many instances in which the individuals [sic] safety and trust have been violated, the rate at which trust is able to be built with a mental health professional like you might expect, takes more time. This means that many of the people that come through our doors for services are in fact taking a brave and bold first step towards healing, but it is only the first of many steps they must take. And taking those additional steps takes time. Under the current FQHC [Federally Qualified Health Center] model, with limited number of sessions and a more medical, sterile and pathologizing environment, clients are unable to build trust and relationships with their providers and therefore in many occasions unable to fully heal the root causes of what is manifesting as depression, anxiety or post-traumatic stress disorder symptoms. In fact I have had several clients who tried receiving counseling services from a local FQHC but did not feel comfortable or like there was enough time or space to fully develop a relationship where healing could happen. In many instances this is due to language and cultural barriers, but most of the time due to the fact that although a sliding scale fee may be offered, the fee is not accessible for the client to pay on a weekly basis when there are competing financial priorities such as food, housing, clothing and other medical needs within the home.

As Ms. Bailey illustrates above, the extent to which services are aligned with an individual's service needs interacts with financial considerations. When community residents must pay the out-of-pocket cost for services, the financial burden limits their long-term participation in services, which in turn limits the extent to which services can truly align with community residents' needs and promote healing from trauma in the long-term.

Invest in Safety Net to Promote Long Term Healing. Not only did community residents describe the long-term impact of untreated trauma and highlight the challenges they experienced accessing mental health services in a context of systemic disinvestment, but they also emphasized that the solution to interrupting perpetual cycles of trauma and violence is to invest in safety net providers in order to promote long-term healing. Mental health providers at the remaining CDPH clinics testified as to the important role that the CDPH clinics have historically played in serving individuals who face access barriers such as cost and insurance status, thus serving as a safety net for Chicago's most vulnerable citizens. Robert Stewart, a mental health provider at the CDPH Englewood clinic, noted that their clinic serves individuals who have been screened for complex conditions and turned away by private providers: *"We offer services to everyone. If someone walks in, they get help. There are no co-pays and no waits for appointments. If someone has no insurance, it doesn't matter. We are*

the safety net...Many times people come to us from private providers, saying, 'They couldn't help me.'" Recognizing that service cost and limited organizational capacity among private, non-profit providers pose barriers to long-term participation in services that promote healing from trauma, safety net providers are critical to ensuring that all individuals, regardless of socioeconomic and insurance status, can receive ongoing, long-term support in their moment of need. Diane Adams, a community leader, STOP board member, and a consumer of CDPH mental health services, spoke to the importance of having ongoing support available to individuals throughout their recovery process. As she stated: *"In 1996, my son was killed; in 1998, I tried to commit suicide; in 2008, I was in a coma for a year."* She went on to describe the long-term nature of her recovery process: *"It's taken me more than 15 years to get to where I am today, and look how far I've come."* Ms. Adams highlighted the invaluable role of CDPH mental health clinics in accompanying individuals throughout the duration of their healing journey and supporting them in reaching their goals.

Prioritizing Investment in Public Services. While participants throughout the public hearing acknowledged the invaluable role of CDPH public mental health clinics in serving as a social safety net, they also recognized that the CDPH clinics as they currently stand are not free of problems. Individuals pointed to the current challenges that the clinics experience resulting from inadequate funding and disinvestment. For example, Fred Friedman, who gave the first testimony at the hearing, reported that the lack of investment in the physical clinic structures led to the roof of the clinic he attended literally caving in before it closed. Mr. Stewart, a CDPH mental health provider whose testimony is referenced above, additionally identified the need for increased investment in promoting clinic services and providing training to staff. Across oral and written testimonies, individuals emphasized that it is a matter of prioritizing investment in the social safety net and exploring innovative solutions for allocating funding, such as assessing how TIF funding is currently allocated.

Holistic Community Based Services. In discussing the need for increased investment in safety net providers, individuals also offered recommendations for what a robust public mental health system can look like. Across testimonies and open-ended survey responses, individuals cited a robust public mental health system as promoting healing from trauma by addressing an individual's range of psychosocial needs. As one Latino male survey respondent stated: *"Mental health treatments need a social lens to address people's needs. Holistic, alternative, and non-medical comprehensive services are necessary for our neighborhoods to heal."* A CDPH mental health provider pointed to the benefits of the Englewood clinic being located in close proximity to a medical center and a WIC office, thus highlighting the potential to promote holistic well-being when public clinics are embedded in locations where other health and social service resources are available. Another survey respondent touched upon this theme, describing how they envisioned mental health centers as places not only for treatment, but as also providing additional services needed by the community, such as, *"Community centers with youth programs. Job prepared / educating providers on their privilege. Outreach programs and workers coming to the members of the community."* Further, a Latina resident in Uptown shared her similar vision, *"Local! Providers live in the neighborhoods. Walk-ins are welcome, no cost and no insurance necessary. They also offer wrap around services—case mgmt [sic], groups, wellness support, community workshops."*

Individuals further described how a robust public mental health system can promote healing from trauma by cultivating consistent networks of social support. This consistent emotional and social support occurs through the development of trusting relationships with mental health providers, but it can also occur by transforming clinics into social gathering spaces that foster a sense of community. Throughout the hearing, individuals repeatedly described how their mental health symptoms worsened in the midst of social isolation and how building a sense of community was invaluable in their recovery process. Individuals delivering public testimony frequently referenced the support networks they had built through organizations including STOP, Brighton Park Neighborhood Council, and Black Lives Matter, with one individual referring to the support network they had built with STOP as their "STOP family." One survey respondent, an African American male from the 20th ward, noted that they had built this sense of community through the CDPH clinic that they attended, and pointed to the sense of loss they experienced when the clinic closed and they were uprooted from their support network: *"They gave me what I wanted, Then they took it away, I lost my adopted family the mental health community."* Survey respondents further identified that with increased investment in the public mental health system, their vision is that CDPH clinics can serve as a central hub or nexus for each neighborhood. As an African American resident in West Humboldt Park stated: *"A city funded public mental health/ substance abuse treatment center should be the operational center of the neighborhood aside from the public schools in the neighborhood."* Furthermore, as CDPH clinics take on the role of neighborhood hubs that promote holistic well-being, there is the opportunity for the stigma associated with accessing mental health services to decrease. As Veronica Smith of Brighton Park Neighborhood Council noted, stigma decreases when there are more mental health centers available within communities. As illustrated through these data, a robust public mental health system thus promotes individual healing by addressing holistic needs, offering consistent, long-term emotional support, and fostering a sense of community. Furthermore, a robust public mental health system can promote healing at the level of the community as a whole by investing in clinics that serve as neighborhood hubs and offer safe gathering spaces within communities that have historically been impacted by systemic disinvestment in health promoting resources.

RECOMMENDATIONS

1 **Increased funding and investment in public mental health services.** Since 2012, the city of Chicago has initiated drastic cuts to mental health services. Public mental health services play a critical role in addressing the mental health needs of the most vulnerable and are an important part of the safety net in a community. The number of public clinics has been reduced to five, leaving many community residents with unmet needs. As illustrated through these data, a robust public mental health system promotes individual healing by addressing holistic needs, offering consistent, long-term emotional support, and fostering a sense of community. Community residents' primary recommendation for interrupting cycles of harm within their communities was to address systemic disinvestment in public mental health services. Community based, public mental health clinics are an important safety net that can provide the space and resources needed to promote healing from trauma and address mental health needs, particularly for vulnerable and low-income communities.

2 **Diversification of funding.** In order to preserve and expand accessible mental health services in the city of Chicago, it is imperative that local and other sources of funding beyond Block Grant funding be explored and obtained. Block grants, a form of fixed funding, create a program structure unable to respond to changing needs. If needs increased, services would have to be rationed, such as cutting eligibility or creating long wait lists. In addition, block grants create disincentives for local investment in services in comparison to matching grants. When social services, particularly for the most vulnerable residents, are funded through block grants, the initial funding level is almost never sustained and typically diminishes sharply over time. These factors will make it likely that the city of Chicago will continue disinvestment in mental health services and could lead to a major crisis if block grant funding was suddenly ended, rendering the public mental health clinics unable to operate.

3 Expansion of public mental health services in underserved community areas, including south, west, and southwest side communities. Data presented in this report illustrate how systemic disinvestment leads to unmet mental health needs within marginalized communities of color. Testimonies highlighted that across African American and Latinx communities, a lack of affordable services in close geographic proximity impede individuals from accessing professional support to address their emotional needs. An expansion of public mental health services is therefore critical to addressing the barriers to care within marginalized communities, including community areas with predominantly African American and Latinx populations on Chicago's south, west, and southwest sides. Furthermore, with changes in the Public Charge rules, safety net providers will play an invaluable role in facilitating access to mental health services among immigrant community residents and their families. These changes in Public Charge, regardless of level of restriction, will disincentivize families from enrolling in publicly funded insurance due to fear of adverse immigration consequences. Public mental health services therefore are vital in facilitating access to affordable care within communities with large immigrant populations, including community areas on Chicago's southwest side, who are unable to access services due to barriers such as cost and lack of insurance coverage.

a. As noted in the first recommendation, public mental health clinics play a vital role in the social safety net for the most vulnerable residents. One of the critical findings of this survey is that it cannot be assumed that those with insurance do not have barriers to access. In this survey, most respondents had insurance through their employer (46.9%) or Medicaid (40.6%), with only 8.2% having no insurance. Most notable, within the category of those with employer insurance, a group often assumed to have access, 53.3% stated that *cost* and 33.3% stated that *insufficient insurance* remained a barrier to service access. Furthermore, a barrier that was common for both those with employer insurance and those with Medicaid was the location of services; 58.3% of those with Medicaid, and 53.3% of those with employer insurance stated that services "not close to home" remained a barrier. Thus, increased availability of public mental health clinics in underserved community areas with a scarcity of providers would increase access to much needed mental health services.

b. Furthermore, wait times, particularly in times of crisis, were a serious concern for community residents. When looking at wait times by provider type, CDPH clinics had the lowest wait times, with 50% of respondents reporting no wait time and 37.5% of respondents reporting a wait time of less than one month. No respondent who reported using services at the CDPH clinics reported wait times longer than three months. For those attempting to access services at non-profit clinics or centers providing other medical services, even a wait time of 1-3 months could be burdensome, particularly during an acute mental health crisis.

4 Increase access and investment in psychotherapy as a crucial form of mental health service delivery. Survey respondents indicated that the most widely used service was individual therapy (80.4%), as compared to the next most frequent service of psychiatry (47.8%). This is contrary to growing trends in the mental health field for the standard of care to be psychopharmacological treatments alone, and a decrease in use of psychotherapy, partially due to an increasing shift of the cost to consumers.[36] The social support offered by individual therapy for both the respondents in the survey and as offered in the testimony is a vital form of support in coping with trauma and isolation.

5 Increase access to trauma informed services that address multiple forms of trauma including historical, intergenerational, and identity trauma. Recognizing that healing from trauma is a long-term process, providers cannot truly address the service needs of community residents if they do not offer the necessary time and space to develop the trusting relationships that are a prerequisite for processing past traumatic experiences. One of the most critical aspects of a trauma informed approach, is what is called a "relational" approach. In other words, any intervention when provided by a caring and supportive provider, who shows "empathy, self-awareness, compassion, and positive regard"[37] will be more effective, independent of empirically tested evidence-based practices. Service cost and limited organizational capacity among private, non-profit providers pose barriers to long-term participation in services that promote healing from trauma. Again, safety net providers are critical to ensuring that all individuals, regardless of socioeconomic and insurance status, can receive ongoing, long-term support in their moment of need in order to address complex forms of trauma.

6 Consider ways to create holistic, culturally responsive, and empowering mental health services. One concerning finding was that for those who had actually accessed services, stigma (42.9%) was a barrier for them. Being treated poorly (28.6%) while attempting to receive services was an additional barrier, as was difficulty finding a provider that understood their culture (40.0%). While stigma was a barrier for those having accessed and utilized treatment, it was only noted as a barrier for 5% of those who *had not received services*. Thus it appears that stigma may increase once services are accessed. This could be related to experiences with service providers. If service providers focus on symptoms, diagnoses, and medication, individuals may feel as if they are being labeled, which in turn could lead them to be hesitant to access services in the future. Indeed, the biomedical model "overmedicates, stigmatizes, and creates long-lasting iatrogenic effects for those most marginalized in society."[38] When mental health challenges are seen as purely individual issues, they can obscure structural issues and perpetuate systemic violence. In addition, prior research has shown that individuals in the southwest side have frequent experiences of discrimination, feel judged, and not heard when trying to access social services.[39]

a. Across testimonies and open-ended survey responses, individuals cited a robust public mental health system as promoting healing from trauma by addressing an individual's range of psychosocial needs, which include access to a range of treatments such as alternative and non-medical services. Another survey respondent touched upon the design of services that described a vision for mental health centers to be community centers that offered a variety of additional services such as youth programs.

b. Another resident shared a vision for local clinics where walk-ins are welcome, and a variety of services including case management, wellness support, workshops, and groups could be offered. Several individuals noted the importance of these community based clinics for offering much needed social support. As services are developed, having consumer voices in the process of developing a vision for services is critical for the development of services that not only address access, but also address the vision of what public, community based services should be.

APPENDIX A

MENTAL HEALTH ACCESS IN CHICAGO – COMMUNITY SURVEY

Please answer the questions below. You may skip any questions that you choose not to answer. Unless you choose to provide your name and contact information at the end of this survey, all of your answers will be anonymous. Thank you for your feedback!

Demographic Information

We are asking the questions below to learn more about the people who complete this survey. Please provide as much information as you feel comfortable sharing.

1. What neighborhood do you live in? _____

2. What is your zip code? _____

3. What is your ward/who is your alderman? _____

4. What is your race/ethnicity? _____

5. What language(s) do you speak? _____

_____

6. What type of health insurance do you have?

- ☐ Medicaid/The medical card
- ☐ Medicare
- ☐ Private insurance/Through an employer
- ☐ ACA/Obamacare/Marketplace
- ☐ I do not have health insurance

7. Have you or someone in your family ever received mental health services in Chicago (for example, individual therapy, couples therapy, family therapy, group therapy, or psychiatry services)? Please check only one box.

- ☐ Yes, I or a family member currently receive mental health services
- ☐ Yes, I or a family member have previously received mental health services

If Yes, please go to page 3.

- ☐ No, neither myself nor a family member have ever received mental health services in Chicago

If No, please go to page 5.

PAGE 3 – PLEASE COMPLETE ONLY IF YOU ANSWERED YES TO QUESTION 1

Experiences with Mental Health Services

8. What services have you or your family member received? Please check all that apply.

- ☐ Individual therapy or counseling services
- ☐ Couples therapy
- ☐ Family therapy
- ☐ Group therapy
- ☐ Support groups
- ☐ Psychiatry services
- ☐ Substance use services
- ☐ Other: _____

9. Where have you or your family member received mental health services? Please check all that apply.

- ☐ At a health clinic where they also provide medical care
- ☐ At a non-profit organization (for example, Catholic Charities, Thresholds, the YMCA or Boys and Girls Clubs)
- ☐ At a Chicago Department of Public Health mental health clinic
- ☐ At a church or other place of worship
- ☐ At a private practice (a therapist or group of therapists that have their own business)
- ☐ I'm not sure
- ☐ Other: _____

10. What is the name of the place where you or your family member get services?

_____

11. How did you or your family member get connected to services?

- ☐ Referred by a doctor
- ☐ Advertisement (on a billboard, flyer, television, etc.)
- ☐ Referred by another organization
- ☐ Referred by a neighbor or a friend
- ☐ Other: _____

12. How long did you or your family member wait to receive services?

- ☐ There was no wait to receive services
- ☐ Less than one month
- ☐ Between 1 and 3 months
- ☐ Between 3 and 6 months
- ☐ Between 6 and 9 months
- ☐ Between 9 months and 1 year
- ☐ Longer than 1 year

13. How much did you pay or are you currently paying for each session?

- ☐ Receive(d) free services
- ☐ Between $1 and $10
- ☐ Between $11 and $20
- ☐ Between $21 and $30
- ☐ More than $30
- ☐ I'm not sure

14. All of these reasons made it difficult for me or my family member to find services (please check all that apply):

- ☐ Cost
- ☐ Don't have insurance
- ☐ Insurance doesn't cover the cost of mental health services
- ☐ Didn't know where to go
- ☐ There aren't services close to home
- ☐ It was hard to find services in our native language
- ☐ It was hard to find providers who understood our culture
- ☐ Couldn't get someone to watch the kids
- ☐ Couldn't get a ride
- ☐ Fear that people would think me or my family member was crazy if we asked for help
- ☐ Fear that family members wouldn't approve if I/we got help
- ☐ Didn't like how I/we were treated
- ☐ Other: _____

15. How would you rate the quality of your most recent experience with mental health services?

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

16. Please share more details below about your experience receiving mental health services, such as positive or negative experiences.

_____

_____

_____

_____

_____

Please go to page 6

Page 5 – Please complete only if you answered No to Question 1

Barriers to Accessing Mental Health Services

17. Have you ever wanted to get mental health services in Chicago?

- ☐ Yes
- ☐ No

18. What has stopped you from accessing mental health services in Chicago? Please check all that apply.

- ☐ Not applicable, I have never wanted to get mental health services
- ☐ Not applicable, I got mental health services outside of Chicago
- ☐ Cost
- ☐ I don't have insurance
- ☐ My insurance doesn't cover the cost of mental health services
- ☐ I didn't know where to go
- ☐ There aren't services close to my home
- ☐ It was hard to find services in my native language
- ☐ It was hard to find providers who understood my culture
- ☐ I couldn't get someone to watch my kids
- ☐ I couldn't get a ride
- ☐ I was afraid people would think I was crazy if I asked for help
- ☐ I was afraid my family wouldn't like it if I got help
- ☐ I didn't like the way I was treated
- ☐ Other: _____

Please go to the next page

Page 6 – Everyone please answer

Chicago Department of Public Health Clinics

19. There is a Chicago Department of Public Health mental health clinic that I can get to easily.

- ☐ Yes
- ☐ No
- ☐ There was one, but it closed
- ☐ I'm not sure

20. I can find information about how to get help from the Chicago Department of Public Health mental health clinics.

- ☐ Yes
- ☐ No

21. Please share your vision for city operated mental health services in your neighborhood.

_____

_____

_____

_____

_____

22. Would you like to be contacted to share your story about your experience accessing mental health services?

- ☐ Yes
- ☐ No

23. If yes, please write your first name and phone number below.

_____ _____

FIRST NAME PHONE NUMBER

24. Do you prefer:

☐ Phone calls ☐ Text messages ☐ I don't care

APPENDIX B

TESTIMONY FORM

Public Mental Health Clinic Service Expansion Task Force

Name: _____

Phone Number: _____

Email: _____

I would like to present spoken testimony ☐ yes ☐ no

I would like to present written testimony ☐ yes ☐ no

My testimony is most focused on (choose the best one):

- ☐ Strengths of the city-run mental health system
- ☐ Recommendations for making existing city clinics more accessible and welcoming; and for better promoting clinic services.
- ☐ Gaps and barriers in the current mental health landscape.

Demographic information:

Age: _____ Gender: _____

Race/Ethnicity: _____ Zip Code: _____

Ward/Alderman: _____

May a research contact you to get further details on your experience?

☐ yes ☐ no

May an organizer contact you to get involved in the movement to protect and expand mental health services?

☐ yes ☐ no

Written testimony: Please use the opposite side of this sheet to write testimony or go to bit.ly\mhpublichearing to fill out an online survey and testimony form.

APPENDIX C

CODES

1. **ADVOCACY:** Captures references to the fact that individuals have become involved in efforts to advocate for change in the city of Chicago, including the re-opening of CDPH clinics. Also includes references to people coming together across communities to engage in advocacy efforts.
2. **ALLOCATION OF FUNDING:** Captures references to the way in which funding is allocated for different entities and services within Chicago, including references to a need to change the way in which funding is currently allocated.
3. **CONNECTION BETWEEN PHYSICAL AND MENTAL HEALTH:** Captures references to the way in which physical and emotional well-being reciprocally impact each other.
4. **CRIMINAL JUSTICE EXPERIENCES:** Captures stories about community residents' experiences with the criminal justice system, including experiences with the police (i.e. experiences of police brutality, experiences with police addressing mental health crises) and experiences in jail or prison.
5. **HOLISTIC SERVICES:** Captures references to the importance of treating the whole person and addressing their range of needs (for example, recognizing the interconnection between emotional, physical, social, and material well-being and promoting well-being in all of these areas) rather than simply treating symptoms.
6. **ISOLATION:** To be used when an individual describes feeling alone as a result of their mental health challenges and/or having limited social support due to being unable to access mental health services that address their needs. Also includes references where individuals describe feeling alone because their mental health challenges are not understood or not validated, as well as references to feelings of hopelessness and contemplating suicide (or stories of individuals who did commit suicide) because they see no end to their pain.
7. **LONG-TERM HEALING PROCESS:** Captures references to the long-term nature of the process of healing from trauma and/or recovering from mental health challenges. To be used when individuals make reference to the length of time of their healing process, the length of time for which they utilized professional support, and/or the need to recognize that coping with mental health challenges and healing from trauma is a process that takes years.
8. **MENTAL HEALTH ACCESS BARRIER—INSURANCE STATUS:** Captures references to the way in which a lack of insurance coverage poses a barrier to mental health service access in Chicago's current landscape.
9. **MENTAL HEALTH ACCESS BARRIER—LACK OF SERVICES IN CLOSE GEOGRAPHIC PROXIMITY:** Captures references to the way in which a lack of mental health services in close proximity to an individual's home poses a barrier to mental health service access in Chicago's current landscape.

10. **MENTAL HEALTH ACCESS BARRIER—LIMITED CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES:** Captures references to the way in which limited availability of services that are culturally affirming and linguistically appropriate poses a barrier to mental health service access in Chicago's current landscape.

11. **MENTAL HEALTH ACCESS BARRIER—LIMITED ORGANIZATIONAL CAPACITY:** Captures references to the way in which limited organizational capacity among private providers (i.e., waiting lists, limited appointment availability) poses a barrier to mental health service access in Chicago's current landscape.

12. **MENTAL HEALTH ACCESS BARRIER—SERVICE COST:** Captures references to ways in which the out-of-pocket cost of mental health services (for both individuals who are insured and individuals who are uninsured) poses a barrier to service access in Chicago's current landscape.

13. **MENTAL HEALTH SERVICE QUALITY:** To be used to capture references to the overall quality of mental health services within Chicago's current service landscape (excluding specific references to service quality at CDPH mental health clinics, which will be captured through the code "Public mental health clinic characteristics"). Can be used to capture broad references to overall service quality when specific providers or facilities are not mentioned, as well as to capture references to the quality of services delivered through private providers.

14. **PUBLIC MENTAL HEALTH CLINIC CHARACTERISTICS:** To be used to capture references to the past and current characteristics of CDPH mental health clinics, including references to the physical conditions of the buildings, promotion (or lack of promotion) of services, working conditions, staff capacity, and the quality of the services provided at these facilities.

15. **SAFETY NET:** To be used to capture references to the fact that there is a need to ensure that everyone in the city has access to mental health services, and/or references to the role that CDPH clinics can and should play in facilitating service access to individuals who are unable to access services through other venues. Also captures references where the speaker identifies a need to re-open closed CDPH clinics and/or discusses the need to expand public mental health services.

16. **STRUCTURAL CONTEXT:** Captures references to the larger sociopolitical context (i.e. structural racism and discrimination, labeling and stigmatization from healthcare and social service providers) and local community context (i.e. living in a high economic hardship community, limited access to affordable housing, community violence and crime stemming from lack of access to mental health services, limited investment in social service and educational infrastructure, limited community investment and attention from local politicians) in which individuals live that impacts their well-being.

17. **TRAUMA:** Captures references to experiences of trauma, including interpersonal and community violence and traumatic grief, that have led to mental health challenges and a need to seek out mental health services.

18. **TRAUMA-INFORMED CARE:** To be used to capture references where the speaker describes what trauma-informed care is, their vision of what trauma-informed care should look like, or a lack of clarity regarding what the term trauma-informed care means and how it is implemented.

19. **YOUTH NEEDS:** To be used to capture specific references to children, adolescents, and/or youth, including their needs and experiences within Chicago's current service landscape. Includes references to the way in which intergenerational trauma and the structural context in which youth live impacts their emotional well-being.

FOOTNOTES

[1] Collaborative for Community Wellness (2018). *Uplifting voices to create new alternatives: Documenting the mental health crisis for adults on Chicago's southwest side*. Chicago, IL: Saint Anthony Hospital - Center for Community Wellness.

[2] Collaborative for Community Wellness (2018). *Report: Mental health provider rate per 1,000 residents*. Retrieved from https://docs.wixstatic.com/ugd/a93a18_049ed5df10e24da297f4031870cec1ad.pdf

[3] Collaborative for Community Wellness (2019). *Report: Assessing CDPH list of mental health providers*. Retrieved from https://docs.wixstatic.com/ugd/a93a18_3239c2f911804585aa5fb868c005952c.pdf

[4] Smith, G., Kennedy, C., Knipper, S., O'Brien, J., O'Keefe, J. (2005). *Using Medicaid to support working age adults with serious mental illness in the community: A handbook*. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. https://aspe.hhs.gov/report/using-medicaid-support-working-age-adults-serious-mental-illnesses-community-handbook

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[7] Fawcett, K. (2014, September 30). What happens to patients when mental health clinics close. *U.S. News & World Report*. https://health.usnews.com/health-news/patient-advice/articles/2014/09/30/what-happens-to-patients-when-mental-health-clinics-close

[8] All of the data on mental health spending was collected from the Approved City Budgets found on the website for the Office of the City Clerk for the City of Chicago from 2008 through 2018. (https://www.chicityclerk.com/legislation-records/journals-and-reports/city-budgets)

[9] Data represent only mental health salaries and positions funded through city corporate funds.

[10] Data represent only mental health salaries and positions funded through city corporate funds.

[11] Bogira, S. (2009). Starvation diet: Coping with shrinking budgets in publicly funded mental health services. *Health Affairs*, *28*(3), 667-675.

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[13] Coalition to Save our Mental Health Centers (n.d.). Mission and history. Retrieved from http://saveourmentalhealth.org/mission--history.html

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[15] Collaborative for Community Wellness (2018). *Report: Mental health provider rate per 1,000 residents*. Retrieved from https://docs.wixstatic.com/ugd/a93a18_049ed5df10e24da297f4031870cec1ad.pdf

[16] Collaborative for Community Wellness (2019). *Report: Assessing CDPH list of mental health providers*. Retrieved from https://docs.wixstatic.com/ugd/a93a18_3239c2f911804585aa5fb868c005952c.pdf

[17] American Immigration Lawyers Association. (2019, August 7). *Doc. No. 19050634*. https://www.aila.org/advo-media/issues/all/public-charge-changes-at-uscis-doj-and-dos

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[19] Parmet, W. E. (2018, September 27). The health impact of the proposed public charge rules. *Health Affairs*. https://www.healthaffairs.org/do/10.1377/hblog20180927.100295/full/

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[23] The Center on Budget and Policy Priorities. *The Problems with block-granting entitlement programs*. https://www.cbpp.org/the-problems-with-block-granting-entitlement-programs

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[25] Ibid

[26] The Center on Budget and Policy Priorities. *The Problems with block-granting entitlement programs*. https://www.cbpp.org/the-problems-with-block-granting-entitlement-programs

[27] Padget, D. K. (1998). *Qualitative Methods in Social Work Research: Challenges and Rewards*. Thousand Oaks, CA: Sage Publications.

[28] The n = number of valid responses to that survey question.

[29] Please note that because respondents could select multiple options for this question, totals will exceed 100%.

[30] Please note that because respondents could select multiple options for this question, totals will exceed 100%.

[31] Please note that because respondents could select multiple options for this question, totals will exceed 100%.

[32] Please note that because respondents could select multiple options for this question, totals will exceed 100%.

[33] Please note that because respondents could select multiple options for this question, totals will exceed 100%.

[34] Please note that because respondents could select multiple options for this question, totals will exceed 100%.

[35] Respondents could indicate more than one answer and select multiple barriers.

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[38] Morrill, Z. (2019, June 10). *Systemic violence and the mental health industrial complex*. Mad in America. https://www.madinamerica.com/2019/06/systemic-violence-mental-health-industrial-complex/

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