Where to Go?: Alternatives to Emergency Departments in the Behavioral Health Crisis System in Cook County

NAMI Chicago
December 2024

NAMI CHICAGO

Table of Contents

NAMI Chicago: Who We Are

Founded in 1979 by four families with adult children experiencing mental illness, NAMI Chicago is the largest affiliate of the National Alliance on Mental Illness (NAMI) in Illinois. Since our founding, NAMI Chicago has fought for families and individuals impacted by mental health conditions. We promote community wellness, break down barriers to mental health care and provide support and expertise for families, professionals, and individuals in Chicago and beyond. At NAMI Chicago, we have the courage to believe that healing is possible.

Introduction

Over the past several years, the behavioral health system in the United States has been a growing focal point among both community members and decision makers. This shift is in part driven by increased awareness and recognition of stress, anxiety, and loneliness, resulting from the COVID-19 pandemic, as well as societal movements around support for those experiencing a behavioral health crisis.[1] There are three components to the behavioral health crisis response system—someone to call, someone to respond, and somewhere to go—that are explored through this white paper, with an emphasis on the current service options for "somewhere to go" in Cook County. The findings elevate a need to shift away from a one size fits-all, emergency department-based approach to crisis intervention that can work for anyone, anywhere, at any time.

The history of the behavioral health system is important to understand, both as context for where we are now and as a basis for where we should be going. First, the behavioral health system has never been effective in meeting the wide variety of needs that impact a person's recovery. While many providers offer valuable and lifechanging treatment from a recovery-focused lens, accessing behavioral health care in Illinois remains difficult, expensive, and in some cases, treatment can even be traumatizing. Lack of resources, stigma, and discrimination have contributed to the system that exists today, underscoring the need for a more comprehensive approach that addresses these root causes.

Additionally, the behavioral health crisis system is built on a flawed assumption: that all behavioral health crises are the same and therefore the response to those crises should be the same. Our current response system relies heavily on law enforcement intervention and care in an emergency department (ED) or hospital setting. If an individual is experiencing a crisis in the community, law enforcement is called to support, and the primary tool used for response is to drop that person off in an ED. But this response does not take the severity of the crisis, individual needs, or treatment tailored to deescalating the crisis into consideration.

Furthermore, the concept of mental health treatment as punitive aligns with a plea to take a more humanistic and culturally sensitive approach to mental health healing and treatment. Recently, Dr. Jennifer Mullan, founder of Decolonizing Therapy, critiques the traditional mental health system for its punitive nature, particularly in its approach to marginalized communities. She argues that the system often prioritizes control and compliance over genuine healing, leading to practices that can retraumatize individuals, especially those from Black, Indigenous, and People of Color (BIPOC) backgrounds.[2]

[1]Behavioral health is an umbrella term that includes mental health and well-being. Examples of behavioral health conditions include depression, anxiety, attention deficit disorder, and substance use disorder. See https://mchb.hrsa.gov/programs-impact/focus-areas/mental-behavioral-health

In her work, Dr. Mullan emphasizes the importance of understanding the historical and systemic roots of trauma. She advocates for therapeutic practices that resist coercive measures, such as forced hospitalization, and instead promote autonomy, cultural sensitivity, and community-based support. By addressing the colonial underpinnings of the mental health system, she calls for a shift towards more compassionate and liberatory approaches that honor the lived experiences of individuals.

Behavioral health is not a linear illness; it can be complicated and therefore requires a more nuanced response. Our current system is driven to put people in one box based on the risk for serious injury to self or self-inflicted death by seriousness of a plan and access to lethal means. This is the most extreme response. Many people experience behavioral health crises that do not result in plans or actions around suicide.

The behavioral health crisis system not only needs interventions that are life saving for individuals intending to act on suicidal ideation, it also needs interventions that respond to the many other challenges someone experiences when their mental health is impacted and they have trouble coping.

An important evolution is occurring around the treatment of behavioral health crises that acknowledges the many ways individuals experience crisis. Research and best practices have shifted to assess the severity of the crisis and provide interventions to first focus on de-escalation. For example, NAMI Chicago's own policy around responding to callers expressing suicidal ideation has changed over the years, from requiring a law enforcement response for any crisis, regardless of severity, to a robust assessment and intervention model that has resulted in law enforcement or mental health mobile crisis response in just 1.4% of cases.

Effectively supporting individuals experiencing a crisis requires a variety of service options to meet many different needs. This involves building a system for behavioral health crisis intervention with someone to call, someone to respond, and somewhere to go, moving away from a one-size-fits-all, emergency department-based approach to crisis intervention. Individuals experiencing a behavioral health crisis deserve a preventative, robust continuum of care like those that are available for other health conditions. A system that is responsible for the quality of people's lives must also emphasize ownership and accountability.

This paper hopes to outline and identify ways to avoid the use of crisis systems that harm individuals and their communities by building human centered options for those needing immediate interventions to maintain safety. NAMI Chicago views alternatives to EDs as a concept to support a less oppressive response. More solutions and continued advocacy are needed to fully achieve this transformation. NAMI Chicago remains committed to identifying, developing, and advocating for policies that contribute to a fundamental shift in our behavioral health system.

Findings and Recommendations

A few notable findings have emerged, along with recommendations for further improvements to behavioral health care in times of crisis:

1. Since the establishment of 988 as a federally mandated crisis line for behavioral health emergencies,[3] there has been a significant shift toward reforming the behavioral health crisis system at both national and local levels. While the State of Illinois has made strides in funding services and assessing the current crisis continuum, the reality is that behavioral health crisis systems are predominantly shaped and implemented at the local level. In Chicago and Cook County, a strong convener is essential to bring together stakeholders, solidify a shared vision, and ensure coordinated, equitable access to behavioral health crisis services.

This convener should be responsible for closing service gaps, aligning resources, and establishing a cohesive system where individuals in crisis receive timely, effective care. Cook County's health system is already emerging as a leader in this space, leveraging its infrastructure and expertise to build on its vision of becoming a Behavioral Health Administration for the region. This white paper underscores the critical need for a dedicated entity to oversee the growth and quality of services within the behavioral health crisis continuum. The continuum spans everything from crisis intervention and stabilization to long-term care, requiring a robust framework to ensure these services are integrated and accessible. Cook County is uniquely positioned to take on this role, creating a model that not only addresses immediate service gaps but also sets the standard for behavioral health crisis systems nationwide.

2. Alternatives to emergency departments (EDs) that integrate housing into crisis recovery are sparse and fail to meet existing demand. Various models must be researched and considered for large-scale implementation across Cook County. One promising model is the Progress Foundation model, which prioritizes self-determination, aiming to help individuals achieve stability and long-term recovery beyond merely managing illness. Building out alternatives that integrate housing and sustainably funding them should be a top priority for regional behavioral health care decisionmakers.

3. People experiencing a behavioral health crisis often do not have real choices for care. Factors such as race, income, geographic location, family involvement, and the severity of their mental illness frequently determine their outcomes. Many end up in EDs, a Living Room Program, homeless, or entangled in the court system. Currently, Cook County residents in crisis only have two primary avenues for crisis stabilization: Living Room Programs and EDs. While Living Rooms play an essential role and must remain a cornerstone of the behavioral health crisis response system, these programs alone are not equipped to address higher-acuity cases. Cook County must expand access to crisis receiving and stabilization units capable of managing a broader range of behavioral health conditions. This expansion should include support for scaling the Certified Clinical Behavioral Health Clinic (CCBHC) model, which provides comprehensive, evidence-based care for individuals with complex needs.

4. Alternatives that have been shown to reduce ED involvement must also be built out. One such model is the Clubhouse model, where individuals living with behavioral health conditions can find community and purpose in a space they help manage. Research on the Clubhouse model[4] has shown to reduce reliance on crisis services like EDs. Some Clubhouse models are working to add housing components, making them communities with access to socialization, education, skill development, housing and improved
wellness.

5. There are few efforts to advertise existing crisis resources, such as Living Rooms, which hinder their potential impact. A comprehensive campaign is needed to raise awareness and encourage the use of these resources, including crisis, prevention, treatment, and recovery services.

A robust behavioral health crisis response system that can be accessed by anyone at any time requires more crisis stabilization facilities that are appropriately developed, staffed, and resourced. With strong leadership and sustainable funding, Cook County can lead the way in Illinois towards a better crisis system.

The Behavioral Health Crisis Response Continuum

When someone is experiencing a mental health crisis, they may require immediate care. Similar to the medical emergency response system, a fully functioning behavioral health crisis response system is needed to respond immediately to someone who is overwhelmed and struggling to cope. A responsive system could be the difference between life or death for someone who needs immediate assistance. A variety of interventions will be necessary to ensure that seeking care feels safe and supportive, recognizing that each person will have different behavioral health conditions and treatment needs. Additionally, a system for a behavioral health crisis response will help alleviate the need for law enforcement, who often are called to respond to behavioral health crises.

It is critical to highlight that focusing on the development of a behavioral health crisis response system does not negate the need to build out an overall comprehensive system of care for mental health conditions and substance use disorders. Many crises occur because individuals cannot afford medication, lack access to therapy, or are unable to obtain necessary support to manage behavioral health conditions. Crises also occur due to deep distrust of the mental health system, which creates significant barriers for accessing care.[5]

After a crisis, the linkage to recovery support is critical to help prevent the likelihood of a future crisis. A comprehensive behavioral health care system requires a cohesive philosophy, thoughtful strategy, dedicated leadership, and sustainable investments unifying prevention, treatment, crisis care, and recovery systems for mental health and substance use health care. This white paper focuses on the crisis response system and acknowledges that this system must be built out as a component of a larger behavioral health care ecosystem.

The Three Elements

To organize the mental health crisis response system, the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) designed a comprehensive continuum of care which prioritizes three crisis service elements: (1) Someone to Call, (2) Someone to Respond, and (3) Somewhere to Go. SAMHSA's three-part crisis continuum and best practices (outlined below) provide a clear outline for filling current gaps in the crisis care system and working toward an integrated and effective crisis system. While not overtly named in the continuum, it is important to share a philosophy that the crisis system should align with a collaborative approach where the hierarchal medical model flattens.[6]

Someone to Call: Crisis Call Centers

The first part of the continuum involves regional crisis call centers. At their core, 988 call centers must operate 24 hours a day, seven days a week, 365 days a year to respond to calls, chats, or texts from anyone who needs support for suicidal, mental health, and/or substance use crises.[7] This service must be available to anyone, anywhere, at any time.[8] In refence to best practice guidelines, all centers must be staffed with highly trained crisis counselors who coordinate connections to higher interventions if needed. Call takers are expected to employ tactics like active engagement with callers to establish a rapport, allowing collaboration with the caller in securing their own safety and using the least invasive intervention.

In the first two years of 988 operations, Congress appropriated $1.5 billion to 988 call centers through funding from the American Rescue Plan and Bipartisan Safer Communities Act (ARPA).[9] The U.S. Department of Health and Human Services (HHS), through SAMHSA, awarded grants to states and territories for mental health emergency preparedness, crisis response, and the expansion of 988 suicide and crisis lifeline services. SAMHSA additionally funds Vibrant Emotional Health, a national non-profit which deploys the network, data, quality, training, and routing of 988 Lifeline contacts.[10]

Crisis Call Centers in Cook County

The Illinois Department of Human Services (DHS) awards state and federal funding[11] to local call centers through the Division of Mental Health (DMH). There are currently eight 988 call centers throughout Illinois as of August 2024.[12] Initially, calls were routed to a call center based on the caller's area code.

As of September 2024, calls in Cook County are routed based on the caller's general geographic location based on cellphone tower pings. Call takers cannot pinpoint the exact location of the caller, but this change ensures all callers in Cook County are connected with call centers which are familiar with local mental health resources available in the area.

Calls originating in Cook County would first be routed to two call centers in Chicago: NAMI Chicago and Community Counseling Centers of Chicago (C4). Should these call centers not be available, calls would be rerouted to Illinois' back-up call center.

At NAMI Chicago, call takers, known as Crisis Counselors, are trained to assess each caller's needs and provide support in ensuring the caller's safety. Our Crisis Counselor answers the call and will actively engage each caller in conversation, listening to their behavioral health needs and, whenever possible, collaborating on a safety plan.

At NAMI Chicago, nearly 99% of calls are resolved with the 988 Crisis Counselor, eliminating the need for higher-level interventions like mobile crisis response team or 911. For approximately the first nine months of operation (from our launch date of January 19, 2024, to October 31, 2024), Crisis Counselors fielded 11,732 calls. On 33% of calls, the caller reported experiencing thoughts of suicide, and on 27% Crisis Counselors identified depression or anxiety as the caller's primary concern. Callers were given the option to receive a follow-up call from one of the Crisis Counselors. During these follow-up calls, the Crisis Counselor assesses the individual's safety, assesses the efficacy of their safety plan, supports in revising the plan as needed, and offers support with resources previously provided.

As noted, most calls are resolved with the Crisis Counselor, meaning that the caller is stabilized. However, for the less than 2% of calls that do require additional interventions, a mobile crisis team may be the appropriate next step.

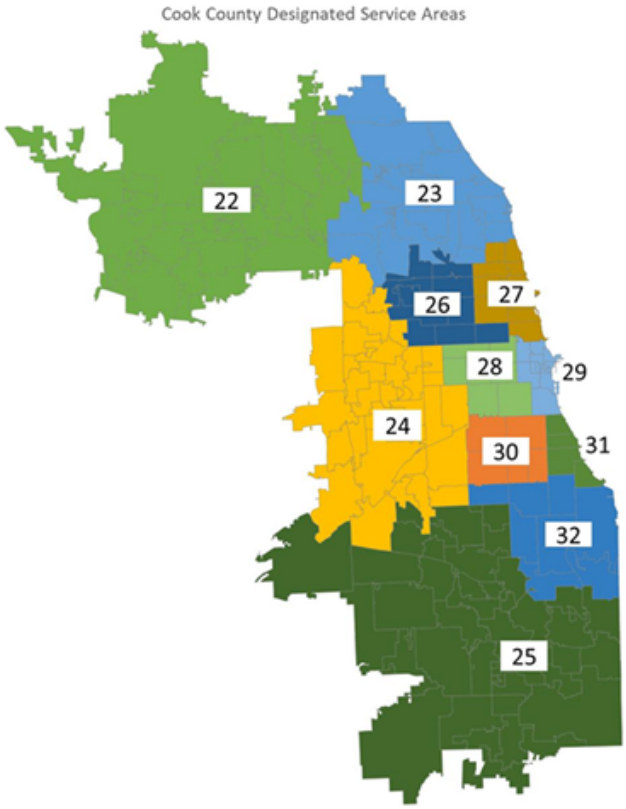
Someone to Respond: Mobile Crisis Teams

The second part of the continuum is designed to meet the individual in crisis wherever they are, which includes a variety of team responses. Co-responder teams are typically defined as a team including a law enforcement officer, an emergency medical professional, and mental health crisis workers. These teams are an example of "someone to respond" in scenarios which warrant assessment of physical and medical safety in addition to behavioral health support based on geographic location.[13] Mobile Crisis Teams (MCTs) are comprised of all mental health professionals and are intended to meet people where they are without limitations based on location. In some cases, MCTs may determine they can de-escalate the situation over the phone. SAMHSA recommends MCTs operate in pairs to divert individuals experiencing crisis from emergency services and law enforcement involvement.[14] At a minimum, teams should be comprised of a licensed or credentialed clinician, respond to the location of the individual without constraints, and connect individuals to facility-based care with a warm handoff, if indicated. SAMSHA recommends that MCT services incorporate peer support and resource specialists, operate without law enforcement involvement unless necessary, use technologies like GPS in partnership with regional crisis call centers to facilitate an efficient response, and schedule outpatient follow-up appointments in support of ongoing care.

Mobile Crisis Teams (MCT) in Cook County

In September 2021, the City of Chicago began a pilot for a co-responder model for a MCT, the Crisis Assistance Response and Engagement (CARE) team. For select areas of the city during weekday hours, the CARE team responds to 911 calls with a mental health component, with the goal of reducing law enforcement involvement in mental health crises through de-escalation, mental health assessments, and linkage to appropriate care.[15] The CARE team was designed and launched as a partnership between multiple City of Chicago departments and agencies, including the Chicago Department of Public Health (CDPH), the Chicago Fire Department (CFD), the Chicago Police Department (CPD), and the Office of Emergency Management and Communications (OEMC). The pilot was funded through a combination of city funds, ARPA, and federal block grants. In September 2024, Chicago Mayor Brandon Johnson announced a plan to continue this work permanently and remove police from the response, so only a behavioral health clinician and an Emergency Medical Technician (EMT) would respond to calls 911 dispatchers deem to necessitate a mental health response.[16]

In other parts of the County, the Illinois Department of Healthcare and Family Services (HFS) is establishing processes and systems to provide the state's nearly four million Medicaid recipients with access to MCTs. HFS established Designated Service Areas (DSA) with specified providers for a mobile crisis response.[17] To access this service, Medicaid recipients can call the CARES Hotline (not to be confused with the City of Chicago's CARE MCT). The call taker will work with the caller to determine the eligibility of the person in crisis and identify if immediate mobile crisis response is needed. If eligible, the CARES Hotline will send an MCT to the location of the person in crisis within two hours.[18] As of July 2024, there are 11 DSAs in Cook County, which are served by eight providers.[19] Four of these providers are in Chicago, and four are in suburban Cook County.



Source: Illinois Department of Healthcare and Family Services

Some MCT providers may not provide mobile crisis response through Medicaid but receive grants from the Illinois Department of Human Services (DHS), Division of Mental Health (DMH) to provide mobile crisis response to anyone in need. As of September 2024, 24 providers are located in Cook County. Of the 24 providers, 14 are located in Chicago (one provider has two locations, but is counted only once) and 10 are located in suburban Cook County (one provider also has two different locations but is similarly counted only once). See Appendix A for the full list.

There are existing challenges in connecting a caller with MCTs, including MCTs responding to other calls, workforce shortage issues, or MCT staff safety concerns. Additionally, MCTs in Cook County are not centrally dispatched or connected directly between 911 or 988. Most MCTs in Cook County are receiving calls directly to their crisis line for support.

"On an overnight shift earlier this year, I received a call from a distraught woman who was experiencing extreme anxiety and had wandered into an urban park alone. Although she stated she was in a moderately safe neighborhood, she did not know what park she was in, and her state of mind, winter weather, and disorientation made me very concerned for her safety. The caller disclosed suicidal ideation and early signs of planning and intent. I attempted to call in the local mobile crisis team, but they were understaffed and unable to assist. So, working closely with the caller to look for landmarks and street signs visible from her park bench, I identified online that a hospital was within a few blocks. I stayed on the phone with the caller and gave her walking directions, but just as she approached the hospital, her phone connection dropped. Unable to reconnect with her immediately, I called the hospital and spoke to an attendant at the front desk of the hospital's [emergency room], explained the caller's situation, and asked them to keep an eye out for her. I was eventually able to get the caller on the phone again and confirmed that she was in good hands with the hospital staff and was feeling calmer and safer already."

- NAMI Chicago Crisis Counselor

Somewhere to Go: Crisis Receiving and Stabilization Services

Crisis receiving and stabilization services are the final piece of the crisis continuum. SAMHSA defines crisis stabilization as "a direct service that assists with deescalating the severity of a person's level of distress and/or need for urgent care associated with a substance use or mental disorder."[20] Crisis receiving and stabilization facilities should operate under a "no wrong door" policy, where anyone can enter and use mental health and substance use services, regardless of their ability to pay, referral status, or other factors.[21] Best practices regarding crisis receiving and stabilization facilities include operating 24 hours per day or less, staffing a multidisciplinary team capable of meeting the needs of individuals experiencing all levels of crisis in the community, and offering intensive care beds that would also be registered in the national crisis bed registry. Additionally, staff members should coordinate connections with ongoing care, and the facility is responsible for transferring the individual to a hospital or another institution if needed.

Because of a lack of a fully integrated and effective mental health care system, law enforcement frequently serves as the initial responders to mental health crises.[22] Given this reality, crisis receiving and stabilizing facilities should accept all walk-ins, including police and fire drops-offs,[23] and have the capability to address minor physical concerns. Staff within crisis receiving and stabilization facilities includes psychiatrists, psychiatrist nurse practitioners, nurses, licensed or credentialed clinicians, and peer specialists.

Despite these outlined best practices, researchers have found that crisis receiving and stabilization facilities lack national standardized regulation, financing, and structure. As of 2023:

"Crisis programs vary widely in scope, capability, and populations served. Some are designed for individuals with low acuity who primarily need peer support and a safe place to spend the night, whereas others can treat individuals with the highest acuity presenting with suicidal behaviors, acute agitation, and substance intoxication. Some are freestanding, whereas others are embedded in or attached to hospital [Emergency Departments]. Furthermore, because most crisis services are financed and regulated at the state level, facility licensure and nomenclature differ widely from one state to another [...] Expert reports such as SAMHSA's National Guidelines for Behavioral Health Crisis Care and the National Council for Mental Wellbeing's Roadmap to the Ideal Crisis System have attempted to catalog types of programs, but no standard classification system yet exists."[24]

Evidently, the crisis receiving and stabilizing infrastructure is evolving. However, individuals in crisis still need a place to go today.

Emergency Departments (EDs)

The number of individuals arriving at EDs for mental health reasons has increased in recent years, a trend observed even before the COVID-19 pandemic. In 2019, mental health disorders were the seventh most common primary diagnosis at ED visits.[25] A National Health Statistics report demonstrated racial disparity within the national total of mental health-related visits to EDs: from 2018–2020, rates of mental health-related ED visits were highest among non-Hispanic Black adults (96.8 visits per 1,000 adults), followed by White (53.4) and Hispanic (36.0) adults. Rates of ED visits for specific mental health disorders, including substance use disorders, anxiety disorders, and mood disorders, were also highest among Black adults.[26] The proportion of ED visits from 2011–2020 for children, teens, and young adults have doubled, including a five-fold increase in suicide-related visits during this time frame.

It is important to recognize possible instances in which the ED is the appropriate crisis receiving and stabilizing facility. If an individual presents with a co-occurring medical condition such as serious self-injury, overdose, withdrawal, or other medical conditions, the individual will likely need both medical and behavioral health care. In this instance, crisis receiving and stabilizing facilities may end up referring the individual to an ED for appropriate medical care. Many EDs across the country, and likely in Cook County, lack a full suite of appropriate behavioral health care modalities, practitioners, and resources. Cook County is home to 73 hospitals, with 40 in Chicago proper.[27] There are two public psychiatric hospitals, one of which is located in Chicago.[28] Generally, an individual walking into an ED will be registered, which involves paperwork and collecting the patient's insurance information, and medical history.

Then, medical staff will make an assessment to determine how urgently care is needed. Medical professionals, which can vary from ED doctors to a team consulting with a psychiatrist, will establish a working diagnosis and a plan of action. Individuals then receive appropriate medication, counseling, and a referral for ongoing care.[29] However, for many experiencing behavioral health crises, EDs often exacerbate psychological distress due to overcrowding, high noise levels, and limited privacy.[30]

When EDs need to refer the patient to an inpatient psychiatric hospital, the wait can be long to find the appropriate resource: "individuals in need of more specialized care can spend hours, or even days, awaiting transfer to a psychiatric hospital. During this time, they are often kept in isolation, monitored by nonclinical personnel such as sitters, security guards, or police, and may be restrained to a gurney if they become agitated."[31] The overflow issue can lead to a higher degree of stress for staff, which is associated with more mistakes and negative patient experiences.[32] Psychiatric visits to the ED have been found to be 42% longer than non-psychiatric visits, and they result in increased inpatient admission (24% vs 12%).[33] However, innovations in ED operations could mitigate these negative experiences for people presenting with a behavioral health crisis.

Emergency Department Innovations in Chicago

While practitioners across the country develop models of care for mental health crisis care in EDs,[34] one hospital in Chicago has experimented with new approaches, such as an outpatient crisis intervention center as an offshoot of their ED. Patients who do not meet inpatient hospitalization criteria, but could benefit from outpatient crisis intervention, are walked from the ED to the outpatient center, which provides a variety of services to treat patients in an outpatient setting and prevent hospitalization. One former ED employee who worked there in the 2010s walked us through what an experience might have been for a patient walking into the ED. The care team responding to the patient was a physician or resident, nurse, crisis worker, public safety officer, and other professionals if needed. Each provider had their own role in administering immediate care. This process begins with an evaluation from the physician, resident, or nurse.

The crisis worker would conduct a full psychiatric evaluation consulting with the psychiatrists who were on call 24/7. The care team would work on discharge planning, which could include resources to shelter, a walk across the street for immediate linkage to outpatient care through their outpatient crisis intervention center, admission to inpatient care (whether at the same hospital or a transfer to another hospital), or substance use treatment, which could include another facility. The hospital also worked with the Chicago Police Department to develop a more effective drop-off process: "we had a full process that police would call, then they would show up, we would do a warm handoff, educate [the police officer] on petition and certificate usage, involuntary commitment. And at that point, it was really designed so that police could

quickly come in and out of the [ED] and not have to wait too long as they did in many other [EDs] in the Chicagoland area. So it was a huge innovation for emergency medicine." The former employee's hope was that this process with local law enforcement would be replicated across the city, but she did not know if this work had been completed as of today. Even so, processes like this have great potential to be replicated across Cook County.

When asked if the ED might be a more appropriate setting for someone experiencing a behavioral health crisis if the ED has the staff, programming, and funding to treat behavioral health crises, the former ER employee told us she feels as *"if this system is built out in that way, it can be the right place for a person who's having a psychiatric emergency or crisis. But I also do feel like not every psychiatric emergency or crisis means somebody needs inpatient hospitalization. So a drop-in center that does offer crisis intervention or our outpatient crisis intervention center [...] is also a great option..."*.

Even with evolving approaches to the ED, there is likely still a space and need for alternatives for people experiencing a mental health crisis.

Alternatives to Emergency Departments

A person experiencing a medical crisis has an idea of where to go and what to expect when they arrive at an ED. However, a person experiencing a behavioral health crisis may go to an ED because they are not familiar with alternative options, and they may not know what kind of care they need. The appropriate level of care should be based on acuity, meaning that individuals with the most serious and complex conditions receive more intensive and specialized care. Not all crisis facilities will be able to treat every person, but a fully functional system will be able to receive everyone, including those with the most serious behavioral health conditions.[35]

CCBHC Model

The Certified Community Behavioral Health Clinic (CCBHC) model has an important role to play in this continuum, but the work is nascent. In 2014, a federal law established CCBHCs, which are healthcare clinics focused on providing integrated and coordinated behavioral health care. They must serve everyone and meet certain standards for a range of behavioral health services, which include crisis services like mobile response and outpatient care.[36] They are also responsible for care coordination and must have prescribers on-staff who can address emergency medication needs.[37] Notably, CCBHCs receive an enhanced Medicaid reimbursement rate because of their expected services to anyone who comes into the clinic.[38] In Illinois, CCBHCs began providing services under their new CCBHC designation on October 1, 2024.[39] However, CCBHCs may not have geographic reach across Cook County. In June 2024, the U.S. Department of Health and Human Services approved Illinois' plan to allow 19 clinics in the state to become CCBHCs; four clinics are in Chicago, and one CCBHC is in suburban Cook County. This model will likely benefit from being supplemented by crisis residential beds, Living Rooms, and hospital-adjacent mental health urgent care settings. As CCBHCs are developed across Cook County, a systematic review of geographic need should help inform placement and service area.

Cook County Research on the Mental Health Crisis Continuum

In spring 2022, the Cook County Board of Commissioners established a task force to help create a pilot program on alternative mental health crisis response models. The Alternative Health Intervention (ALT-HIR) Task Force developed a final report in August 2022 with a brief landscape overview and two recommendations to improve the crisis response continuum in suburban Cook County.[40] One recommendation asked the County to conduct a needs assessment to determine what crisis response services are being provided and to understand the demographic need. A guiding question for research on the County's "Somewhere to Go" part of the continuum includes: "What is the current state of the crisis receiving and stabilization system in Cook County, and how can the County assist in building out a continuum of crisis receiving and stabilization facilities in Cook County?"[41] As of September 2024, the Cook County Department of Public Health (CCDPH) did not have an update on the report or additional information on the research question suggested by the task force.

CCDPH staff did confirm that they are working on a Cook County crisis response needs assessment and hope to be able to answer these questions in the future. This work could help identify the potential geographic distribution of crisis receiving and stabilizing units, as well as housing and other basic needs critical to treatment and recovery of behavioral health conditions.

Although neither the City of Chicago nor Cook County had a comprehensive, publicly available list of alternatives to EDs for behavioral health crises, what follows is an overview of alternative supports available in Cook County as of September 2024.

Cook County Living Rooms

In Illinois, the Department of Human Services (DHS) provides state-funded grants for Living Rooms, a program designed for individuals in need of a crisis-respite program with services and supports, with the goal to proactively divert crises and break the cycle of psychiatric hospitalization.[42]

According to DHS, Living Rooms are intended to provide a safe, inviting, and home-like atmosphere. The staff must consist of peers, who are individuals with personal lived experience in recovery from mental health and/or substance use challenges. Participation in the Living Room is entirely voluntary, allowing individuals to choose the level of care with which they are comfortable. Upon arrival, the guest is greeted by a peer who makes the guest feel welcome and explains the Living Room in simple terms to help the guest know what to expect. Guests are then screened by staff for suicide and homicide risk. They are also assessed for the suitability of the Living Room to meet the guest's needs, including the safety of the arriving guest, and other guests and staff occupying the Living Room.[43]

On the Ground: Interviews with Two Living Room Programs in Cook County

As of August 2024, there were nine total Living Room providers in Cook County, including seven Living Room Program providers in suburban Cook County (two providers operate two locations each), and two Living Room providers in the City of Chicago. See Appendix B for the full list.

Based on interviews with two Living Room providers in Cook County, we found that Living Rooms can be impactful interventions for people experiencing a mental health crisis such as depression and anxiety, although a short-term facility stay may be less equipped to work with high-acuity cases.

Both Living Room program providers, denoted as Provider 1 and Provider 2, are fully funded by the state's Living Room program grant and do not bill Medicaid or commercial insurance for services. The providers operate 24/7, are free regardless of ability to pay or insurance status, and staffed with peers. They provide a space for individuals experiencing a mental health crisis or significant stress to receive support, de-escalate, and plan for next steps. Both providers stated that they see a variety of mental health conditions, from anxiety to bipolar disorder.

Provider 1 mentioned that because of a growing awareness in the community that anyone can walk in and talk to someone for free, staff have encountered individuals who may be simply stressed and need peer support rather than clinical intervention. Provider 1 admitted that “on the higher acuity end, there are definitely times … this is not the right fit.”

Provider 2 similarly sees guests living with a variety of mental health conditions. They described a recent stay of an individual living with active hallucinations and experiencing housing insecurity. Provider 1 allows guests to stay up to 23 hours. Since their launch in 2016, they noticed that their overnights are slow, and guests typically stay for no more than four hours. Provider 2 allows stays up to four nights and five days and does have guests regularly stay overnight.

Despite this support, short-term stays are not a long-term solution, especially for people in need of housing. Provider 2 mentioned that it is always a challenge because shelters are difficult to get into, and it impacts the Living Room staff: “it is always difficult on staff when there is a feeling we are going to send somebody back on the streets without being able to have them linked to somewhere to go.” Provider 2 mentioned they would like to add a transportation budget to help individuals access their next location in the treatment plan. While there can be a plethora of public transit options in Chicago, there are fewer public transportation options in suburban Cook County. Transportation is important because, as both providers pointed out, linkage to ongoing care is a critical part of the plan for recovery, and guests must have the ability to travel to their ongoing care.

Interestingly, both providers mentioned they rarely receive referrals from 988 or MCTs. Provider 1 had only one 988 referral through April 2024 and did not have MCTs dropping off individuals to their facility. Similarly, Provider 2 mentioned they do not get many 988 referrals. Both providers mused it could be because both 988 call takers and MCTs are deescalating on the call or on-site, and it could speak to the efficacy of these interventions, not necessarily a lack of connection to Living Rooms. Additionally, while 988 call centers refer callers to Living Rooms, individuals may choose not to go.

When asked what the ideal “somewhere to go” part of the continuum should look like, Provider 1 spoke about the need for basic awareness about the existence of the Living Room: "Other than stigma, there needs to be some type of public education campaign on what we’re doing. So many folks don’t know about it, even folks in the mental health field don’t really know about it.”

Although the state does publicly provide information about Living Rooms, Provider 2 expressed similar thoughts, sharing that “when the state endorsed the living room, there were no public service announcements.

There is no education for the public of what a Living Room is. People still think that Living Room is a furniture store." Both providers spoke about the need for a strong state effort to educate the public about these programs and de-stigmatize seeking help.

Overall, both providers attributed the peer-led model as a successful intervention, one that requires continued funding. Both providers are operating on three-year grants and are concerned about the sustainability of the future.

Crisis Residential Units

In Illinois, DMH also provides grants for crisis residential units. These units must deliver a safe crisis residential level of care to eligible adults with serious mental illness (SMI). This housing setting must provide short-term stays with supervision, crisis intervention, assessment, and treatment in a community facility with crisis beds.[44] DMH has awarded grants to eleven providers, one operating in two locations. None of these providers are based in Cook County, although four of them are in the surrounding counties of Lake, Kane, DuPage, and Will. See Appendix C for the full list of providers.

Based on responses to our August 2024 inquiry if crisis residential services are available to Cook County residents, one provider in Will County has a capacity of ten beds, which are available to anyone in crisis. In response to a similar inquiry to a crisis residential unit in Elgin, their staff indicated that their eight-bed short-term crisis residential program is available to Cook County residents, but staff flagged that there is a waiting list for a bed. The DuPage County Health Department houses a 12-bed unit for short-term psychiatric stabilization, but it is only available to DuPage County residents.[45] Similarly, Lake County offers a crisis care program where individuals in crisis may stay in their program for one to two weeks, but participation in this program is restricted to Lake County residents.[46] Overall, there are no crisis residential units in Cook County, and only 18 beds are potentially available to Cook County residents in Will and Kane counties. As of September 2024, there is a waitlist for at least eight of these beds.

Housing in the Behavioral Health Crisis Continuum

Fundamentally, secure housing supports overall mental wellness and physical health. For individuals living with behavioral health conditions, supportive housing might be needed as part of long-term recovery. Support and access to housing are often critical resources to reduce the likelihood of behavioral health crises and can prevent hospitalization. However, people living with mental illness are overrepresented in the unhoused population, as about one in five people experiencing homelessness in the U.S. have a serious mental health condition.[47]

Behavioral health crisis prevention and recovery are often served by emergency shelters, transitional living placements, and supportive housing. Emergency shelters are meant to be short-term, immediate housing options.[48] As of August 2024, Cook County is served by 34 emergency and transitional housing providers.[49] The City of Chicago oversees a network of overnight and interim housing shelter programs which includes over 3,000 shelter beds at 50 separate facilities operated by 29 different providers.[50]

Transitional housing "provides temporary housing with social services to individuals and families experiencing homelessness with the goal of interim stability and support to successfully move to and maintain permanent housing."[51] In September 2024, the City of Chicago opened a transitional living placement in the Lincoln Square neighborhood, allowing for 40 individuals to live there for at least three to six months and receive intensive services, such as case management and health care, to support their wellbeing.[52]

Supportive housing is meant to provide "housing and supportive services on a long-term basis to formerly chronically homeless people."[53] According to the Illinois Supportive Housing Providers Association, there are 346 supportive housing projects in Cook County.[54] For example, Thresholds, the largest provider of supported housing in Illinois, operates supportive housing units in Chicago and across Cook County. Their housing models allow for residents with a serious mental illness to have their own living spaces while receiving support services.[55]

An important contributing factor to ensuring housing support is available to prevent crises and support ongoing recovery is the existing housing stock. Currently, the need outpaces the supply for housing across the country. Different estimates on the currently unhoused population in Chicago alone range from 18,000 to 68,000 individuals.[56] A 2021 report on rental housing in Cook County also underscores a supply and affordability gap for housing, exacerbating challenges to obtaining permanent housing.[57]

Even before the COVID-19 pandemic, Cook County faced a stagnant affordable housing pool, driving more low-income and older residents away. The development of affordable housing is inextricably linked to the supply of permeant supportive housing; if affordable housing is not developed, service providers cannot obtain units sustainably. Without additional housing options, thousands of Cook County residents may be severely impaired in both preventing a future behavioral health crisis and entering recovery.

Clubhouse and Progress Foundation Models

Certain behavioral health care models may be useful as the County determines how to ensure housing is integrated into treatment, crisis, and recovery supports. The Clubhouse model is particularly notable. In a Clubhouse, individuals living with a behavioral health condition can find community and purpose in a space they help manage.[58] Research on the Clubhouse model has shown to reduce reliance on crisis services like EDs.[59] In New York, an organization called Fountain House operates a Clubhouse and is working to add housing components, creating communities with access to socialization, education, skill development, housing and improved wellness. The Clubhouse movement adheres to a set of standards and an accreditation process managed by Clubhouse International. Because this model is evidence based and recovery-oriented, public entities have funded Clubhouses in several states, including New York and Texas.[60] In many cases, Clubhouses are standalone models without housing attached, but can play an important role in reducing ED visits and psychiatric hospitalizations.

The Progress Foundation is an example of a behavioral health crisis and recovery services program integrated with housing. This model's emphasis shifted from stabilization to long-term recovery, with a focus on client-driven goals, such as independent living and rebuilding relationships. It prioritizes self-determination, aiming to help individuals achieve stability and long-term recovery beyond merely managing illness – a paradigm shift in treatment and recovery practice. Based in northern California, the Progress Foundation offers short-and medium-term housing and supportive services to over 4,500 individuals experiencing a behavioral health condition. The model integrates crisis intervention, transitional housing, and scattered-site permanent housing with intensive case management, focusing on diverting individuals from unnecessary hospitalizations to supporting recovery in a community setting. They have been able to carry out this work through funding primarily at the county level, with San Francisco, Sonoma, Napa, and Marin counties providing funding for the operation of 19 regional programs.[61]

As Cook County builds out a behavioral health crisis response system, it must establish sustainable and evidence-based alternatives to EDs that integrate housing into treatment and recovery supports. Although some exist throughout the County, they are insufficient to meet the growing demand for these services.

Findings and Recommendations

Based on this research, a few notable findings emerge, along with recommendations for further improvements to crisis care.

1) Finding: While the State of Illinois has spearheaded efforts to fund services and develop Illinois' current crisis continuum, local entities are key leaders in the effective delivery and operations of our behavioral health system. Cook County can step into the role of the regional convener and establish ownership and accountability to an effective, recovery-oriented system. Cook County should also examine their role in funding services and coordinating efforts.

Recommendation: Cook County Health has announced intentions to serve as a Behavioral Health Administration, an entity that can provide, maintain, promote, and fund behavioral health services to a designated region. As a model, BHAs serve as designated points of entry into publicly funded behavioral health services.[62] This work requires coordination with municipalities in the County, including the City of Chicago, and may require formal agreements to ensure effective delineation of authority and scope of work. Given the need for oversight, accountability, and coordination of the behavioral health crisis system at the local level, Cook County should step into this role and continue considering models of oversight, accountability and funding authority to support the needed growth within the behavioral health system.

2) Finding: Alternatives to Emergency Departments that integrate long-term recovery and housing into crisis recovery are sparse and fail to meet demand. Housing is a critical component of both crisis prevention and recovery, and without stable housing options, individuals may continue to cycle from crisis to crisis.

Recommendation: Various models must be researched and considered for implementation in Cook County. Further, sustainability of funding options must be considered for programs and services that offer recovery support and stable housing. Models such as Progress Foundation incorporate a continuum of housing into behavioral health service needs, from crisis to ongoing care. The Clubhouse model offers a supportive environment and community which can reduce reliance on emergency departments and be coupled with housing options. These service models do not currently exist in Cook County, but they offer needed and complimentary support for mental health recovery.

3) Finding: Cook County residents experiencing a mental health crisis only have two options as places to go for crisis stabilization: Living Rooms Programs and Emergency Departments. These options may not be the most appropriate option for high-acuity cases. Living Rooms staff may instead refer the individual to crisis stabilization programs or an ED for more appropriate care. Even so, Living Rooms play a critical role in helping to stabilize individuals and should remain a critical component of the mental health crisis response system. The current nine Living Room program providers and the EDs in Cook County are the most resourced and accessible programs that can receive someone in crisis, help them stabilize, and link them to another resource. Although the state funds crisis residential units, the dearth of available crisis stabilization beds for Cook County residents makes this resource effectively inaccessible to them.

Recommendation: Cook County must ensure access to crisis receiving and stabilizing units that can address a variety of behavioral health conditions. This can include working with the state and other key stakeholders to support the expansion of the CCBHC model across the county, which would house crisis receiving units. The urgent care model may offer insights into alternatives to the ED as well. The 2010 Patient Protection and Affordable Care Act (ACA) expanded health insurance coverage to various populations. As visits to the ED increased considerably, urgent care centers emerged as a step-down from EDs. According to recent research, "it is estimated that urgent care centers prevent around 24.5 million emergency room visits annually, which not only reduces the burden on emergency rooms, but also saves patients and the healthcare system valuable time and money."[63] The financing structure, connection to EDs, geographical reach, services offered, and staffing models could serve as an example for how alternatives in behavioral health care could be developed in a way that differs from the current Living Room model.

Ultimately, sustainable funds must be invested in this level of care to establish crisis stabilization beds in Cook County and publicize and expand Living Rooms. Without sustainable funding streams, these services can be cut at any time. Further research is needed to determine the communities of highest need of these services.

4) Finding: Little public information about existing resources hinders outreach and research efforts. A lack of public information about the mental health crisis continuum, including receiving and stabilizing units, for both consumers and advocates, hinders efforts to improve utilization of Living Rooms in Cook County.

Recommendation: A comprehensive campaign is needed to raise awareness and encourage the use of these resources, including crisis, prevention, treatment, and recovery services.

Conclusion

The behavioral health crisis care system in Cook County and across Illinois is still in development. However, Cook County must continue to build the system and focus on alternatives to Emergency Departments that reduce the likelihood that an individual will experience a crisis in the future. Effective leadership, research, sustainable funding, community outreach, and coordination are necessary at the county level. With these elements, it may be possible to meaningfully impact the wellbeing of thousands of residents across the county. NAMI Chicago stands ready to continue working with all stakeholders to ensure we build a better, sustainable system that will serve Cook County residents for generations to come.

Acknowledgements

NAMI Chicago is grateful to the several NAMI Chicago staff who were instrumental in the development of this work, and we graciously thank them for their expertise, thought partnership, feedback, and dedication. NAMI Chicago thanks Lily Rocha, who led this effort and was the primary author of this document. NAMI Chicago extends its heartfelt thanks to the Living Room providers for sharing insights about their operations, the experts in the field for their valuable time, and our Summer 2024 interns, Rose McCormack, Nathan Siskel, and Halli Watts-Rich, for their contributions to drafting this white paper.

Citations

2. Mullan, Jennifer. (2023). *Decolonizing Therapy: Oppression, Historical Trauma, and Politicizing Your Practice.* W.W. Norton & Company.

3. Federal Communications Commission. (2024). Open Commission Meeting Thursday, April 25, 2024. Federal Register. https://www.federalregister.gov/documents/2024/04/24/2024-08745/open-commission-meeting-thursday-april-25-2024

4. Henderson, R.C., Williams, P.,Gabbidon, J., Farrelly, S., Schauman, O., Hatch, S., Thornicroft, G., Bhugra, D., Clement, S. (2014). Mistrust of mental health services: Ethnicity, hospital admission and unfair treatment. *Epidemiology and Psychiatric Sciences, 24*(3), 258-265. doi: 10.1017/S2045796014000158.

5. Living Well UK. (2022). *Community Mental Healthcare, Trieste, Italy.* https://www.livingwellsystems.uk/trieste#:~:text=Trieste%20represents%20a%20relational%20response,people%27s%20subjectivity%2C%20their%20personal%20reality

6, 58. Clubhouse International. (n.d.). What are Clubhouses? https://clubhouse-intl.org/what-we-do/what-clubhouses-do/

7. SAMHSA. (2023). 988 Frequently Asked Questions. https://www.samhsa.gov/find-help/988/faqs

8, 14, 21, 22, 30. SAMHSA. (2020). National Guidelines for Behavioral Health Crisis Care, Best Practice Toolkit. SAMHSA. https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

9. U.S. Department of Health and Human Services. (2024 July 16). Now in Its Second Year, 988 Lifeline Continues to Help Millions of People. HHS.gov. https://www.hhs.gov/about/news/2024/07/16/second-year-988-lifeline-continues-help-millions-people.html

10. SAMHSA. (2024 April 9). 988 Suicide & Crisis Lifeline, The First Year and Beyond. SAMHSA. https://www.samhsa.gov/sites/default/files/988-one-year-anniversary-issue-brief.pdf

12. 988 Lifeline. (2024). Crisis Centers by State and U.S. Territory. 988 Lifeline. https://988lifeline.org/learn/our-crisis-centers/crisis-centers-by-state-and-u-s-territory/

13. NAMI Chicago. (2020). Building a Mental Health Crisis System in Chicago. https://www.namichicago.org/blog/building-a-mental-health-crisis-system-in-chicago

15. City of Chicago. (n.d.). Crisis Assistance Response & Engagement Program (CARE). City of Chicago. https://www.chicago.gov/city/en/sites/community-safety/home/CARE-Dashboard.html

16. Chicago Office of the Mayor. (2024 September 25). City of Chicago Transitions Mental Health Crisis Response Program to Public Health. Mayor's Press Office. https://www.chicago.gov/city/en/depts/mayor/press_room/press_releases/2024/september/Mental-Health-Crisis-Response-Program.html

17. Illinois Department of Healthcare and Family Services. (n.d.). Find a Provider. HFS Illinois. https://hfs.illinois.gov/medicalclients/behavioral/findaprovider.html

18. Illinois Department of Healthcare and Family Services. (n.d.). Crisis Services. HFS Illinois. Retrieved August 13, 2024, from https://hfs.illinois.gov/medicalclients/behavioral/crisisservices.html

19. Illinois Department of Healthcare and Family Services. (n.d.). Cook County Designated Service Area. HFS Illinois. https://hfs.illinois.gov/content/dam/soi/en/web/hfs/sitecollectiondocuments/cookcountydesignatedserviceareas.pdf.

20. SAMHSA. (2014). Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies. https://store.samhsa.gov/sites/default/files/sma14-4848.pdf

22. NAMI National. (n.d.). Crisis Response for Mental Health, Where We Stand. https://www.nami.org/advocacy/policy-priorities/responding-to-crises/crisis-response/

24, 31, 35. Balfour, M. and Zeller, S. (2023). Community-Based Crisis Services, Specialized Crisis Facilities, and Partnerships with Law Enforcement. FOCUS 21(1). https://doi.org/10.1176/appi.focus.20220074

25, 26. Peters, Z., Santo, L., Davis, D., & DeFrances, C. (2023). Emergency Department Visits Related to Mental Health Disorders Among Adults, by Race and Hispanic Ethnicity: United States, 2018–2020. CDC. https://www.cdc.gov/nchs/data/nhsr/nhsr181.pdf

27. Cook County Sheriff's Office. (n.d.). Hospitals in Cook County. https://cookcountysheriffil.gov/departments/c-c-s-p-d/cemeteries/hospitals-cook-county/

28. Illinois Department of Human Services. (n.d.). Illinois State Operated Hospitals. IDHS. https://www.dhs.state.il.us/page.aspx?item=61890

29. NAMI National. (n.d.) Getting Treatment During a Crisis. https://www.nami.org/about-mental-illness/treatments/getting-treatment-during-a-crisis/

32, 33. Nordstrom, K., Berlin, J., Nash, S., Shah, S., Schmelzer, N., & Worley, L. (2019). Boarding of Mentally Ill Patients in Emergency Departments: American Psychiatric Association Resource Document. Western Journal of Emergency Medicine, Volume 20, Issue 5, 20(5), 690–695. https://doi.org/10.5811/westjem.2019.6.42422

34. Hepburn, Stephanie. (2024 March 19). The Rise of Emergency Room Mental Health Crisis Units. Crisis Now. https://talk.crisisnow.com/rise-of-emergency-room-mental-health-crisis-units/

36. Illinois Department of Human Services. (2024). IDHS: Quarterly Updates on the Crisis Continuum. IDHS. https://www.dhs.state.il.us/page.aspx?item=163162

37. Illinois Department of Healthcare and Family Services. (2023 September 22). Illinois Certified Community Behavioral Health Clinic Service Requirements. HFS Illinois. https://hfs.illinois.gov/content/dam/soi/en/web/hfs/medicalproviders/ccbhc/Illinoisccbhcservicerequirements.pdf

38. Illinois Courts. (n.d.). What are Certified Community Behavioral Health Clinics (CCBHCs)? https://www.illinoiscourts.gov/News/1363/What-are-Certified-Community-Behavioral-Health-Clinics-CCBHCs/news-detail/#:~:text=CCBHCs%20are%20designed%20to%20provide%20a%20comprehensive,meet%20the%20needs%20of%20these%20complex%20populations

40, 41. Bennett, M., Das, A., Davis, J., Degnen, B., Hernandez, J., Joshi, K., Mora, I., Story, O. (2022 August 3). Alternative Health Intervention and Response Task Force Final Report. Cook County, IL. https://www.cookcountyil.gov/sites/g/files/ywwepo161/files/documents/2022-08/ALT-HIR%20Task%20Force_Final%20Report_08032022.pdf

42. Illinois Department of Human Services. (n.d.). Living Room Program. IDHS. https://www.dhs.state.il.us/page.aspx?item=126349

43. Illinois Department of Human Services. (n.d.). 510-RTLR Regions The Living Room. IDHS. Retrieved August 7, 2024, from https://www.dhs.state.il.us/page.aspx?item=148641

44. Illinois Catalog of State Financial Assistance. (n.d.-b). 860 Crisis Residential. Illinois.gov. Retrieved August 7, 2024, from https://omb.illinois.gov/public/gata/csfa/Program.aspx?csfa=1205

45. DuPage County Health Department. (2024). Crisis Residential. DCHD. https://www.dupagehealth.org/184/Crisis-Residential

46. Lake County Health Department and Community Health Center. (n.d.) Crisis Care Program. LCHD CHC. https://www.lakecountyil.gov/705/Crisis-Care-Program-CCP

47. NAMI National. (n.d.). Social Determinants of Health: Housing. https://www.nami.org/advocacy/policy-priorities/supporting-community-inclusion-and-non-discrimination/social-determinants-of-health-housing/

48. Illinois Department of Human Services (n.d.). Emergency & Transitional Housing Program. IDHS. https://www.dhs.state.il.us/page.aspx?item=30362

49. Cook County Sheriff's Office. (2024). Emergency Shelter – Transitional. https://cookcountysheriffil.gov/evictions/social-services/emergency-shelter-transitional/

50. Chicago Family & Support Services. (n.d.). Homeless Shelters. DFSS. https://www.chicago.gov/city/en/depts/fss/provdrs/emerg/svcs/shelter_system.html

51. Housing and Urban Development. (n.d.). Community of Care, Transitional Housing. HUD Exchange. https://www.hudexchange.info/homelessness-assistance/coc-esg-virtual-binders/coc-program-components/transitional-housing/

52. Chicago Department of Public Health. (2024 September 30). Mayor Brandon Johnson, Chicago Department of Public Health and Chicago Department of Housing Break Ground on Haven on Lincoln. CDPH. https://www.chicago.gov/city/en/depts/cdph/provdrs/health_protection_and_response/news/2024/september/cdph-press-release-09-30-2024-haven-on-lincoln.html

53. United to End Homelessness. (2024). Types of Housing Support for the Homeless. Orange County United Way. https://unitedtoendhomelessness.org/blog/types-of-housing-support-for-the-homeless/

54. Supporting Housing Providers Association. (n.d.) Supporting Housing Projects in Illinois. University of Illinois at Springfield, Geographic Information System Laboratory. https://univofillinois.maps.arcgis.com/apps/webappviewer/index.html?id=f68131fa000c4b86bc41c552dc1c6789

55. Thresholds. (2024). Housing & Residential Programs. https://www.thresholds.org/programs-services/housing-residential-programs

56. Chicago Department of Family Support Services. (2024). Annual Report on Homelessness. DFSS and DOH. https://www.chicago.gov/content/dam/city/depts/fss/supp_info/Homeless/2024PITCOUNT/2024%20Annual%20Homelessness%20Report-FINAL.pdf

57. Institute for Housing Studies. (2021 September 30). 2021 State of Rental Housing in Cook County. DePaul University. https://www.housingstudies.org/releases/state-rental-2021/

58. O'Brien, E., Tse, J. (2024 March 27). The Clubhouse Model for Depression and Serious Mental Illness. Psychiatric Times. https://www.psychiatrictimes.com/view/the-clubhouse-model-for-depression-and-serious-mental-illnesses

60. Texas Health and Human Services. (2024). Clubhouse Model. HHS Texas. https://www.hhs.texas.gov/providers/behavioral-health-services-providers/clubhouse-model#:~:text=The%20Clubhouse%20Model%20is%20an%20evidence%2Dbased%2C%20recovery%2Doriented,clubhouses%20as%20well%20information%20for%20program%20providers.

61. Progress Foundation. (n.d.). About Progress Foundation. https://www.progressfoundation.org/about/

62. Virginia Legislative Information System. (2024). Behavioral Health Authorities. Virginia LIS. https://law.lis.virginia.gov/vacode/title37.2/chapter6/section37.2-601/

63. Urgent Care Association. (n.d.) Role of Urgent Care and Patient Volume. UGA. https://urgentcareassociation.org/the-role-of-urgent-care-and-patient-volume/#:~:text=Urgent%20Care%20centers%20contribute%20to,healthcare%20system%20as%20a%20whole.

Appendices
Appendix A: Mobile Crisis Teams

City	County	Provider	Phone Number	Website
Chicago	Cook	Advocate Northside Health Network DBA Advocate Illinois Masonic Medical Center	773-896-4173	https://www.advocatehealth.com/immc/health-services/behavioral-health-care/
Chicago	Cook	Bobby E. Wright	773-645-0245	www.bewcbhc.org
Chicago	Cook	Community Counseling Centers of Chicago (C4)	773-365-7277	http://c4chicago.org/
Chicago	Cook	Community Counseling Centers of Chicago (C4)	773-769-0205	http://c4chicago.org/
Chicago	Cook	Habilitative Systems, Inc.	773-261-2252 Crisis Line: 773-745-2620	http://www.habilitative.org/
Chicago	Cook	Human Resources Development Institute (HRDI)	312-756-6237	http://hrdi.org/
Chicago	Cook	I Am Able Center for Family Development	Crisis Line: 1-855-52-23-9355 *(yes, it is an 11-digit number)*	www.iamablecenter.org

Chicago	Cook	Loretto Hospital	773-626-4300	https://www.lorettohospital.org/
Chicago	Cook	Lutheran Social Services of IL (LSSI)	833-610-5774	http://www.lssi.org/
Chicago	Cook	Mount Sinai Hospital	773-257-5300	https://www.sinaichicago.org/en/
Chicago	Cook	National Youth Advocate	773-596-9045	https://www.nyap.org
Chicago	Cook	Pilsen Wellness Center	773-820-9003 call4calm@pilsenmh.org	www.pilsenwellnesscenter.org
Chicago	Cook	Rincon Family Services	773-564-9070	www.rinconfamilyservices.org
Chicago	Cook	The Thresholds MCRT	773-572-5464	http://www.thresholds.org/
Chicago	Cook	Trilogy, Inc.	800-322-8400	http://www.trilogyinc.org/
Arlington Heights	Cook	Alexian Brothers Center for Mental Health	708-681-4357	www.amitahealth.org/centerformentalhealth

Berwyn	Cook	Pillars Community Services	708-745-5277	https://pillarscommunityhealth.org/
Elk Grove Village	Cook	Kenneth Young Center	847-524-8800	http://www.kennethyoung.org/
Franklin Park	Cook	Leyden Family Services	847-260-8860	www.leydenfamilyservice.org
Homewood	Cook	Trinity Services	815-320-7300	https://www.trinityservices.org/services-and-supports/trinity-counseling-center
Melrose Park	Cook	Presence Behavioral Health Procare Centers	708-681-4357	https://www.amitahealth.org/find-a-service/behavioral-medicine/
Merrionette Park	Cook	Metropolitan Family Services	708-974-5856	https://www.metrofamily.org/contact-us/
Oak Park	Cook	Thrive Counseling Center	708-383-7500	http://thrivecc.org/

Orland Park	Cook	Trinity Services	708-981-3347	https://www.trinityservices.org/services-and-supports/trinity-counseling-center
Skokie	Cook	Turning Point Behavioral Health Care Center	847-933-0051	http://www.tpoint.org/
Tinley Park	Cook	Grand Prairie Services	708-444-1012 Crisis Line: 708-331-0500	http://www.gpsbh.org/

Data Source: https://www.dhs.state.il.us/page.aspx?item=30893
Compiled by NAMI Chicago, August 2024.

Appendix B: Living Room Programs

City	County	Provider	Living Room Site	Phone Number	Website
Marshall	Clark County	Human Resources Center of Edgar & Clark Counties	Forsythe Center: 406 North 2nd St., Marshall, IL 62441	217-826-6212	https://www.hrcec.org/how-we-help/mental-health-services
Chicago	Cook County	Healthcare Alternative Systems	5001 W. Fullerton Ave., Chicago, IL 60639	773-235-5100	https://www.hascares.org/
Chicago	Cook County	Thresholds	4423 N. Ravenswood Ave., Chicago, IL 60640	773-537-3601	https://www.thresholds.org/programs-services/crisis-response/the-living-room
Elk Grove Village	Cook County	Kenneth Young	Temporary Location: 1001 Rohlwing Rd., Elk Grove Village, IL 60007	847-524-8800	https://www.kennethyoung.org/
Elk Grove Village	Cook County	Kenneth Young	1585 W. Dempster St., Elk Grove Village, IL 60007	847-383-0406	https://www.kennethyoung.org/

Flossmoor	Cook County	Envision Unlimited	3325 Vollmer Rd., Flossmoor, IL 60422	708-967-7216	https://www.envisionunlimited.org/envision-unlimited-living-room
Franklin Park	Cook County	Leyden Family Service and Mental Health Center	10013 Grand Ave., Franklin Park, IL 60131	847-861-7702	https://www.leydenfamilyservice.org/leyden- living-room
Hazel Crest	Cook County	Link & Option Center	Location 1: 3330 W. 177th St. Suite 2CN, Hazel Crest, IL 60429	708-914-2104	www.Link-option.com
Hazel Crest	Cook County	Link & Option Center	Location 2: 17577 Kedzie Avenue, Suite 106, Hazel Crest, IL 60429	708-991-2513	www.Link-option.com
LaGrange	Cook County	NAMI Metro-Suburban, Inc	Location 2: 4731 Willow Springs Rd., LaGrange, IL 60525	708-524-2582 ext.200	https://namimetsub.org/recovery-programs/the- living-room
Northfield	Cook County	The Josselyn Center	1779 Maple Ave., Northfield, IL 60093	847-441-5600	https://josselyn.org/livingroom/

Orland Park	Cook County	Trinity Services	Location 1: 16514 South 106th Ct., Orland Park, IL 60467	708-981-3370	http://trinityservices.org/livingroom
Skokie	Cook County	Turning Point Behavioral Health Care Center	8324 Skokie Blvd., Skokie, IL 60077	847-324-6188	https://www.tpoint.org/services/mental-health-services/#
Summit	Cook County	NAMI Metro-Suburban, Inc	Location 1: 7602 63rd St., Summit, IL 60501	708-524-2582 ext.300	https://namimetsub.org/recovery-programs/the-living-room
Dekalb	DeKalb County	DeKalb Behavioral Health Foundation	Ben Gordon Center: 12 Health Services Dr., DeKalb, IL 60115	815-756-4875	http://www.nm.org/DeKalbLivingRoom
Paris	Edgar County	Human Resources Center of Edgar & Clark Counties	LifeCenter: 745 East Court St., Paris, IL 61944	217-465-4118	https://www.hrcec.org/how-we-help/mental-health-services

Aurora	Kane County	Association for Individual Development	309 West New Indian Trail Ct., Aurora, IL 6050	630-966-4110	https://www.aidcares.org/
Ottawa	La Salle County	Arukah Institute of Healing	613 West Marquette St., Ottawa, IL 61350	815-443-5160	https://arukahinstitute.org/
Waukegan	Lake County	Independence Center	1730 Washington St., Waukegan, IL 60085	888-707-1614	https://icwaukegan.org/the-living-room
Lawrenceville	Lawrence County	Lawrence County Health Department	2101 James St., Lawrenceville, IL 62439	618-943-3302	https://lchealth.com
Decatur	Macon County	Heritage Behavioral Health Center	147 North Main St., Decatur, IL 62523	217-362-6262	www.heritagenet.org
Carlinville	Macoupin County	Locust Street Resource Center	320 S. Locust St., Carlinville, IL 62626	217-854-3166	https://www.locuststreetresourcecenter.org/

Peoria	Peoria County	Trillium Place: (formerly Human Service Center of Peoria)	130 North Richard Pryor Pl., Peoria, IL 61605	309-671-8084	https://trilliumplacehealth.org/Programs-Services/Mental-Health-Programs-Services/The-Living-Room
East St. Louis	St. Clair County	Comprehensive Behavioral Health Center of St. Clair County, Inc.	505 South 8th St., East St. Louis, IL 62201	618-482-7330	https://cbhc1.org/
Joliet	Will County	Trinity Services Inc.	Location 2: 2000 Glenwood Ave., Joliet, IL 60435	779-341-5090	http://www.trinityservices.org/livingroom
Rockford	Winnebago County	Rosecrance, Inc.	http://www.trinityservices.org/livingroom	815-720-4881	https://rosecrance.org/rosecrance-ware-center/

Source: https://www.dhs.state.il.us/page.aspx?item=126349#:~:text=The%20Living%20Room%20Program%20(LRP,the%20cycle%20of%20psychiatric%20hospitalization.

Compiled by NAMI Chicago, August 2024

Appendix C: Crisis Residential Providers

County	Provider	Site Location	Phone Number	24/7 Crisis Line	Website
Williamson	Centerstone of Illinois	403 Municipal Dr., Carterville, IL 62918	618-319-6069	855-608-3560	https://centerstone.org/programs/crisis-stabilization-unit-2/
Madison	Chestnut Health Systems, Inc.	2148 Vadalabene Dr., Maryville, IL 62062	618-512-1815	618-877-0316	https://www.chestnut.org/
DuPage	DuPage County Health Department	115 N. County Farm Road, Wheaton, IL 60187	630-682-7400	630-627-1700	https://www.dupagehealth.org/
Kane	Ecker Center for Mental Health	1845 Grandstand Place, Elgin, IL 60123	847-695-0484	888-325-3750 (888-ECKER-50)	https://www.eckercenter.org/
Will	Grand Prairie Services	67 E. 34th Street, Steger, IL 60475	708-331-0500	866-477-8632	https://gpsbh.org/

Macon	Heritage Behavioral Health	151 N. Main St., Decatur, IL 62523	217-362-6262	217-362-6262 x1 TEXT 741741	https://www.heritagenet.org/
Peoria, also serving Tazewell & Woodford	Trillium Place formerly Human Service Center of Peoria	130 N. Richard Pryor Pl., Peoria, IL 61605	309-671-8084	Peoria County: Call 24/7: (309) 671-8084 Tazewell & Woodford Counties: Call 24/7: (309) 347-1148	https://trilliumplacehealth.org/
Sangamon	Lake County Health Department BHS	3002 Grand Ave. 3rd Flr., Waukegan, IL 60085	847-377-8088	847-377-8088	https://www.lakecountyil.gov/684/Behavioral-Health-Services
Winnebago	MHCCI DBA: Memorial Behavioral Health	"Elm House" 200 W. Lakeshore Dr., Springfield, IL 62703	217-588-7926	217-788-7070	https://memorial.health/medical-services/behavioral-health/memorial-behavioral-health-residential-services/

Champaign	Rosecrance Inc. (Mulberry)	605 Mulberry Street, Rockford, IL 61103	815-720-4960	815-720-4953	https://rosecrance.org/rosecrance-mulberry-center/
Lee	Rosecrance Inc. (Champaign)	2302 Moreland Bld., Champaign, IL 61822	217-373-2428	217-693-4553	https://rosecrance.org/locations/rosecrance-moreland/
Lee	Sinnissippi Centers Inc.	403 E. 1st St., Dixon, IL 61021	815-288-5531	800-242-7642	https://sinnissippi.org/

Source: https://www.dhs.state.il.us/page.aspx?item=164781
Compiled by NAMI Chicago, September 2024.