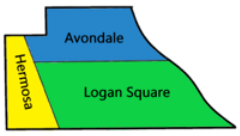
REQUEST FOR PROPOSALS COVER PAGE

LSAH Governing Commission



En Las Tablas
4111 W. Armitage Ave.
Chicago, IL 60639

Representing the communities of

Logan Square
Avondale
&
Hermosa

Organization Name: EXPANDED MENTAL HEALTH SERVICES OF CHICAGO, NFP

Address: 4141 N. KEDZIE AVE, Suite 2, CHICAGO, IL 60618

Telephone Number: (773) 754-0577

Website: www.thekedziecenter.org

CEO email: asedeno@thekedziecenter.org

CEO's telephone: (773) 580-0153 cell

Program Administrator Name: Angela Sedeño, Ph.D.

Program Administrator Email: asedeno@thekedziecenter.org

This proposal is being submitted on behalf of Expanded Mental Health Services of Chicago, NFP and, if awarded, the applicant agrees to abide by provisions and guidelines set forth in the contract. Furthermore, the individuals listed in the application are authorized to act on behalf of the organization.

Angela Sedeño, Ph.D. 5/10/2021

Executive Director Date

TABLE OF CONTENTS

I. Proposal Summary

Expanded Mental Health Services of Chicago, NFP strives to provide accessible, culturally informed, quality mental health care to communities and their residents through the integration of clinical practice, education, evaluation, and the cultivation of community partnerships. EMHS-NFP was formed following the passage in Illinois of the Community Mental Health Services Act of 2012 in order to develop a model of in-depth, publicly-funded psychotherapeutic treatment that could be available to those in need regardless of their ability to pay. EMHS-NFP proposed such a model to the first EMHSP governing commission, and was chosen in February of 2014 to oversee the creation of this new agency, soon to become the Kedzie Center. Since that time, the Kedzie Center has continued to grow and thrive, and has become known both locally and nationally for its unique approach to providing community mental health services that are deeply-informed, compassionate, culturally responsive, and collaborative.

EMHS-NFP has based its proposed LSAH program service structure upon an in-depth study of the trio of neighborhoods that form the LSAH community. For this study, we drew together available Needs Assessments, including the one created by the Coalition to Save Our Mental Health Centers and a dozen others, along with news and scholarly articles, databases and portraits of the community gleaned through our own interviews– both in-person pre-Covid and remote – with members of the LSAH community. We also commissioned data visualizations by a Senior Policy Analyst associated with the University of Chicago's Chapin Hall in order to create a more vivid sense of neighborhood trends and concerns. And we drew upon our own experience in overseeing the day-to-day operations of the Kedzie Center, whose clients have much in common with those of their LSAH neighbors.

The Needs Assessment we created has allowed us an appreciation of the area's complexity, as the three neighborhoods that comprise the LSAH catchment area have both distinctive characteristics and overlapping concerns. It has also afforded us a stark portrait of the ways in which systemic inequity and violence manifest in cycles of trauma and poverty, especially without the provision of safe and healing spaces in which alternatives can be envisioned. In our Needs Assessment, we provide a snapshot of the intertwining of social pressures, including immigration, gentrification, housing instability, racism, losses and separations, and, more recently, Covid-19, with individual and family depression, anxiety, behavioral issues and general distress. In listening to the community, we heard about the value of on-site services for children, teens, older adults and other groups within the LSAH neighborhoods. Most of all, we heard about an urgent need for services, and the widespread difficulties in accessing counseling and other treatments due to financial concerns, access barriers, and a lack of awareness of them.

The program we propose for the LSAH clinic includes a full spectrum of modalities, including counseling for individuals, couples and families, groups in which people can come together to work through common concerns, and community-wide events that can welcome residents to the clinic and offer community support. These events create a more seamless connection between residents and the clinic in order to demystify and destigmatize mental health concerns and treatments, aligning them instead with other vital neighborhood resources. We propose to extend the clinic walls to encompass on-site offerings in schools, community centers, senior centers, and to work alongside existing organizational partners to provide coordinated care that can address basic physical and emotional needs in concert. We anticipate that the outcomes

of our work would be felt both in the transformation of individual lives and in a vitalization of the LSAH community through providing a home for healing and hope.

II. LSAH Community Mental Health Needs Assessment

General Introduction

We believe that the inner struggles of individuals and the breakdowns in families can only be understood within the context of the communities in which they live, as these communities respond to, reflect, interpret and buffer the impacts of the larger world. Given the power of the inquiry, "*What happened to you?*" to serve as an entryway into a path for healing both individual and social distress, a Community Needs Assessment must evaluate not only the specific forms in which trauma and suffering manifest in the individuals it aims to serve, but also the ways in which the community itself, despite its strengths, is suffering. While all communities are suffering in the wake of COVID-19, we view the pandemic as the Great Amplifier, which has intensified the distinctive patterns of existing vulnerabilities of each community, leaving a deeper fingerprint on those that were already the most taxed. COVID-19 may be a tide that has lowered all boats, but we cannot underestimate the extent to which it has lowered some more drastically than others.

While an assessment of the needs of a community without doubt requires a focus on the most difficult aspects of experience within it, a balanced appraisal of community need will set this assessment against the background of the strengths, vibrancy and spirit of determination of its members and cultures. Strengths and liabilities go hand-in-hand, and often turn out to be two sides of the same coin. Communities with large immigrant populations, for instance, tend not only to bear distinctive collective wounds of displacement, loss, and trauma, but also manifest the cultural resources for healing that have traveled along with them on their journeys. An assessment of community need must consider these resources in order to make best use of them in the creation of a milieu in which, simultaneously, the process of mourning one home sows the seeds for the creation of another.

Further, assessing the needs of a community and the individuals and families that comprise it involves not only an enumeration of the specific challenges it and they face, but a frank assessment of the *structural* barriers to their potential remedies. For example, the most skillfully-delivered therapy in the world will be for naught if the individuals who could most benefit from it cannot access transportation to reach it; community nights will not truly serve the community if they neglect to provide childcare for those who otherwise could not attend; and remote offerings will be of no benefit to those without the space, privacy and broadband access to make use of them.The means for addressing additional programmatic barriers to treatment – such as by offering services in the preferred language of the individual, and by providing additional safeguards regarding client privacy for those who are undocumented or reluctant to access treatment for other reasons – must be evaluated along with an overall evaluation of community members' mental health needs.

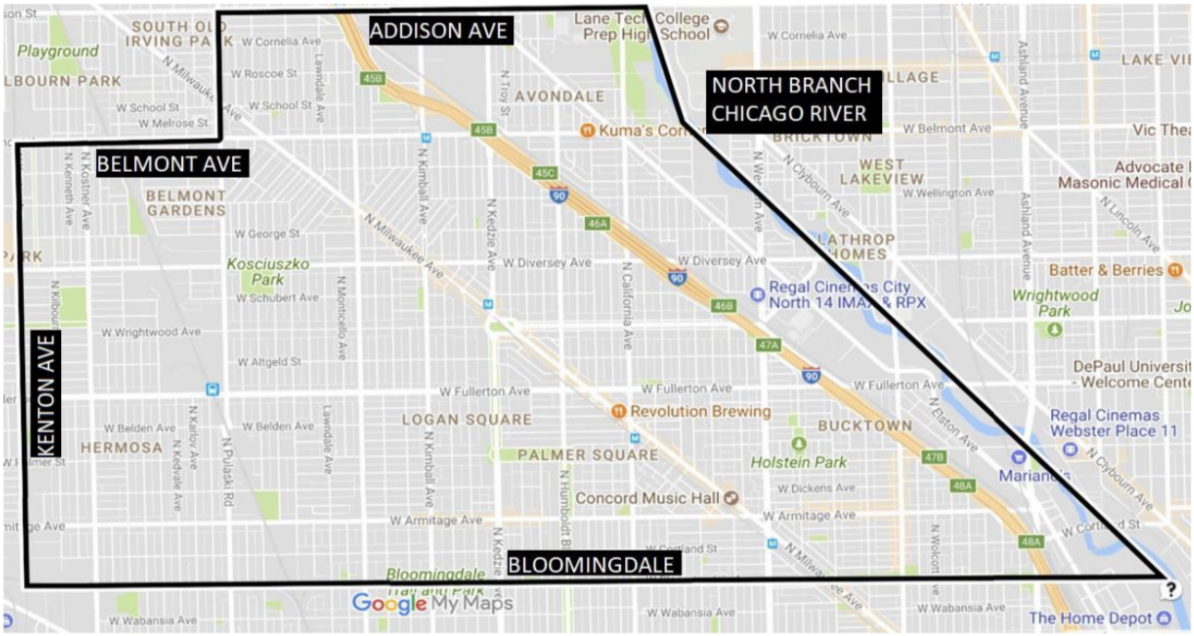
This Needs Assessment has taken a mixed-methods approach towards creating a picture in time of the overarching and specific needs of the Logan Square, Avondale and Hermosa communities. We have undertaken such a multi-modal approach because we believe that our understanding of community distress must go beyond the typical models that center upon, and indeed are often limited to, a narrow focus upon symptoms as the exclusive measures of well-being. We view symptoms as communications that arise as reactions to our clients' histories, cultures, and individual experiences. Likewise, we view people and their struggles as complex and multi-faceted and expect that we can best serve them by not only anticipating the

outward signs and patterns of their distress, but also the life challenges whose impacts they would wish to comprehend, respond to and overcome by walking through our doors. We hope that the resonance between quantitative demographic information gleaned from prior Needs Assessments, our own quantitative imaging, qualitative insights gleaned from our discussions with community members and partners, and information presented through our individual "case study" can offer a three-dimensional portrait of the supports our community members need to lead full and healthy lives within and beyond the thriving and struggling area that this newest EMHS clinic will call home. We held conversations with:

- 26 LSAH community residents
- 4 school social workers
- 1 parent mentor coordinator
- 1 street outreach supervisor
- 1 mental health instructor

The LSAH community is particularly complex because it is both one unified area and three separate neighborhoods, each with its characteristic challenges, cultures and resources. For this reason, we have chosen to offer profiles of each community separately as well as an assessment of the needs of the LSAH area as a whole. We believe that doing so lays the groundwork for service offerings that are truly tailored to the specific needs of residents, allowing us to meet them "*where they're at*," both literally and figuratively. The relationships between these three neighborhoods are salient as well. Our proposed clinic would aim to act as a hub for integration and solidarity between these geographic and cultural spaces, while allowing their distinctive cultures to be shared and celebrated (See Figure 1).

FIGURE 1. MAP OF LSAH AREA.

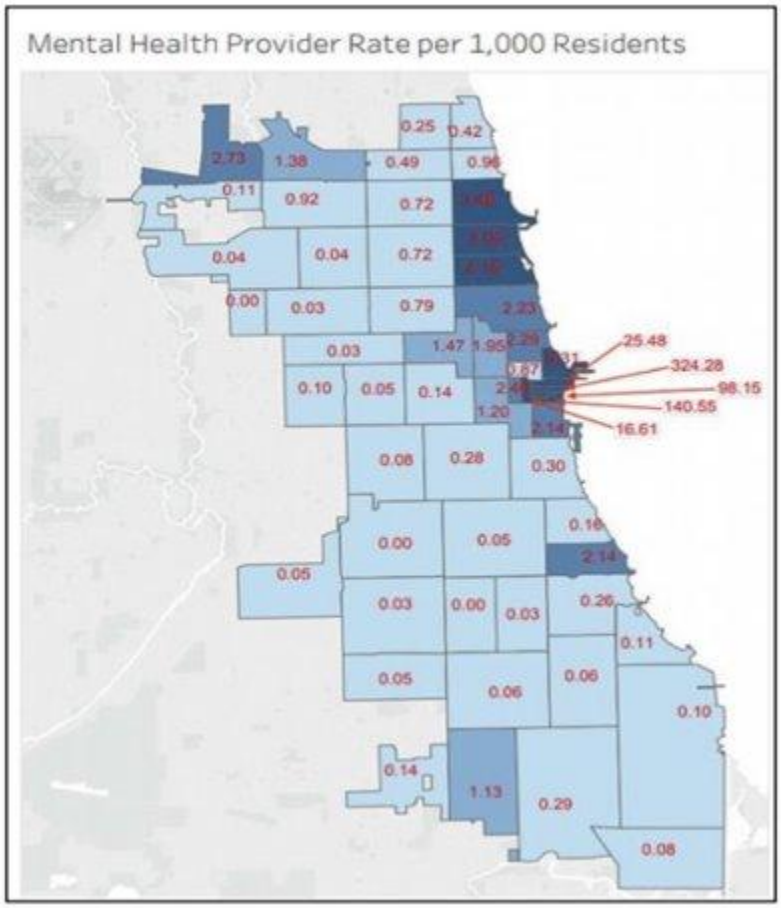


As we reflect on our process of creating this Needs Assessment in comparison to the process of creating the Needs Assessment for the first EMHS clinic, we long for the contact we were able to have then. For that first community portrait, we were able to knock on a thousand doors, and in that way engage in close to 300 in-depth conversations with residents where they lived, face to face. Although we have all learned to adapt to the world of remote work as phone and video have become lifelines connecting clinic offices and those we serve, we recognize the limitations of digital interaction, even as we have come to appreciate certain of its advantages in terms of flexibility, convenience and cost. We are grateful to have been able to interview residents in public settings before the pandemic, and are appreciative that we were able to connect with others over zoom. We look forward to refining our pre-pandemic insights with additional information acquired on-site and on a continuous basis.

As we profile the needs of this three-in-one community, we hear the echo of the words of one community member with whom we spoke in person before the city locked down: "*I don't really see mental health needs...I see poverty.*" This comment poignantly raises the question: Why propose a clinic dedicated specifically to mental health when there is so much material need? The question is an important one, and gets to the heart of our vision, which acknowledges the absolute interdependence of the needs of mind and body at the same time as it rejects the common practice of justifying the dearth of psychotherapeutic services in low-resourced communities by saying that physical needs must be attended to "first," while neglecting emotional health as those physical needs remain unmet. Rather, we believe, it is precisely those who have faced dehumanizing conditions who can make the best use of interventions that support self-awareness, self-determination and the capacity to develop supportive relationships of trust and purpose. It is this base that allows us, in close collaboration with our partner organizations, to support clients' efforts to attain the safety and stability necessary for healthy development and successful lives. While we integrate case management and street outreach into our therapeutic services, and while we work to promote the mental health of individuals, families, groups and communities, our core mission is to provide truly personal, in-depth and culturally responsive services that meet the needs of traumatized people who require treatments of sufficient length and depth to heal.

As is, many LSAH residents find themselves in a relative mental health desert, in which it is hard enough to find available practitioners of any kind, let alone ones who are trauma-trained, Spanish-speaking, accepting of public or even private insurance and culturally informed (See Figure 2). Often, they must wait for months to be seen, have limited ability to have a substantive say in their own treatments, and are prioritized only at the point at which everyday difficulties become crises. In contrast, we hope to provide the kinds of community-responsive treatments we have cultivated over the half-dozen years of our oversight of the Kedzie Center, where our experience has given us a first-hand appreciation of what it takes to not just address symptoms, but to nurture the healing of whole people. We have found that by attending to what we do best, without diluting our services in an effort to "do it all," we can offer a comprehensive therapeutic milieu that can allow our clinic to become a true community resource and partner, working hand in hand with other community assets to deliver comprehensive and integrated care.

FIGURE 2. CHICAGO MAP OF PROVIDER RATE



HERMOSA

Of the three neighborhoods that comprise the LSAH area, Hermosa is the smallest – its population is roughly one third of that of Logan Square, the largest - and the most financially disadvantaged, with a median annual income of just over half that of its larger neighbor-community (see Figure 3). Although it may be known to some as the birthplace of Walt Disney, there are many aspects of life in Hermosa that hardly fit the magical and enchanted image for which his films are known. While Hermosa's quaint streets are truly '*hermosas',* its challenges are not.

Snapshot of challenges

Simple demographics tell a story of *a stressed population*, more than one-third of which is foreign-born and self-describe as speaking limited English. Residents note the impact of financial instability on health; "When a bill or any scary cost has the ability to cause everything to spiral downward, stress really builds," remarked one young man we interviewed. While it may be that its *household* poverty rate is not significantly different from that of the other neighborhoods in our treatment area, this equivalence is offset by the fact that the households in Hermosa, on average, are larger than those in the other two neighborhoods, and are fully twice as likely to contain four or more people than the average Chicago household,[1] the impact of which has advantages but also disadvantages, which have only been heightened by Covid-19 and virtual schooling. Consistent with this fact, and essential to recognize, the child poverty rate is significantly higher in Hermosa than it is in either of the other two neighborhoods.[2] Further, although the unemployment rate is lower than that of Chicago as a whole[3], these numbers are deceiving; not only must many Hermosa residents cobble together a patchwork of temporary, part-time, non-benefit-eligible, low-paying jobs in order to make ends meet, but when they are unable to find work, they are unlikely to be able or willing to file for unemployment for fear of deportation and, until recently, public charge repercussions. Given that adults in Hermosa are twice as likely to not have finished high school or college as adults in Chicago as a whole,[4] and in light of the established correlation between educational attainment and income,[5] Hermosa residents must likely work longer hours to attain the same income, which translates into less available time for family or rest. They also spend a great deal of time commuting; close to half work outside the city (41.3%), and very few (4.9%) are employed within their neighborhood. It's not surprising that they get less sleep on average than the residents of other communities,[6] and less than is recommended for adults.[7] Indeed, more than half of the adult population of Hermosa gets fewer than seven hours per night, which tends to be highly correlated with overall stress, as well as poor physical and emotional health.[8]

Residents of Hermosa face an abundance of environmental stressors. Some might appear seemingly small – for instance, we could highlight the relative lack of open space in the area –

---

[1] [https://www.cmap.illinois.gov/documents/10180/126764/Hermosa.pdf

[2] Ibid.

[3] https://saveourmentalhealth.org/uploads/3/6/4/8/36488901/LSAHMentalHealthNeedsAssessment2020.pdf

[4] Ibid

[5] https://blogs.worldbank.org/education/strong-link-between-education-and-earnings

[6] Mental Health & Sleeping - CDC PLACES Data, 2018

[7] https://www.cdc.gov/sleep/about_sleep/how_much_sleep.html

[8] Scott AJ, Webb TL, Rowse G. Does improving sleep lead to better mental health?. A protocol for a meta-analytic review of randomised controlled trials. *BMJ Open*. 2017;7(9):e016873. doi:10.1136/bmjopen-2017-016873

and yet even these minor factors can prove to have a significant impact upon stress given the substantiated correlation between a lack of green space and higher cortisol (stress hormone) levels.[9] And many of the major sources of environmental stress in the area are *anything but small.* With 90% of its population consisting of Latino, Black and Asian individuals, the current climate of intensified anti-immigrant and anti-minority sentiment that has flourished in the United States, especially during the past four years, has provided a general undercurrent of danger and threat that Hermosa residents highlight: "Anxiety is high because of political issues and fears of deportation."[10] This general climate of hostility is amplified by direct exposure to violence among community members, both within and outside the home.

[9] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3799530/

[10] https://www.cct.org/2018/11/as-immigration-debates-intensify-hermosas-health-challenges-grow/

FIGURE 3. LSAH ECONOMIC HARDSHIP

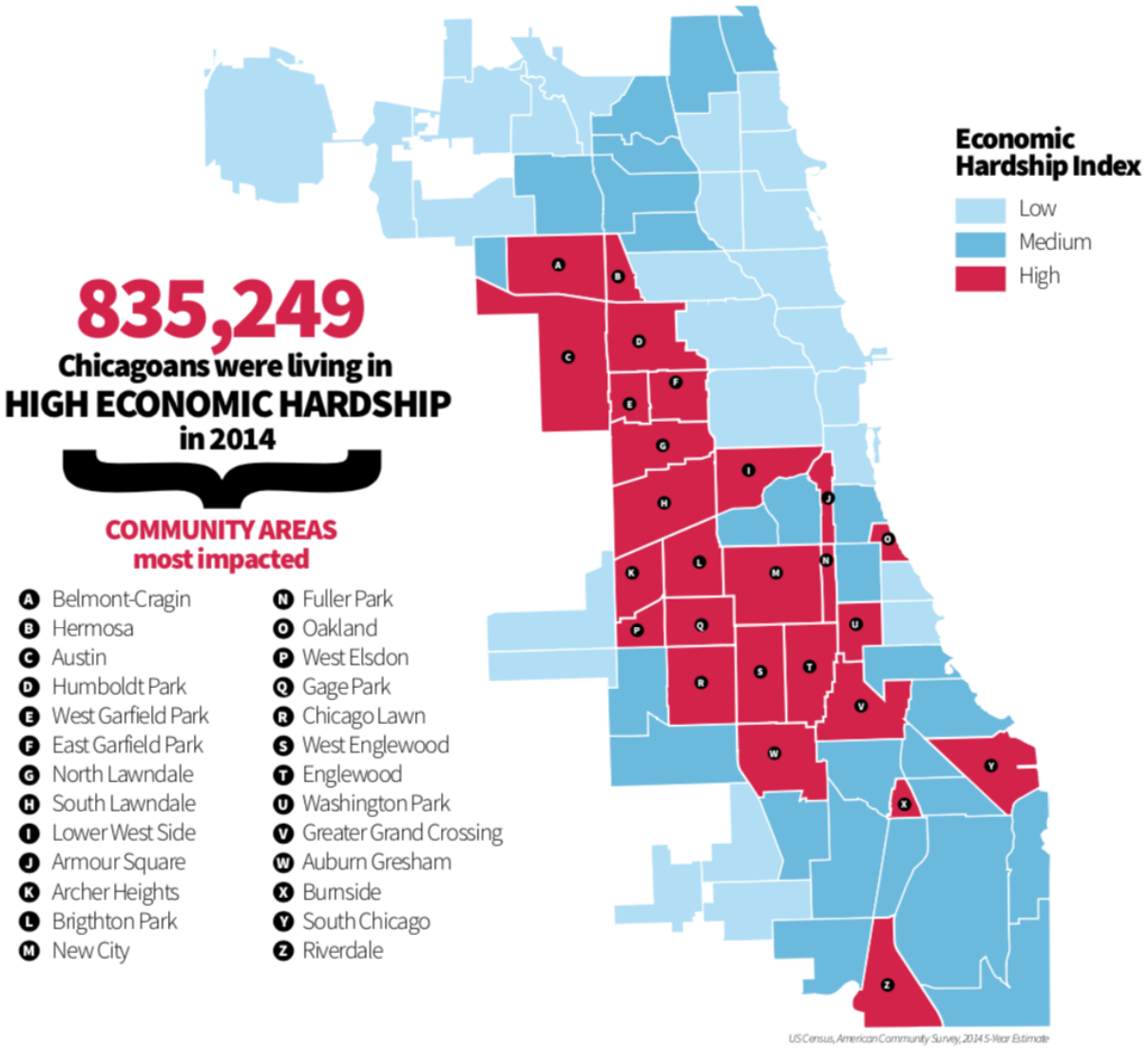


TABLE 1. LSAH Demographics.

	LOGAN SQUARE	AVONDALE	HERMOSA	CHICAGO
POPULATION	72,724	37,909	23,489	718,555
POPN DENSITY	23,000	18,033	21,788	11,861
MEDIAN HS INCOME	75,333	60,000	43,009	55,198
HSHOLD 4+	16.7%	22.8%	37.3%	19.8%
DN SPEAK ENGLISH WELL	16.3%	26.9%	37.5%	14.7%
FOREIGN BORN	18.8%	22.5%	35.5%	20.3%

Meanwhile, we cannot overemphasize the importance of the word, "*home*." Immigrant populations are not just demographic phenomena; they are composed of people, each of whom has left behind a place which, even if it has been traumatizing, has been their home. The fact of housing instability compounds the immigration experience, as reflected in respondents' continual highlighting of the fear of housing loss as a constant stressor in their lives.[11] In the other LSAH neighborhoods, gentrification threatens to price people out of their homes, but in Hermosa, other factors seem equally if not more concerning and disruptive. Among Chicago neighborhoods, Hermosa's rent burden stands out among the surrounding neighborhoods, as nearly half (47.9%) of households pay more than a third of their income in rent.[12] Housing in Hermosa is more often rated as overcrowded than in most other areas of the city.[13] Meanwhile, Covid's impact on housing stability has been apparent throughout the city but has hit Hermosa hard. As Joseph Lopez, Executive Director of the Spanish Coalition for Housing noted, "we've seen a surge in demand… Pre-Covid, we only serviced about 100 households across the city, with our emergency mortgage rental assistance. Within this Covid environment, we've surged to over 450 families that we supported through that program, many of them here in the Hermosa community."[14]

Indeed, even though Hermosa's proportionally larger immigrant population would have more reasons for underreporting violence to authorities than do the other two neighborhoods to be served by the LSAH clinic, the area has higher overall reported rates of violence than either Avondale and Logan Square, both domestic and otherwise.[15] Often in immigrant communities, and especially in communities with a high proportion of new immigrants, "odds plummet that a victim will go to police to report crimes such as aggravated assault, robbery and rape."[16] While the crime data collected by the City of Chicago suggest that rates of violent crime are lower in the LSAH area than in other areas of the city, Hermosa still stands out as a far more precarious community in which to live than either Avondale or Logan Square. It reports nearly twice as many physical abuse crimes, child abuse crimes, domestic violence crimes and felony convictions than either of its sister communities (see Table 2).

While it is not possible to extrapolate from this data to obtain the exact actual incidence of violence in the community, additional factors bolster the hypothesis of a vast understatement in the amount of crime in the area. According to the Sinai Survey 2.0, "one of the largest community-driven, face-to-face health surveys ever conducted in Chicago," nearly half of adults in Hermosa had witnessed domestic violence, and 41% of male Hermosa residents had been arrested, booked or charged with a crime.[17] Though this may be a result of over-policing, it suggests an area of significant tension nonetheless. Clearly, the fear of violence in the community isn't merely a fear of other residents, but of the police themselves. Fully 65% of Hermosa men reported that "*racial or ethnic profiling by police is extremely or very common*," a fact which likely reinforces the reluctance of Hermosa residents to report even serious crimes. As one resident is quoted as saying, "*It's hard to believe it's okay to call police. People don't*

---

[11] https://saveourmentalhealth.org/uploads/3/6/4/8/36488901/LSAHMentalHealthNeedsAssessment2020.pdf
[12] https://www.chicagohealthatlas.org/indicators/severe-housing-cost-burden
[13] https://allhealthequity.org/wp-content/uploads/2019/06/FINAL_2019_CHNA-Report_Alliance-for-Health-Equity.pdf, p. 78
[14] https://news.wttw.com/2020/07/16/chicago-tonight-your-neighborhood-hermosa
[15] Crime Data - City of Chicago Data Portal, All Crimes in 2020
[16] https://journalistsresource.org/politics-and-government/immigration-crime-research-victim/
[17] http://cct.org/wp-content/uploads/2018/11/SCHS_Hermosa.pdf

want ICE involved." [18] Further, even though violence affects not only the victims and perpetrators but also their family members, friends and neighbors, there aren't enough services to treat these secondary traumas, as attested to by a Street Outreach worker we interviewed. Thus, each incident of violence might be viewed as an epicenter, from which ripples of effect spread throughout families, communities, and beyond.

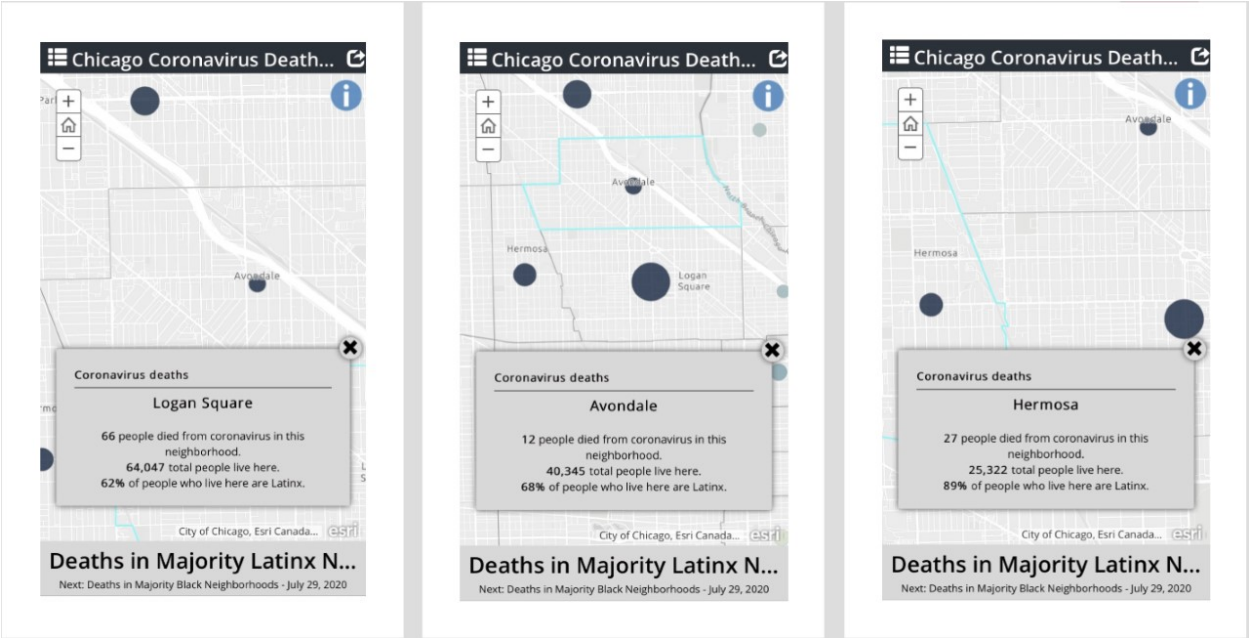
While earlier we called Covid-19 the great amplifier of social stressors, we might offer a fuller picture by noting the circular relationship between it and pre-existing social stress. Indeed, the pandemic has been nothing short of devastating to Hermosa, even more so than to its two LSAH neighbors. In terms of both cases and deaths from the virus, Hermosa stands out as a hotspot, as the highest density of cases quite literally appears to follow the contours of its borders, as does a correspondingly high rate of death from the disease. This tragic fact is not surprising. We know that immigrants are far less likely to have health insurance than native born individuals,[19] and that a correlation has been clearly documented between Covid devastation and a lack of health insurance, such that "roughly 1 out of every 3 COVID-19 deaths" and "more than 40% of all COVID-19 infections are associated with health insurance gaps."[20] The lack of insurance indicates limited access to health care, underemployment, job insecurity and economic hardship. While the LSAH area, as a whole, is far less likely than the rest of the city to have health insurance, Hermosa's uninsured population stands out among the three neighborhoods (see Figure 4). Additional factors, such as the lack of unemployment insurance, sick leave that comes with salaried positions, and other social benefits and supports likely contribute greatly to the need for Hermosa residents to continue to work even when the threat of contagion is high, and even when they themselves are sick. In short, the trauma and social stress that all of us have felt during the past year has hit the Hermosa community harshly, exacerbating its challenges while its challenges, in turn, have escalated its spread.

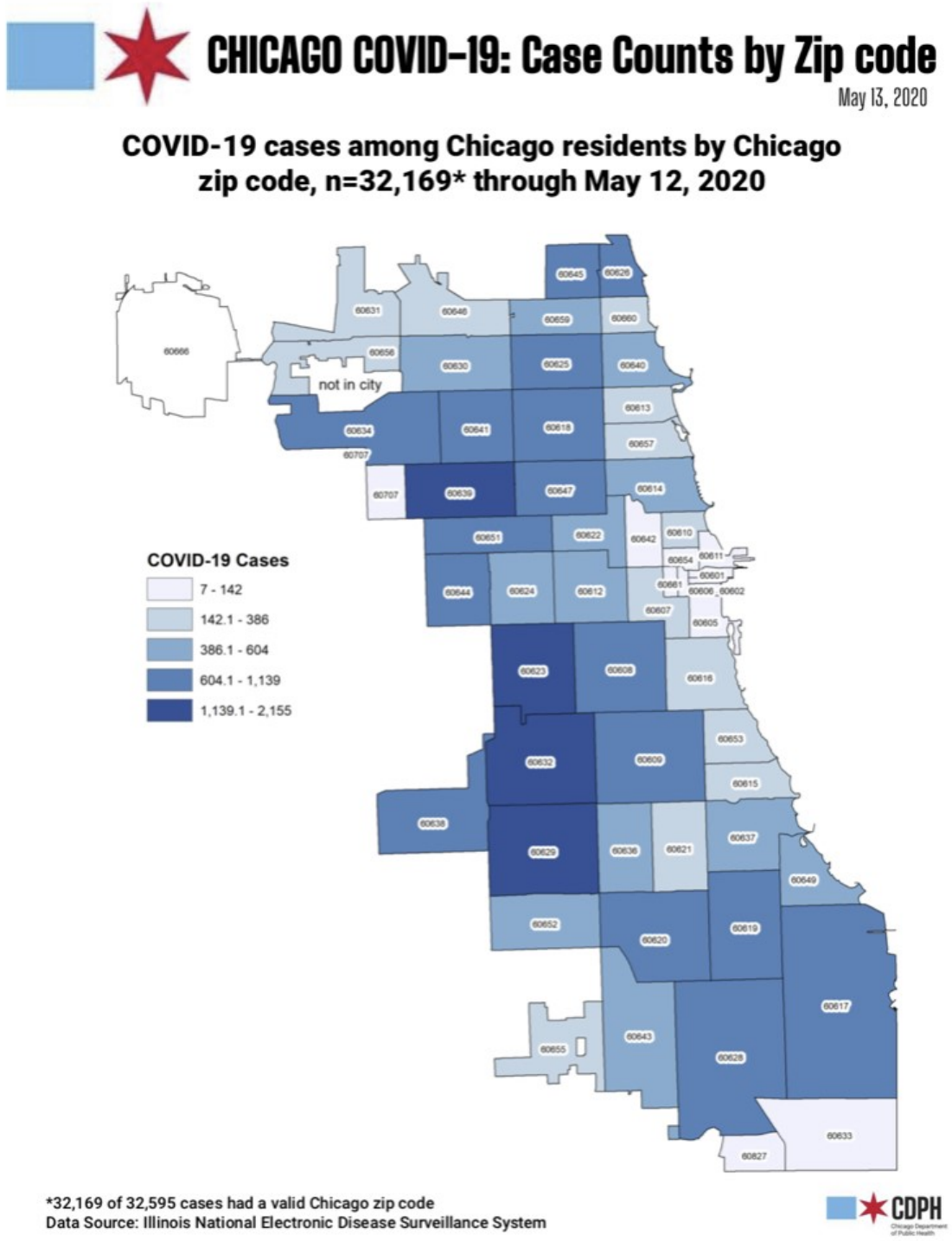
[18] https://www.cct.org/2018/11/as-immigration-debates-intensify-hermosas-health-challenges-grow/

[19] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1449861/#:~:text=Immigrants%20were%20more%20likely%20to,differed%20considerably%20from%20each%20other.

[20] https://familiesusa.org/wp-content/uploads/2021/03/2021-37_Loss-of-Lives_Report_AnalysisStyleB_Final.pdf

FIGURE 4. LSAH COVID-19 DEATHS

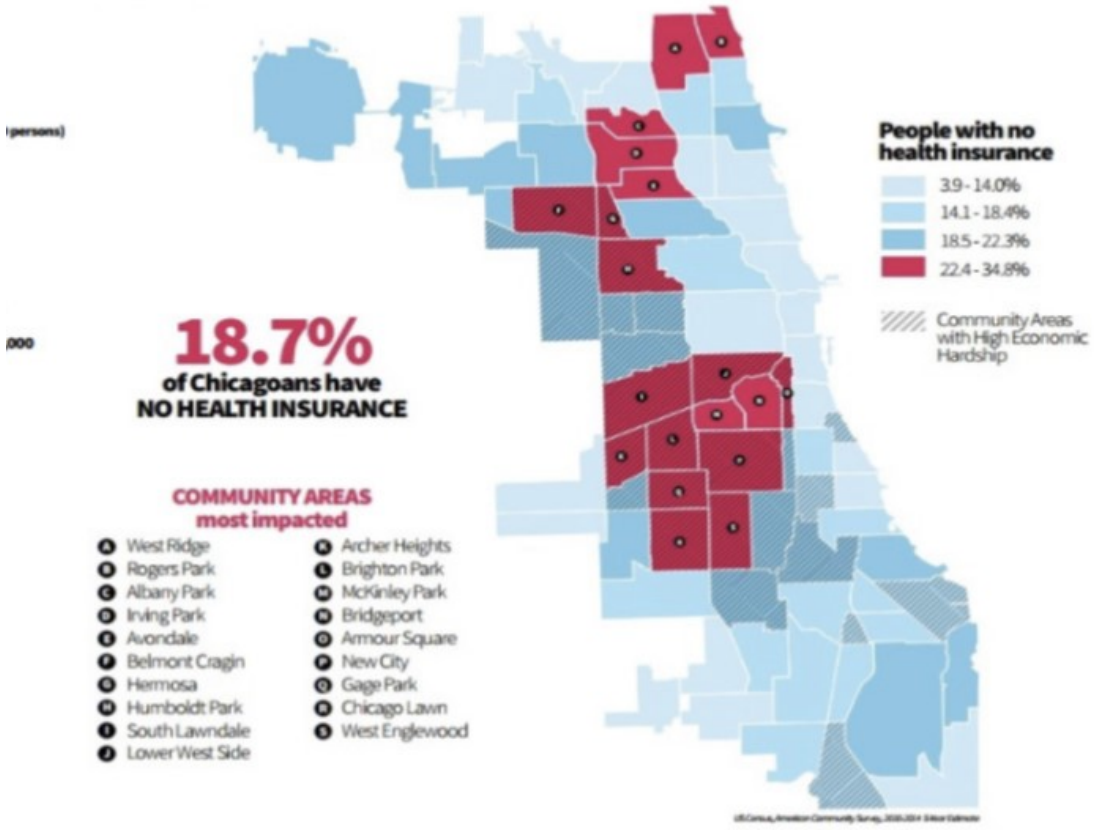




Credit: Chicago Department of Public Health

Figure 5. MAP OF COVID CASES BY ZIP CODE.

FIGURE 6. AVONDALE/HERMOSA ECONOMIC HARDSHIP



U.S. Census, American Community Survey (2014).

At the end of this Needs Assessment, we offer a more detailed focus on the needs of children in the LSAH area, but we make note here that many of these needs are deepest in this area. In order to minimize the incidence of ACEs (Adverse Childhood Experiences), and to treat their sequelae in children before they can disrupt development and relationships and determine life courses, we must assess the resources that already exist to help children thrive, and plan our own services in accordance with those gaps and opportunities. Most often, for children and young people, needs are addressed through a partnership between parents and schools, but in Hermosa, the schools are much less available to play their part, despite the hard work of many dedicated teachers and administrators. For instance, while the Learning Policy Institute notes that "/students who attend high-quality preschool programs reap benefits that can last through school and their lives,"[21] preschool enrollment in the Hermosa area is significantly lower than that in the other two neighborhoods (See Table 2). Schools are scrambling to provide sufficient assistance to their students, from young children to adolescents. A high school social worker in Hermosa noted expanding needs that are characteristic of the makeup of the neighborhood (See Community Conversation #1, Appendix, p. 36). For instance, a growing incidence of Central American recent immigrant youth who are being reunited with their parents and experiencing abandonment and trust issues are exhibiting academic disruption. Needless to say, the hardship Covid has placed upon school-age children and their parents has been devastating to their educational attainment and to their engagement in the sorts of experiences that can buffer youth from risk and facilitate their path to growth. Family troubles, including violence and neglect, contribute to the difficulty teachers confront in their attempts to make a meaningful impact on student school performance. One teacher we surveyed in Hermosa highlighted students' experiences of neglect and the burden of providing for younger siblings as directly impacting their school performance.

Yet Hermosa is a neighborhood of many strengths. We recognize that immigrants, in general, possess characteristics that are assets for them as they adapt to a new culture. Persistence, future-orientation, a strong work ethic, courage and a willingness to sacrifice are driven by a desire to improve their life conditions for themselves and for their children.[22] There is an inherent appreciation for and interdependence in families that fosters cohesion and mutuality. These qualities offer opportunities to frame services in ways that strengthen families and support youth development. The natural reliance that occurs among recent immigrants lends itself well to peer support services and opportunities for leadership development. Indeed, many of our first-generation immigrant youth report feeling strongly motivated to succeed due to their parents' sacrifices. As one of our DACA students reported "*Everything I do is to make my parents proud so that they know they made the right decision and their sacrifices were worth it*."

AVONDALE

In many respects, Avondale has far more in common with the City of Chicago as a whole than it does with its neighbor, Hermosa. Its overall poverty rate is like that of the rest of Cook County, and measures of financial and social stability such as median household income and educational attainment are commensurate with Chicago's overall averages.

Yet Avondale does, in fact, diverge markedly from the demographic profile of Chicago, and cleave closer to Hermosa, in significant respects. Most prominently, it boasts a much larger

[21] https://learningpolicyinstitute.org/press-release/what-does-research-really-say-about-preschool-effectiveness
[22] Falicov, C.J. (2014) *Latino Families in Therapy*. New York: Guilford Press

Latino/x community, and a larger percentage of people who are described as not speaking English well, denoting more first-generation immigrants and/or more recent immigrants. In fact, Avondale, with its historical large industrial base, has always been seen as a hospitable place to resettle. As it was home first to African Americans, then to waves of immigrants from Poland and elsewhere in Eastern Europe, and finally, beginning in the 1980s, to an influx of Spanish-speaking immigrants, Avondale earned its nickname: "Where Eastern Europe meets Latin America." While most of the immigrants to the area are Mexican, relatively recent immigrants from Poland, Ecuador, the Philippines, Guatemala and El Salvador have put down roots in the community as well.[23]

Currently, Avondale has a distinctive cache, an aura of hipster-chic, that has thus far not fanned out to cover its more-challenged neighbor. Its reputation as an up-and-coming neighborhood where one could live amid new restaurants, easy expressway access and small boutique and ethnic shops, has led many to consider it "the next Wicker Park,"[24] reinforcing the impression that at least in certain respects, it has more in common with its Logan Square sibling than it does with Hermosa. Most attractive of all to young adults who are early on in their careers is the fact that the rents in Avondale are significantly lower than the rents in more well-known post-college Chicago destinations such as Lakeview, and today are even roughly 9% lower than the rents in Logan Square.[25]

Yet the affluence that comes with being seen as up-and-coming creates other sorts of challenges, and there are clear indications that the gentrification the neighborhood is experiencing[26] affects different demographic groups in strikingly different ways. The Needs Assessment developed by the Coalition to Save our Mental Health Centers found that housing instability and fears of gentrification were a central source of stress in the LSAH area,[27] and their findings make sense in the light of recent research suggesting that gentrification hits minority communities harder,[28] "perpetuat/ing/ racial and ethnic inequality" in the process.[29] Researchers note that "/the/ transition in the economic status of neighborhoods often occurs along racial lines, as … Hispanic residents move and are replaced by higher-income white gentrifiers.[30] During our interviews, it was young adults who reported these observations with what appeared to be concern and even remorse. While greater immigration into a community generally increases its prosperity, the recipients of this prosperity tend to be homeowners rather than renters. As recent immigrants tend to be more often poor,[31] and more often rent than own, they are more vulnerable

---

[23] https://statisticalatlas.com/neighborhood/Illinois/Chicago/Avondale/National-Origin

[24] https://www.chicagotribune.com/news/ct-xpm-2010-01-20-1001200142-story.html, Lekach, Sasha (August 23, 2015). "Chicago's hottest neighborhoods: These areas have seen their markets rise this summer". Chicago Tribune. Chicago, Illinois.

[25] https://www.zumper.com/rent-research/chicago-il/avondale, https://www.zumper.com/rent-research/chicago-il/logansquare

[26]https://blockclubchicago.org/2019/05/02/as-avondales-gentrification-heats-up-some-residents-want-more-control-this-isnt-logan-or-wicker-park/

[27] https://saveourmentalhealth.org/uploads/3/6/4/8/36488901/LSAHMentalHealthNeedsAssessment2020.pdf

[28]Hwang, J & Ding, L. (2020) Unequal Displacement: Gentrification, Racial Stratification, and Residential Destinations in Philadelphia American Journal of SociologyVolume 126, Number 2 DOI: 10.1086/711015

[29]https://www.researchgate.net/publication/279277351_Gentrification_in_Changing_Cities_Immigration_New_Diversity_and_Racial_Inequality_in_Neighborhood_Renewal

[30]https://ncrc.org/gentrification/#:~:text=From%20its%20inception%2C%20gentrification%20has,an%20increase%20in%20property%20values.

[31] https://www.nap.edu/read/21746/chapter/2#5

to this change.[32] This is certainly true of Avondale, in which the waves of Latino/x immigrants that surpassed the Polish population have begun to subside. In fact, gentrification has been highlighted as a root cause of their displacement. In a recent study, Avondale was found to be among the three Chicago neighborhoods that have seen the most displacement of Latinos over the past decade.[33] It is also one of the two neighborhoods experiencing the greatest displacement pressure overall.[34]

We discussed above the potential loss of home as a source of traumatic echoes for many immigrants, and have noted in our discussion of trauma how these echoes filter through the generations. As Maritza Nazario, Executive Director of En Las Tablas Performing Arts notes, this housing instability "*affects children with a migration background the most because there is a great deal of uncertainty in their lives*,"[35] which no doubt contributes to the finding that Latino youth have been found to experience far more mental health difficulties than their white peers.[36] Indeed, there are challenges faced by Avondale children which may not be apparent from general statistics on poverty rates, household income, and other overall indices of individual and community health. Among telling metrics are those indicating that Avondale's rate of children living in poverty is actually higher than that of adults around them.[37] Indeed, this lack of stability and higher poverty rate can impact a child's development in multiple, long lasting ways, creating disruptions in stable quality childcare, education and community social support. Childhood poverty can also compromise exposure to possibilities, community stability and pride, long-term relationships as social supports, and institutional trust. In addition, Avondale can be seen as relatively resource-challenged in terms of outdoor outlets for children given its poor air quality and relative lack of green and outdoor spaces, park-based cultural centers, festivals and even block parties,[38] as well as its high pediatric population density as compared to the surrounding city (30-34.9% vs 20% for Chicago).[39] One person we interviewed added that concern about community violence further prevents the use of even the open community spaces that do exist (Community Conversation #3, Appendix p. 37). Perhaps unsurprisingly then, Avondale is

---

[32]https://www.nahbclassic.org/generic.aspx?genericContentID=186289&fromGSA=1#:~:text=A%20fundamental%20decision%20for%20an,own%20or%20rent%20a%20home.&text=The%20ACS%20data%20show%20that,new%20in%20a%20foreign%20country.

[33]https://www.wbez.org/stories/group-fights-gentrification-on-chicagos-northwest-side/cfebab49-775b-45db-a88f-139309806724, https://www.chicago.gov/content/dam/city/depts/cdph/CDPH/Healthy_Chicago_2025_Data-Compendium_10222019.pdf

[34]https://www.chicago.gov/content/dam/city/depts/cdph/CDPH/Healthy_Chicago_2025_Data-Compendium_10222019.pdf

[35] https://saveourmentalhealth.org/uploads/3/6/4/8/36488901/LSAHMentalHealthNeedsAssessment2020.pdf

[36] edcitynews.com/2021/02/more-states-require-telehealth-coverage-going-into-2021/?utm_campaign=MCN Daily Top Stories&utm_medium=email&_hsmi=110414154&_hsenc=p2ANqtz-_hVPdlo9Kj6gB3cFP5joOmsVQipWCCwLS9kcITE1bEYaBrjChYqEaYs5UW8-33ARq47AxQcubUKT47XDJ6xBES5ulp9A&utm_content=110414154&utm_source=hs_email&rf=1

[37]https://www.amitahealth.org/assets/documents/about-us/supportingcommunities/stjosephchicago/sjh_chicago_community_health_profile.pdf

[38]https://www.chicago.gov/content/dam/city/depts/cdph/CDPH/Healthy_Chicago_2025_Data-Compendium_10222019.pdf

[39]https://www.luriechildrens.org/globalassets/documents/luriechildrens.org/community/community-health-needs-assessment/chna-2019.pdf

among the top 15 of the city's 77 neighborhoods in terms of childhood obesity,[40] which is well known as a precursor not only of later physical illness but of mental illness as well.[41]

These factors, which beg for increased community support, are coupled by significant barriers to locating and accessing that support, as expressed by both quantitative metrics and by Avondale residents themselves. First, many area residents do not make use of social supports at all, no doubt in part due to concerns about immigration status and public charge that have cast a heavy and seemingly indelible shadow upon the public confidence, even when the supports in question concern physical health and well-being. Second, in many cases, Avondale residents told us, they do not even know that these supports exist, or, if they do, where to find them, highlighting mental health resources as especially confusing to access. And they're not wrong: both physical and mental health services are not sufficiently accessible within the community. Avondale has no Federally Qualified Health Centers within its borders,[42] and has been highlighted as a health professional shortage area for primary care, as well as a shortage area regarding mental health services for low-income residents[43] (See Figure 5). An equally concerning issue is that even if services were theoretically accessible, most community members would likely not be able to pay for them. Avondale residents, even more than LSAH residents in general, lack health insurance despite the area's more promising indicators of economic strength, especially for Latinos, young adults, and those in older middle age (See Figure 5; Table 2).

The relative lack of health insurance, information about service access, and area-wide outdoor play space opportunities for children leave the schools as an essential intervention point for children and families. Through their own resources as well as federal initiatives, Avondale schools already provide for their students in extra-academic ways. At all Avondale schools, for instance, 70% or more of the children in attendance are eligible for free or reduced lunches.[44] While schools work to serve the children in their care, helping families to help their children constitutes an essential part of intervening with students. This can multiply the beneficial effects of intervention but can also necessitate more intensive resources that already-strapped schools cannot easily provide. Further, these services would need to be provided in both English and Spanish, as almost 1 in 5 students and far more of their parents have limited English skills.[45] School counselors, who are often the conduit to needed services, face the same difficulties with service capacity and accessibility as do individuals. One interview subject, who works as a Parent Mentor at Avondale Elementary, told a wrenching story of a parent who had lost her son to suicide after complications related to a gunshot wound. She reported that, to her knowledge, the family never sought or received mental health support, but simply grieved and went back to work (See Community Conversation #2, Appendix p. 36). From a community mental health

---

[40] https://www.chicago.gov/content/dam/city/depts/cdph/CDPH/OverweightObesityReportFeb272013.pdf, https://www.chicago.gov/content/dam/city/depts/cdph/CDPH/Healthy_Chicago_2025_Data-Compendium_10222019.pdf

[41] https://salud-america.org/the-effects-of-childhood-obesity-on-mental-health/#:~:text=Childhood%20obesity%20can%20lead%20to,become%20a%20target%20for%20bullying.

[42] https://www.luriechildrens.org/globalassets/documents/luriechildrens.org/community/community-health-needs-assessment/chna-2019.pdf

[43] https://www.amitahealth.org/assets/documents/about-us/supportingcommunities/stjosephchicago/sjh_chicago_community_health_profile.pdf

[44] https://www.amitahealth.org/assets/documents/about-us/supportingcommunities/stjosephchicago/sjh_chicago_community_health_profile.pdf

[45] Ibid.

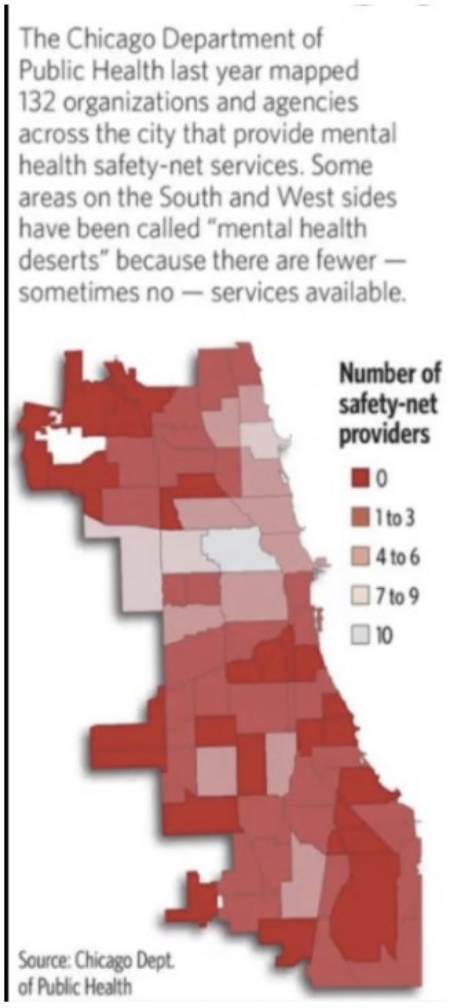
perspective, there should have been multiple pathways for that family to have been identified and offered mental health support.

Yet Avondale, for all its challenges, has enormous strengths as a neighborhood. The mix of its dominant demographic groups, Latino/x and Polish families, gives it a diverse foundation that in some ways multiplies pillars of stability in the community. Locating a new Restorative Justice Community Court within Avondale, only one of three such courts in Chicago, sends a message of hope and humanity to the community as a whole, [46] and creates an additional pathway to services for individuals who may be justice-involved. The fact that Avondale has perhaps the highest concentration of artists of any neighborhood in the city[47] suggests a potentially limitless resource if it can be engaged and linked with school-based and community programs. Programs at Kedzie that integrate mental health and the arts as a source of healing have been successful on many levels, building upon community collaborations, reducing stigma, and promoting alternative methods to achieve wellness. Avondale clearly has these resources for forging links between creativity and healing, creating vectors that can reach from clinic to community and back again.

[46] https://chicago.suntimes.com/crime/2020/7/31/21349836/restorative-justice-courts-open-englewood-avondale

[47] https://www.chicago.gov/content/dam/city/depts/cdph/CDPH/Healthy_Chicago_2025_Data-Compendium_10222019.pdf

FIGURE 7. NUMBER OF SAFETY-NET PROVIDERS



LOGAN SQUARE

Avondale may be bracing for new waves of gentrification, but for Logan Square, that train has left the station. "Longtime Latino Stronghold Logan Square Is Now Majority White, New Data Show!" blazes a December 2020 headline across a WBEZ web page.[48] In certain respects, Logan Square offers a useful illustration of the distinction between neighborhood improvement and gentrification. While few would object to cleaner streets, more options for entertainment and shopping, and enriched social resources, gentrification tends to bring these benefits at a high and often overlooked cost. Rising property values bring higher rents, upscale chain stores displace small businesses and investment dollars bring changes that can seem generic, incongruous and disrespectful of the existing built environment. Most of all, gentrification creates a chasm between two economies. As the WBEZ report details, "…Logan Square is home to the city's highest white-to-Latino household income ratio." While the median household income for Latinos in Logan Square is lower but not radically so than that of the city as a whole, income *disparity* in itself can be as problematic as *relatively* low income has been linked to a myriad of social and emotional ills.[49]

Further, because so many metrics are presented as averages across neighborhoods, they often disguise the real deficits behind these measures. Specifically, neighborhood-wide statistics are not sufficiently sensitive to show what is apparent to residents: that there are, in many respects, two Logan Squares. While the eastern and northeastern areas of the community, in which a largely Latino population has been replaced by a largely white one, are thriving by almost all economic and quality-of-life measures, the areas bordering Hermosa and its contiguous neighbors of Humboldt Park and West Town show a very different story, which can perhaps be most appreciated visually. Measures that range from quality-of-life indicators to indicators of more serious threats to the safety of residents (see Table 2) clearly bisect the eastern and western edges of Logan Square. These within-neighborhood disparities are associated with discrepancies in economic hardship as well as health measures such as health literacy and high lead levels in children.[50] Logan Square's composite rating on the Child Opportunity Index (see Figure 7), comprised of Educational, Health and Environmental, and Economic indicators, is rated as high, but it ranges from very high at its eastern tip to low at its western edge. In 2017, there were 52 Logan Square white children of ages 0-5 living at or below the poverty line, but there were 723 Logan Square Latino children living in such difficult financial straits.[51]

When neighborhoods change, health and social services become even more crucial in order to stabilize communities and individuals alike, and support can make the difference between suffering and adaptation. The sad irony: in 2012, just as Logan Square was undergoing a transformation that prompted additional stress for residents who were at increased danger of being displaced, its one public mental health center was shuttered, creating even more obstacles to accessing even basic services. The structural obstacles to finding support remain formidable for this less visible Logan Square. While much of the eastern tip of the neighborhood has the

---

[48]https://www.wbez.org/stories/longtime-latino-stronghold-logan-square-is-now-majority-white-new-data-shows/80f2b464-6ff9-49e6-90f5-48bd517248c2

[49] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5775138/, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2350835/

[50]https://www.chicago.gov/content/dam/city/depts/cdph/CDPH/Healthy_Chicago_2025_Data-Compendium_10222019.pdf

[51]https://www.chicago.gov/content/dam/city/depts/fss/supp_info/ChildrenServices/DFSS2019CommunityAssssment.pdf, p. 106

means, through insurance, to afford help when needed, those living to the west are not so fortunate. Further, undocumented Logan Square individuals, who were estimated to number approximately 7,000 in 2015,[52] and whose lives have undoubtedly been marked by increased stress due to the previous administration's policies as well as to displacement and political traumas, would be far less likely to have health insurance than those who are native born. Nationally, "23% of lawfully present immigrants and more than four in ten (45%) undocumented immigrants were uninsured compared to less than one in ten (9%) citizens,"[53] according to the Kaiser Family Foundation.

Meanwhile, for those who are insured, and especially for those who aren't, there are few affordable options for mental health treatment, and often little knowledge of which options exist and how to access them. Listen to a sample of the Logan Square residents with whom we spoke: "*It takes 6 months for someone with insurance to access mental health care, let alone someone without insurance!*" lamented a 30-something woman to our team. A man in his 20's spoke about the need for a better referral process and more availability, and a woman, also in her 20's, stated that there were not enough financially accessible resources. There are limited options for treatment and greater need for education about them, said one young woman, while another woman in her 30's spoke of the limited awareness of the resources that exist, in addition to her wish for more places to go for mental health care. A woman in her 20's spoke about the fact that there is little availability of affordable counseling services, and another, who called herself "a gentrifier" was concerned that "*many minorities get displaced from their homes as affluent neighborhoods extend their reach; there are not many services available for them*." It was bittersweet to hear a therapist in her 40's speak (unprompted) about the lack of "*a community-based mental health center like the Kedzie Center that is cutting edge*."

Covid has upended life in Logan Square as it has the other communities, but as usual, has hit some sectors especially hard. For instance, LGBTQI+ individuals face lower pay, employment and housing discrimination and a vastly lower probability of having health insurance.[54] Further, a Harvard University study recently found that bisexual women were four times less likely to have health insurance than their heteronormative peers. [55]Increasingly visible and powerful anti-LGBTQI+ and specifically anti-trans social movements are reinforced by legislation that is snowballing rather than receding.[56] Even when LGBTQI+ individuals do have health coverage, it is difficult for them to find responsive clinics whose staff appreciate and understand their needs, one Logan Square mental health consultant noted (See Community Conversation #4, Appendix p. 38). For students, whose isolation due to Covid has been coupled with a lack of available services and social support, this time has been especially trying. Organizations like The Trevor Project, which focus on suicide prevention and crisis intervention in the LGBTQI+ community, have highlighted the need now more than ever for competency in working with these individuals.

The Logan Square community has a full range of strengths as well as struggles, some as a result of gentrification and some in response to it. Like its neighbor Avondale, it boasts a high

---

[52] https://logansquarist.com/2016/11/16/trump-undocumented-logan-square/

[53]https://www.kff.org/racial-equity-and-health-policy/fact-sheet/health-coverage-of-immigrants/#:~:text=In%202018%2C%20more%20than%20three,in%20ten%20(9%25)%20citizens.

[54] https://www.givingcompass.org/article/study-finds-lgbt-individuals-are-less-likely-to-have-health-insurance/

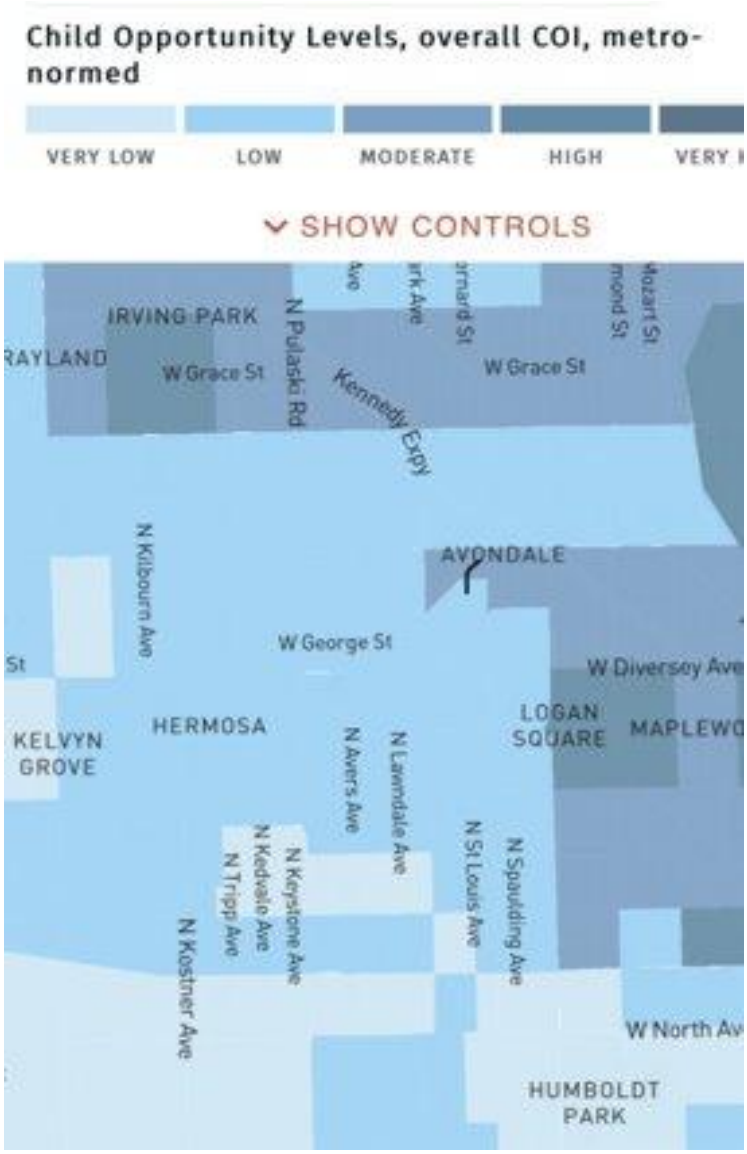
[55]https://www.reuters.com/article/us-health-lgbt-employment-insurance/lgbt-adults-in-u-s-less-likely-to-have-jobs-health-insurance-idUSKBN1KG36V

[56] https://www.cnn.com/2021/04/15/politics/anti-transgender-legislation-2021/index.html

concentration of artists, and unlike Avondale, it is home to arts and cultural organizations as well as performing arts venues that enrich the cultural fabric of the area.[57] It has an active and dedicated group, Logan Square Preservationists, who have been effective in galvanizing the neighborhood to preserve its character and history, and the Logan Square Neighborhood Association (LSNA) offers programs and services to promote and preserve social justice within its borders and beyond, and has acted as a needed resource for many who have faced eviction and other threats to well-being. LSNA has been a strong backbone for the community in general, but particularly in schools, where so much need exists. As is demonstrated in the community partnership section of this proposal, EMHS believes that the wellness of communities rests upon the ability to forge collaborative bonds that allow for both specialization, integration and a comprehensive view of community need, and we would be pleased to foster ways for our organizations to move forward together.

[57]https://www.chicago.gov/content/dam/city/depts/cdph/CDPH/Healthy_Chicago_2025_Data-Compendium_10222019.pdf

FIGURE 8. LSAH CHILD OPPORTUNITY INDICES



Listening to the Community: LSAH's Mental Health Needs

In the LSAH Needs Assessment created by the Coalition to Save Our Mental Health Centers, interview subjects named Gentrification/Housing Concerns, Financial Difficulties and Immigration Status as the three most common stressors in the community, and Depression, Housing Concerns and Immigration/Legal Status as the three most important mental health issues.[58] These two lists, taken together, tell us something noteworthy: This is a community that understands acutely the strong connection between systemic traumas/stressors and human emotional suffering. While people are complex and there is no one-to-one correlation between the types of stressors they endure and the types of symptoms they manifest, there is a lot we can know about people's inner experiences from the paths they've walked. We see the toll these chronic stressors can take in our work with clients at The Kedzie Center, and understand that in order to relieve emotional distress, we must attend to the context in which this distress has occurred.

As the above community portraits emphasize, most of the LSAH residents in need of clinic services are not experiencing just one kind of stress. The sources pinpointed by the Coalition's Needs Assessment are seen three-dimensionally when they occur in daily life, each interlocking with the others. Clearly, community responses and the portrait of the community presented by quantitative metrics indicate that what is called for in LSAH is Trauma Informed Care, as interpreted through a developmental and contextual lens, since individuals of different ages experience different challenges and forms of distress, since past painful experiences resonate with those experienced in the present, and since social inequality, discrimination, and displacement can trigger or exacerbate trauma responses. For example, childhood trauma is often followed by enduring challenges as an adult, and for immigrants, pre-migration, migration and post-migration traumas are intertwined. In addition to these traumas, there are systemic traumas that impact the quality of life available to individuals and families, and the long-term implications of such traumas. Thus, healing is less about treating single symptoms or the sequelae of discrete events than about supporting individuals as whole persons within a healthy environment in which they can thrive.

For each age demographic, depression, anxiety and general emotional issues, in various permutations, were cited as predominant mental health issues. This is not surprising, as these are the common ways in which people's minds tell them that something in their lives has hurt them, and that the remnants of this hurt have become problematic for themselves and/or others. Clearly, because this expression is somewhat different at each life stage, it must be tailored to developmental context, and use both intergenerational and cohort resources. Children clearly have needs for intervention aimed at helping them learn and grow, and aimed at helping them develop channels for expression other than exhibiting problematic behavior. While this behavior may seem protective, it also has repercussions that can be serious and lifelong. In order to reverse problematic trends in the lives of children, direct intervention is needed within three interlocking levels - with children, with families, and with schools. LSAH schools have identified an acute need for evaluation and referral resources as well as groups to address parenting issues, teachers' challenges, and student groups to address reunification challenges, loss, loneliness, bullying and other acute issues. In addition, teens present with, and require support to address, sexual abuse, substance use, and gang pressures, as well as support to persist in school and to face the unknown challenges ahead as they enter adulthood. Young and

[58] https://saveourmentalhealth.org/uploads/3/6/4/8/36488901/LSAHMentalHealthNeedsAssessment2020.pdf, p. 6

middle-aged adults are often overwhelmed by the responsibilities of work and young families, and need mental health resources at times and in places that are most convenient. All of these groups need to have access to treatment in their own languages, and in spaces that are welcoming, accessible and culturally responsive.

One cohort that often gets overlooked is that of older adults, who do not necessarily stand out in demographic tables, and whose distress is often assumed to be similar to that of middle-aged adults. We know the value of addressing the unique needs of older adults, and understand that many of them are isolated, grieving multiple losses, adjusting to changes in their abilities and environment, and sometimes suffering from cognitive decline and depression. We also recognize that while the current population of LSAH is distinguished by its immigrant groups, it is far more common for younger people, as opposed to older adults, to migrate to the U.S. Because most immigrants are here to stay,[59] however, we need to be prepared for a significant increase in older adults as the immigrant population ages, some of whom may prefer services in their native languages and may have increased medical needs.[60] For many immigrants, these needs are currently addressed by their families. Multi-generational households offer both blessings and challenges -- financial, medical, and emotional -- to younger generations. Caregivers often feel squeezed into multi-layered generational "sandwiches," as older family members turn from providers of childcare to requiring care themselves. Other older adults, if they are without family, may suffer from acute loneliness that must be addressed.[61] Further, this older cohort is less likely to have had access to emotional and physical health care all along, so that difficulties can often manifest more acutely.[62] Clearly, provision in the present must also be accompanied by building foundations for future increased services, both on-site where older adults live and interact as well as in a clinic setting.

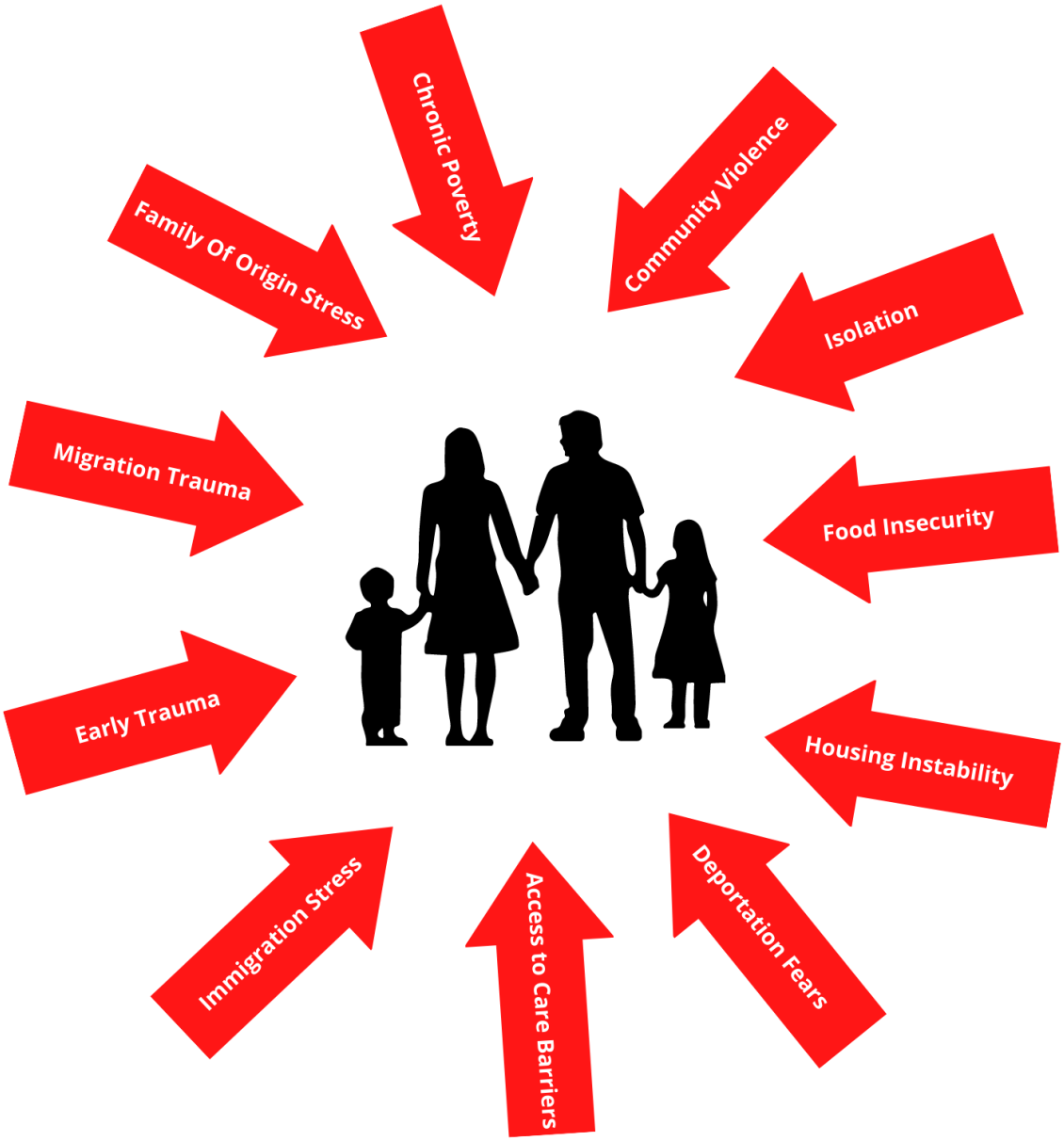
[59] https://qz.com/1641076/how-long-the-typical-undocumented-immigrant-has-been-in-the-us/

[60]https://socialinnovation.ucr.edu/health-needs-undocumented-older-adults-view-health-status-access-care-and-barriers

[61]https://aging.rush.edu/wp-content/uploads/2020/12/FINAL_A-Collaborative-Report-on-the-Aging-Undocumented-Population-of-Illinois-1.pdf

[62]https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2018/01/03/aging-undocumented-and-uninsured-immigrants-challenge-cities-and-states

FIGURE 9. MULTIPLE STRESSORS IMAGE



Listening to the Community: Needed Treatment Strategies

Our Program Services section, created in light of the community challenges that we have been outlining in this Needs Assessment, details our vision for the creation of a responsive and life-giving hub that centers mental well-being. In this section, however, we wish to highlight briefly the specific gaps and opportunities for interventions that have been underlined through our interviews and the views of community members. While, most of all, we have heard a *general* outcry regarding the lack of accessible, affordable, and culturally responsive services, we are also aware of specific services that our interviewees have pointed to that a community clinic must provide. Overall, we envision four pillars that we see as essential for the LSAH clinic to provide: clinic-based services, community-based services, community-wide services and community partnerships for referral and collaborative care. Each of these represents an essential element of creating an effective community care response, and each was highlighted by both community leaders and community members. We will offer an overview of the first three of these and refer you to the Community Partnership section for more on how we envision our contribution to the network that strives to be a safety net for LSAH residents.

The LSAH Needs Assessment completed by the Coalition to Save Our Mental Health Centers demonstrates the felt needs for each of these pillars, as expressed by their interviewees. Community members interviewed for that survey and in our own discussions seemed to envision mostly clinic-based services, and overwhelmingly placed counseling services at the top of their "wish list" of modalities the new clinic should provide, including long-term therapy for those suffering from complex trauma, as well as groups, medication services, education and activities. Meanwhile, the Community Leaders interviewed by the Coalition and by us also addressed multiple needs for outreach, including outreach in schools for students, parents/families and teachers/administrators, outreach to community centers, and outreach to older adults and immigrants. Our own community respondents also spoke about the need for services for unsheltered individuals and others who may require street outreach efforts (See Appendix: Interview #4). Meanwhile, we have heard clear expressions regarding the need for family and couple counseling, and about many types of issues that might be addressed in therapeutic groups. Topics could include groups for survivors of specific traumas, immigrants, the family members of victims of violence, children who have been separated from their parent(s) due to deportation or are in the process of reuniting, individuals at risk for becoming unsheltered, parenting support, grief, trauma related to sexual abuse, how to build healthy relationships, and youth suicide awareness and prevention. One of our respondents called specifically for "community talks about mental health" and each of these topics, and more, could be addressed at the community level as well, in open forums and larger groups.

Listening to the Community: Addressing Barriers to Treatment

Even more central than the specific treatments highlighted by community members, however, is the overarching need to remove barriers to care. We cannot emphasize enough the necessity of raising awareness about mental health and treatment options, as *quite literally every single one of the non-mental-health-professional community members we interviewed stressed that they did not know what services existed, or even how to find out.* Community education, in a readable, portable, printable, widely available form, in multiple languages, was cited as a necessity. Our respondents suggested having information available in stores, posting information

on community websites, and providing "brochures" that show both the where and the how of accessing services. As one woman at Sip of Hope suggested, "something people can grab walking out of the coffee shop."

While stigma was mentioned as a barrier to treatment, prejudice against mental illness or options for addressing it took a clear backseat to obstacles associated with systemic unresponsiveness such as long wait times, limited treatment options, unreachable locations, limited scheduling that did not allow attendance by those who worked long hours, and difficulties encountered in attempting to make use of insurance even if an individual had it. A lack of childcare was another barrier to treatment, as was a lack of accessibility by public transportation. One young community member remarked that "my friend had to stop going to her therapy sessions because of distance/accessibility." We also know that the proposed clinic will have to grapple with the widespread fear of using services of any kind, and with the reluctance that remains in the wake of public charge restrictions that presented an aggressive threat to accessing care even after their repeal. And we recognize that many of the people who come through our doors will have been treated poorly by previous services, agencies and authorities, and will need time to develop trust that "help" can be provided in a way that respects and affirms their dignity and agency.

We celebrate the fact that the residents of LSAH have come together to lift the second of the two largest barriers to treatment by resoundingly endorsing the new clinic, which will be dedicated to providing services regardless of ability to pay. We believe that this clinic can be a vital home for healing, both for individuals and for the community as a whole. In interview after interview, we listened as community members and leaders lamented the lack of opportunities for humane treatment that would not cause greater financial problems than they addressed. We believe that making mental healthcare affordable will serve to not only ease financial barriers to treatment, but also help to eliminate the additional barriers of mistrust, stigma and lack of awareness that have kept in-depth healing out of reach for those who need it most. Indeed, we like to consider the EMHS community-funded model a model of open arms, extending hope and wellness to all LSAH residents. LSAH has created a new opportunity to heal itself from the inside out, and we look forward to seeing the new clinic flourish along with its clients in the coming years.

TABLE 2. LSAH DATA ON ACE INDICATORS

nce **ACES Measures**

RATE PER 10,000 ACES METRICS					
Measure	**Avondale**	**Hermosa**	**CHICAGO**	**Logan Square**	**Rate Type**
Total 3 to 4 year olds enrolled in school	5,916	3,828	5,833	7,009	Rate per 10,000 3 to 4 year olds
COVID-19 Positive Cases	959	1,573	948	830	Rate per 10,000 people
COVID-19 Deaths	13	22	18	15	Rate per 10,000 people
Mental Health Not Good > 14 Days	1,531	2,009	1,740	1,311	Rate per 10,000 people >18
Sleeping Less Than 7 Hours	4,401	5,251	4,978	3,976	Rate per 10,000 people >18
Physical Abuse Crimes	47	69	102	39	Rate per 10,000 people
Child Abuse Crimes	16	28	34	17	Rate per 10,000 people <19
Domestic Violence Crimes	44	61	94	36	Rate per 10,000 people
Felony Convictions	51	87	97	50	Rate per 10,000 people >18
Sources:					
1. 3 to 4 Year Old Enrollment - 2018 U.S. Census, ACS 5 Year, Table: S1401					
2. COVID-19 Data - City of Chicago Data Portal as of 2/27/21					
3. Mental Health & Sleeping - CDC PLACES Data, 2018					
4. Crime Data - City of Chicago Data Portal, All Crimes in 2020					
5. Felony Convictions - The Chicago Justice Project / Cook County Courts, All Felony Convictions in 2009					

CASE ILLUSTRATION

Juan is a bi-racial (Latino/African-American) 17-year-old high school junior who began therapy at The Kedzie Center when he was 13 and in the 7th grade. He was referred by his school social worker due to concerns regarding his social interactions with peers at school, including a conflict that had arisen over inappropriate language in an email with a peer. He was experiencing increased anxiety around peer interactions and being in the classroom. While Juan immediately expressed interest in therapy, his maternal grandmother, who was his legal guardian since toddlerhood, seemed more hesitant to think such intervention was needed. She expressed shock at his reported behavior as well as the school staff's concern about his mood, since everything at home was "fine." Yet she reluctantly complied with the school recommendation, and his weekly therapy began.

During his first year of treatment, Juan's therapist made slow but steady progress in gaining Grandma's trust while also working closely with school staff to coordinate care. As the months passed, Grandma began to trust The Kedzie Center, and she began to share her concerns more readily. She described his social isolation, his "excessive" online use, his fears and worries about the danger in the world and his preoccupation with death.

Juan's mother is African-American and his father is Latino. Per his maternal grandmother, Juan became involved with DCFS as an infant and again as a toddler, both times over concerns of neglect and non-organic failure to thrive. He was removed from his mother's care twice and had been placed with his maternal grandmother at the age of 3. As trust grew between the therapist and Juan' grandmother, she confided that Juan' mother was diagnosed as a young adult with schizophrenia. She and Juan's father, who Grandma reports also struggles with mental health issues, have had years of inconsistent treatment, substance abuse issues, and repeated bouts of homelessness. They had three children after Juan, two of whom were removed from their care and adopted through traditional foster care by the same family, while Juan's youngest sibling remained in the care of his parents. Grandma reported that Juan's parents have been predominantly absent from his life, rarely seeing him or bringing his youngest sibling to visit. Over time, Grandma has also reported various concerns and stressors within her immediate and extended family, including poverty, incarceration, mental health challenges, and substance abuse.

For the first two years of treatment, Juan exhibited significant anxiety, expressed by tremendous social withdrawal and dysregulation. Per school reports, these social avoidance and anxious behaviors had been long-standing. He would hide under desks and interact minimally with peers, and would become angry or upset after misinterpreting comments by peers or school staff. When he felt rejected, and often in school, he would threaten self-harm.

In sessions, Juan would often hide under his hoodie, hunched over, or hiding under, the office desk. He would regularly ask to turn the lights off, and for the first twenty minutes of each session, he would often remain quiet or talk minimally through figures or toys. During this initial phase of treatment, Juan had two inpatient psychiatric stays, followed by two intensive outpatient groups. Both hospitalizations were due to significant acts of aggression at school and at home and increased suicidal statements. His therapist continued regular collaboration with psychiatrists, the hospital staff and school staff during this time. Juan's first Individual Education Plan was created upon his return to school from the hospital, when he was in the 8th grade.

Slowly, Juan began to trust his therapist, and the transition time he needed to get comfortable in the therapy space decreased. He would make more eye contact and began sharing his worries about the dangers in "the world," about "getting into trouble," and about his overall abilities. Juan described being regularly paralyzed with fears about the future, including worries about high school graduation, homelessness, self-harm, independent decision-making, getting a job and being able to take care of his family. Along with strengthening his regulatory capacities and establishing trust, therapy focused on helping him identify and utilize sources of support at home and in school. The therapist also helped him identify and connect to his abilities and interests while developing both concrete skills and an emotional capacity to prepare for the transition to high school.

The therapist collaborated closely with various systems at each of these critical junctures. In grade school, she maintained consistent communication with his school social worker as well as the special education staff working with him, which intensified during his acute episodes. Intervention plans with SASS (Screening, Assessment and Support Services) were shared and communication was maintained with Grandma to ensure clear and consistent information, support, and follow through among all of the caring adults in his life. His therapist maintained this same degree of consistent coordination of care with his high school social worker, again with more involved intervention during acute periods of crisis.

Many layers of complex trauma have presented themselves over the course of treatment: racism, poverty, child welfare involvement, intergenerational trauma, incarceration, substance abuse, homelessness, and significant mental health issues. Meanwhile, Juan's grandmother's trust in the therapist and in Juan' psychiatrist continued to grow, as did a positive institutional transference (possibly define term or use more recognizable term like positive feelings about/relationship with) to the Center itself. She began to reveal more about their family history of losses and her own personal struggles. As the relationship between Grandma and therapist strengthened, Juan began to focus more on his relationships at home, as he strengthened his bond with his grandmother and an aunt and uncle. Juan's transition to high school also came with building new relationships with multiple new teachers and a new support system. He confided more openly with both his therapist and the school counselor about his concerns about himself and others. As Juan's capacity to identify and explore interests grew, he was able, with the support of his therapist and school personnel, to be accepted into a paid extracurricular enrichment activity that allows him to focus on his interest in the visual arts.

As Juan approaches his senior year, he shows an increased capacity to self-regulate, to articulate what is challenging for him both academically and socially, and to advocate for himself. Though cautious, he is thoughtful about relationships and understands that there are many people in his life to help and support him. Recently, he has reflected back on his struggles in middle school and expressed remorse for an aggressive act against a teacher, trying to brainstorm how to apologize and take accountability for his actions. He understands now that relationships are important and that sometimes repair is needed. Increased collaboration with the school and family is still underway as Juan prepares for his transition from high school. As he launches into adulthood, we will continue to work with him to support what we hope will be a successful transition into a life of meaning and connection.

APPENDIX: Community Conversations

Interview #1: High School Social Worker, Hermosa

We spoke with a school social worker of 25 years who shared her knowledge of the mental health needs of the Hermosa community. She identified a growing need for family counseling in Spanish, school-based grief counseling and psychiatric evaluations. She noted that there is an emerging number of Central American recent immigrant youth who are being reunited with their parents and present with abandonment and trust issues. She reports that there are "few outpatient clinics in the area that are Spanish-speaking, culturally informed, and accept Medicaid MCOs. Many of these have a 3-6 month waiting list."

Due to low school enrollment, the school is now 7th through 12th grade and has approximately 400 students from the Hermosa area and beyond. Nearly 98% of the students are Mexican or Central and South American and many of the students are enrolled in English as a second language programming. In recent years, the crises at school have resulted in calls to SASS (Screening, Assessment, and Support Services) to evaluate students for suicidality and trauma. "There is a prevalence of vaping and marijuana use resulting in referrals to First Community Hospital. School security officers were voted out by the Local School Council this past year; those officers traditionally intervened when school behavior escalated."

Teachers are addressing social-emotional learning in the classroom, which include topics such as Community Builder - We're all connected, Healthy Choices stress management, Winning Behaviors, and Gratitude Journal. The school has an emerging behavioral health team (BHT) charged with identifying students in need of mental health services and coordinating community services to address mental health and risk behaviors. Other issues addressed by school mental health staff include dating violence, conflict resolution, and social skills. Parent engagement has been low, in part due to parents working multiple jobs to make ends meet and other obstacles which make it difficult to engage in school activities.

INTERVIEW #2: Parent Mentor Coordinator, Avondale

Sonia, an Avondale School Parent Mentor Coordinator, has been employed with LSNA for 15 years. Her team serves Avondale School (Pre-k to 4th grade) students in remote and in-school learning, primarily in reading and math. She described their student population as greater than 90% Latino/x. Prior to Covid-19, there were as many as 18 Parent Mentors, but currently, there are seven. These Parent Mentors are sponsored by LSNA (Logan Square Neighborhood Association*) and meet Chicago Public School volunteer requirements. On average, they are serving 6 students in-person and 14 students remotely. Logandale Middle School serves 5th-8th grades and is located on the same campus.

She notes that when family problems or depression are identified, students are referred to their teacher, who then refers to the school counselor, who may refer the family to a community organization. She feels that the "stress upon families has been worse during Covid-19 due to being at home, virtual learning, job loss, and deaths related to various causes." She perceives community violence to be a greater concern to families than domestic violence, keeping them from going out to parks and even stores. She reports that "*parents in the area have limited*

transportation and tend to walk everywhere, so street safety is a significant concern. People don't feel safe. Gun violence has been worse during Covid."

Asked about trauma, she told a story of a parent who had lost her son to suicide after complications related to a gunshot wound. She reported that, to her knowledge, the family never sought or received mental health support. "*They grieved and then went back to work*."

She reports that the Parent Mentors provide peer support to one another and referrals to families, though there are limited community resources, especially in Spanish. Asked if they would benefit from mental health support and consultation, she agreed that workshops and resources for families would be helpful. Workshops for parents would include managing family conflict, discipline, and communication. She believes that families turn to their health care physicians, their churches, community groups, friends and family. Asked for her wish for mental health care for Avondale, she listed child therapy, family therapy and special education support and advocacy.

*Logan Square Neighborhood Association provides resources related to housing, employment, education, and immigration needs of residents in their community.

Interview #3: Street Outreach Supervisor, Hermosa

Heather Perkins, LCSW, is a Street Outreach Supervisor for Metropolitan Family Services serving Hermosa. She reports that the program for which she works provides short-term therapy (3-6 months) for those most at risk of becoming gun violence victims or offenders, and serves clients between ages 18-49. The program is unable to offer services to family members of victims or offenders. A primary concern that has emerged "in Hermosa regards young people who have been separated from their parent(s) due to deportation. These clients are only able to be seen for three sessions." Many of the clients are young women who are vulnerable to exploitation, drug use, and victimization.

Her organization is also able to see clients at risk of homelessness, with family histories of violence, with high-risk behavior or who have recently been released from prison. Referrals come from community organizations and not from the police department. Due to the time it takes to engage clients, services are often extended past the six months. Their clients are treated for depression, anxiety, PTSD, and grief. They have no access to psychiatric care. They use a strength-based, trauma-informed approach to therapy. Regarding what they would need in a mental health partner, they would benefit from "*services for young children, the siblings or children of their clients; parenting and guardian (often grandparent) support; and long-term therapy for clients with complex trauma*."

Interview #4:
Mental Health Instructor/Educational Consultant, Hope for the Day, Logan Square

Allison Herman is an educational consultant and mental health instructor for ***Hope for the Day***, a suicide prevention and mental health education program, supported by ***Sip of Hope*** coffee shop located in Logan Square. Asked about mental health needs in the community, Allison reported that the biggest concern is that "*people lack health insurance and access to close, affordable, culturally competent care*." She specifically identified the needs of the LGBTQI+ community. She said that during the pandemic, her organization has been offering digital education to provide mental health support and referrals.

Ms. Herman noted that residents sought support for dealing with "social unrest and racism." Individuals she spoke with reported not wanting to "*have to explain why I'm upset and educate others so I can be understood*." She described their current demographic as "mostly White, 18-40 year-old adults, mostly English speaking and heteronormative." Middle and high schools have reached out because "students are struggling and not knowing how or where to get help." Her perception is that individuals have "gotten through but are now starting to feel their feelings and are getting overwhelmed." She's also hearing anxiety about "how to return to the world." She noted significant stress related to trans legislation and hopes to continue to offer safe and supportive spaces. She reported that there is a shortage of clinics that have staff who "understand the LGBTQI+ community" and intersectionality.

III. Program Services

A successful and meaningful Program Service Plan is one that grows directly from the soil of the community it serves, tailored to community needs. It reflects both an appreciation of the resiliencies, resources and challenges of local residents and a demonstrated expertise in the psychological and social interventions that can address multi-faceted distress and allow communities to thrive. Our Program Service Plan aims to recognize the complexities of its community members, viewing participants in their cultural, historical, familial, developmental, and physical contexts, and it provides services that are affirmative, personal and transformative. It offers the clinic as a hub and home for these services while branching out from its center to reach people where they are, in schools, community centers and other social spaces.

The cultivation of a healthy community rests on the health of its children and youth, and our plan to serve them is informed by the urgency of providing enriched services to vulnerable children in light of the indisputable correlation between exposure to adversity in childhood and later dysfunction and distress. The effects of ACEs (Adverse Childhood Experiences) can be mitigated, creating lifelong resiliency, if they are addressed early and comprehensively. Even very young children can benefit from intervention, but benefit most if their caregivers can be sufficiently supported to provide a protective, healing space, which can be especially challenging when parents are themselves taxed by traumatic experiences, family tension and social stressors. By supporting families to create safe environments for children, and by addressing childhood distress early on, we are investing in our collective future while we invest in theirs.

To meet children's needs, we would plan to offer parent-child groups, play/socialization groups, parent support and process groups, family interventions, and ongoing individual child and family treatments. Our groups would make use of art, music and movement to facilitate self-expression and the working through of painful feelings and experiences. While crafting programs that are tailored as closely as possible to the specific needs of LSAH, we would, of course, draw upon the success of our experiences at Kedzie hosting parent education groups such as *Abriendo Puertas* and parent-child groups such as *Little Explorers*. We would also provide consultative services to school administrators and teachers as well as school-based services to children and their families who, as seen in our Needs Assessment, have requested parent support resources in schools, in group and individual form, as well as interventions with children.

Older Children and Teens: Older children and teens are directly affected not only by family stressors, but by the challenges of navigating the transition to adulthood. Such transitions are especially difficult when trauma due to violence, immigration history, marginalization or loss has occurred personally and/or in the family, and when security is threatened by unemployment, unstable housing or lack of adequate health care. These young adults confront questions of identity, separation, socialization and responsibility while they are simultaneously affected by intergenerational trauma and exposed to drugs, gangs, pressures to conformity, and racial and economic tensions. Family therapy for older children and teens can often be surprisingly effective, but needs to increasingly accommodate their needs for autonomy and peer support. Tweens and teens incrementally require their own services, both individual and group, that can offer them the space to develop their identities, emotional capacities and goals. These resources would be offered both in the clinic and on-location at schools and community centers. We would expect that our LSAH clinic could draw upon the many programs we have developed at Kedzie, including our school-based parent workshops, trainings on trauma and immigration for teachers, and process groups for teens, and DACA (Deferred Action for Childhood Arrival) students, as

well as breaking new ground in response to community need. Our interactions with school staff members, as described in our Needs Assessment, have pointed to the need for group and individual interventions addressing experiences of depression and anxiety through the context of both individual counseling and groups for those undergoing family separations and unifications, stress because of their LGBTQI+ status, the sequelae of community violence and racism, and concerns about impending adult responsibilities.

Young Adults and Adults. Our adult programs would encompass a wide range of offerings, allowing individuals to participate in the ways most suited to their situations and concerns. Adults need programs that can help them cultivate agency, self-worth, relational stability and insight as they navigate life transitions and stresses of parenting, elder care, poverty and trauma that have left shadows of depression and anxiety across both present and future. The unique and shared stressors experienced by adults reflect the range of their histories and identifications. Thus, both general treatment. Young adults express an interest in learning to negotiate new relationships with their families of origin, solidify their adult identity, develop healthy relationships, and explore career/work options. Those who have felt uprooted and displaced need to be engaged in groups that can be offered in their first languages, and can draw upon the resources of their cultures of origin and current community contexts to support the transition to new homes and lives. As highlighted by the surge in reported marital/couple tension and discord we have seen, especially as amplified by the isolation brought on by the pandemic, we would also offer couples and family treatments, either on their own or in conjunction with the individual psychotherapy of one or more of the participants.

The term “adulthood” represents a vast stretch of time, covering many stations on the journey of development. The needs of young and emerging adults often overlap with those of established individuals and families -- for instance, both groups report that the major stressors in their lives revolve around finances, followed by job/work issues -- but there remain topics and interests that are distinctive to each group. Emerging adults can benefit from groups that address the transition to adulthood explicitly, as the movement from student life to life out in the world can be intimidating, lonely and confusing, and these feelings are amplified for those who have been exposed to trauma, are new to the US, or both. In addition to referrals to partners offering vocational opportunities, emerging adults can find both support and continued growth by processing their experiences with others confronting the same life transitions from relative dependency to assuming financial and relational commitments. Navigating relationships is challenging at any age, but can often be especially so for young people, for those with young children, and for those who are assuming a caretaking role with older parents. Established adults are faced with many of the same difficulties, but, for example, find that the dilemmas faced by parents of teens are vastly different that those faced by younger adults. Parent illness and loss, burnout, health issues, grandparenting, and other topics might more often be the focus of these groups. Meanwhile, the experiences of immigration, acculturation, and adaptation can be vastly different for those at different ends of the spectrum of adulthood, and would often be most effective if group members could establish a sense of belonging and cohort with others whose experiences were at least somewhat similar to their own.

Older Adults. Older adults face particular challenges, both internal and external, that require a response that is tailored to their needs. Physical challenges, such as diminishing capacities, vulnerability to violence and exploitation, cognitive decline and financial insecurity, are exacerbated by feelings of loss, loneliness and regret, as well as by heightened fears of impending disability and death. Yet seniors can also come, through therapeutic interaction, to

discover new strengths, to further consolidate a sense of self through life review and prospective accomplishments, and to build sustaining relationships and avenues for making significant social contributions. As older adults can find it more difficult than others to access off-site clinical services, and often feel a stronger stigma against needing the services of mental health professionals, interventions that come to them, taking place in churches, senior centers and senior living facilities will be necessary to engage this often more reluctant group.

Community Engagement: To be a true community clinic requires not just treatment-behind-closed-doors, though it certainly does that, but our being valued community partners as well, working side by side with other organizations in order to reach those who might not otherwise see themselves as benefitting from intervention because they believe their problems to be shameful, too personal, or insufficiently worthy of clinical attention. Community nights, partnerships with organizations that can identify individuals in need and serve the physical and social needs of clients, and other open events, are not add-ons, but integral aspects of a thriving therapeutic hub. Whether we work with groups, individuals, families/couples, or whole communities, our interventions will be informed by a consistent treatment perspective that view clients as whole and unique individuals with depth, inner lives and motivations that can be understood and worked through when they become problematic in daily life. It is the quality of our interventions that set us apart from other treatment programs that rely upon impersonal, manualized or brief interventions, and it is our community investment that gives our interventions their value. We would estimate our community-based work to be approximately 30-35% of our total encounters.

IV. Community Partnership and Development

In "Community Mental Health Center," the word "community" comes first. We believe that a community mental health center should view itself as part of a care team made up of other mental and physical health providers, organizations and community institutions. We can only focus on what we do best by developing mutually supportive relationships with other resources – faith institutions, community organizations and agencies, schools, shelters, housing programs, among many others – that are doing the same. Seeing ourselves as constituents of a larger whole has allowed us to better attend to our clients as whole people as well. The phrase "it takes a village" applies, in our view, both to the individuals who live in one and to the arts, social services, housing, health and other institutions great and small that weave the net beneath it.

Becoming and being a true and trusted community partner has much in common with building alliances with clients. It takes time, requires cultural and psychological sensitivity and relies on the cultivation of mutual respect. We view this process of growth-in-community as consisting of several overlapping steps, including outreach to organizations, the development of coordinated organizational relationships, the creation and implementation of content we can offer, and the use of our resources to reduce the stigma associated with mental health concerns and their treatment so that community members can feel welcome, understood and empowered when they walk through our doors. Each of these aspects is essential and ongoing, as we have learned through our experiences in building community through The Kedzie Center.

Engagement with community partners and community members alike is often viewed by some as a means to an end, while therapy represents the "real work." However, when serving an entire community, we believe that engagement itself is an essential aspect of the "real (therapeutic) work," as it enables trust, fosters mutual commitment, and improves access, collaboration and outcomes. We have developed many ways of connecting with partner organizations directly, and of entering into dialogue with them to explore the contributions we can make. We start by identifying key stakeholders that have already been active, known and trusted in the community and develop relationships with those groups, often to discover that those initial contacts lead to others. We also work to identify the gaps in services and to coordinate with other agencies so that service duplication is avoided and so we can add value to their efforts. We have discovered that many agencies appreciate our ability, because of our funding model, to provide services that are not necessarily billable, giving us breadth and flexibility to complement and provide essential therapeutic services they cannot afford to offer.

At The Kedzie Center, our outreach has brought us a vital web of partnerships that is dense and thorough enough to have prevented many from falling through the cracks. Through Kedzie, Expanded Mental Health Services of Chicago, NFP has developed strong and effective partnerships with more than 60 community-based agencies and programs and over 20 schools. Some of these organizations also reach into the LSAH neighborhoods, so that we would not be moving into community partnerships as strangers, but rather as "kin" to established LSAH services. We have relationships with LSAH community resources as diverse as Hope for the Day, the YWCA, ALSO (Alliance of Local Service Organizations), LSNA (Logan Square Neighborhood Association), and neighborhood city officials, which we would be eager to cultivate further as we develop a community niche. The Executive Director, Site Director and staff clinicians of our proposed center all would be involved in cultivating such organizational collaborations according to our clinic plan, and will be given training, as our Kedzie staff has, on

community engagement, outreach and referral. It may be noteworthy that our director has previously established new services in the Logan Square Avondale area earlier in her career.

Building and tending mutually beneficial collaborations has taught us that we can do more when we work together, while expanding the reach of each resource to both groups and new individual community members. For instance, through Kedzie's connection with Israel's Gifts of Hope, an organization created by a North River family in honor and memory of their son, a gun-violence victim, we became a resource for many more families in similar straits while we fostered the growth of that organization. Sometimes this cooperation can be based simply upon the value of and need for the services we provide. We have discovered over and over that our counseling approach, which offers a depth and a respect for the cultural, relational and experiential lives of our clients, is both needed and rare. But sometimes, we find that we can build on the work of other organizations in innovative ways, not only by participating in their events, for instance, but by introducing a mental health perspective to various social issues like community safety and racism. While our partners are addressing the legal issues regarding immigration cases, for instance, we can be addressing the psychological effects of displacement and instability, uncertainty and anger, grief and fear. We can address community violence not only by working collaboratively with street outreach and other community partners, but can enhance their prevention and early intervention work by providing alternative social connections to school-age youth, who may be vulnerable to gang recruitment, as well as parent education and support that can help mitigate the root causes of community violence.

We have many examples of the ways in which community partnerships have enhanced the services we provide at Kedzie, and could enhance those that the new clinic would provide, while simultaneously building upon the services that are available in the community. In response to the lack of child programming in the community, for example, the LSAH clinic could offer art/play programming while also facilitating program development in other organizations. We would work to coordinate care with substance abuse treatment centers, such as HAS (Healthcare Alternative Systems), Gateway and Rincon Family Services as individuals recovering from addiction process the pain that sustained their addiction. Partnerships with immigrant assistance organizations that provide essential services offer an opportunity to connect with individuals who are likely in great need of our services. We have found that participation by our Latina members with trauma histories in empowerment groups offered by our Kedzie partners Healing to Action and Organized Communities Against Deportation have provided meaningful healing opportunities. Collaboration with agencies that offer economic and job/workforce development can offer client's another form of empowerment, while coordination of care with agencies such as the YWCA that focus on domestic violence can provide an additional context for healing. When unsheltered individuals have difficulty finding the stability to attend therapy, area programs devoted to assisting this population, such as The Night Ministry and La Casa Norte, are invaluable conduits to care. Because LGBTQI+ individuals are overly represented among the young unsheltered, we could provide culturally responsive psychotherapeutic care that allows them to feel more comfortable.

In order to be useful, our outreach efforts must be built around content that is in direct response to community need, and must be offered in locations that are accessible and inviting. We have offered groups, seminars, workshops and other community events at schools, homeless shelters, senior homes, churches and other locations identified by our partners and clients. In the schools, we have offered a wide variety of trainings, conversations and seminars to address behavioral concerns, depression, anxiety, trauma and self-care. Support for school-based

social-emotional learning has included programs on such topics as bullying prevention, fostering self-esteem, healthy relationships, and diversity/anti-racism in the classroom, as well as programming addressed specifically to parents, at convenient hours, on suicide prevention, general mental health, supporting student/family transitions, communication and conflict resolution, parenting and discipline, and supporting virtual learning during a pandemic. We've also offered training in trauma, diversity, and child development to teachers. Further, to help children become ready for school, we have offered clinic- and school-based parent-child playgroups and *Abriendo Puertas*, an evidence-based parent program for parents of children 0-5. It will be essential to have a therapist with early child development training on-staff to oversee these programs.

In schools, the workshops we have thus far offered, in English and Spanish, have addressed the following topics, in direct response to community request and need:

- Child and adolescent development
- Child and adolescent mental health
- Supporting social emotional development
- Supporting virtual learning
- Stress management and coping
- Parent-child communication and conflict resolution
- Supporting adolescent transitions (jr high to high school; high school to college)
- Navigating immigration stress and acculturation
- Fostering healthy relationships
- Understanding self-harm and suicide prevention
- Bullying prevention
- Youth trauma and resilience
- Early child development
- Early child school readiness
- Sexual health and informed consent
- Diversity, Equity and Inclusion

Many of these offerings have been adapted and offered to students in classroom workshop series and to teachers and staff as professional development. Most recently, we have offered summer programs with a stipend for participants and after school workshops for students. After School art-groups and yoga for school-age and adult clients, have allowed for a seamless connection with clinic-based services.

In addition to holding these workshops in schools, we have made some of these topics available to local organizations for non-clinical staff, and have created more clinically-focused workshops in these areas for clinicians. These workshops have been provided to refugee organizations, faith-based groups, sex worker ministries, meal programs for the unsheltered, and to older adult residences. During COVID-19, they were offered community-wide on Facebook or Zoom, at neighborhood association meetings, community safety meetings, partner events, and at the invitation of professional organizations. We also participate regularly in CAPS (Chicago Alternative Policing Strategy) and Domestic Violence committee meetings to work with our police district to better serve our community. On-site workshops and groups for seniors are especially important given their greater challenges with mobility, which can provide extra obstacles to access to the clinic. This programming could be offered in coordination with local hospitals, such as Amita Health Saints Mary and Elizabeth, which can provide cognitive screenings and collaboration in the management of chronic pain and other emergent and

long-standing but undiagnosed health issues. Groups and gatherings are especially important to this population, where isolation and loneliness can prove not only difficult, but even life-threatening. To date, we've offered older adults in our community mental health education on depression, anxiety, hoarding, family relationships, communication, stress management, self-care, memory enhancement and mindfulness, as well as art therapy.

We have devoted much of our work thus far to developing engagement strategies that can literally meet people where they're at, not only by offering on-site services, but by joining in existing activities, events and programs that expand our reach. For example, attending a meal program for the unsheltered in a church basement can allow us to meet and develop trusting relationships with participants who can be engaged in conversations about grief, trauma and mental health. This strategy has led to stabilizing unsheltered adults who had previously been unable to sustain housing. Some reported that until they came in contact with us, they "didn't know that (their) mental health was affecting (their) housing situation." Indeed, our outreach is grounded in the fact that while it's not the case that everyone will require our services, it's absolutely true that each of us struggles at times, and can use some comfort, guidance, a non-judgmental relational space, and a new perspective on ourselves and others.

Our fundamental strategy as we work to raise awareness and reduce stigma is to make mental health relatable and common by educating community members on mental health as an essential aspect of a good life. When people feel valued as human beings, they can come to see that their experiences and quality of life are important, not as manifestations of self-centeredness but rather as part and parcel of belonging to and participating in a human community. By becoming aware of the ways in which mental health is relevant to physical well-being and our overall quality of life and relationships, we move the needle away from the stigma of "mental illness" and closer to the realms of wellness, growth and meaning. This is especially true when we work with parents, who are motivated to engage our services in order to ensure that their children have full, meaningful and comfortable lives. When parents come to understand that their children's distress has developed as an expectable reaction to difficult experiences rather than a sign that there is something "wrong" with their child, they often end up seeking help for themselves as well. For example, our parent-child play groups have often led to developmental assessments, individual, marital or family therapy, and to ongoing parent education.

We also work under the assumption that many of our most vulnerable clients have likely had negative experiences with systems. For example, one walk-in client at the Kedzie Center reported that he was failed by the public school system, child welfare, health care and the justice system by the time he came to our office as a man in his 50's. He needed to know early on that we understood this and that we would not do the same. This client has been with Kedzie for four years now and is stable and thriving – employed, sheltered, sober and with supportive relationships. We understand that individuals whose prior circumstances are similar to this client's may require an intentional effort to earn their trust by proactively anticipating concerns and addressing those explicitly. We are transparent and forthright, for instance, about how information will be shared with others, including authorities. We recognize that concerns regarding confidentiality may be especially delicate for clients who are undocumented or have criminal backgrounds, as well as youth, persons of color, and the LGBTQI+ community, many of whom have likely had experiences in which their privacy or agency was not respected, or their experiences were minimized or misperceived. This transparency goes hand-in-hand with a commitment to allowing each of our clients, whose autonomy has so often been disregarded, a full and respected voice in treatment decisions.

Offering programming for the entire community also serves to reduce the stigma that comes with viewing the clinic as a place only for people with severe problems. Community Nights serve as invitations to all neighborhood residents to engage in conversations around mental health topics of general interest and community impact, ranging from depression and suicide prevention to human trafficking and gun violence. These are larger gatherings consisting of both a short formal presentation and an opportunity for questions and dialogue, allowing each participant to determine the degree of interaction with which they feel comfortable. As such, these events constitute a relatively low-demand introduction to the clinic, and allow the idea of a mental health center to become less forbidding to those who might otherwise be intimidated from seeking services. They also serve other functions, such as providing safe networking spaces for young adults. In addition, we regularly solicit input in even less structured ways from the greater community, encouraging members to provide feedback, suggestions and reflections. For instance, residents can stop by the clinic to inform us of a community need, or they can contact us through our social media platforms, through email, or by calling us to share their perspectives. In all these ways, we work to reinforce the idea that this is a community-owned center in which they are stakeholders; while we bring our expertise, we do so at their request and on their behalf.

In order to best serve the Latino/x clients who make up the majority of the population at Kedzie and would, we expect, make up the majority of clients at the new clinic as well, we would begin by hiring staff with the linguistic capacity to serve the largest demographic group of our community and then supplement this capacity by recruiting students and partnering with other culture-specific agencies to serve our community or to build the capacity of others to better serve them. We are mindful of a need for sufficient staff who can deliver services in Spanish, and who are trained to assess and treat migration-related trauma and stress, acculturation issues, and discrimination. As an interdisciplinary team, we are able to monitor symptom patterns such as post-partum depression among Latinas, and distress and isolation among emerging Latinx adults. We are also aware of the variety and intersectionality of cultures, backgrounds and experiences of our Latino/x clients, and understand that we must listen, rather than assume, so that we can know the internal cultural environment each client brings to the work.

We are pleased to see the emphasis placed in this RFP upon diversity, equity and inclusion as essential grounding values in community treatment. During this past year of Covid-19, we have been confronted with the harsh realities of the economic and health inequities at the intersection of race, class, immigration status and gender. The tragedy and social unrest we have seen all around us during this time has launched us into a full year of anti-racism training, consultation, and review and revision of our clinic policies and practices. We have worked with a consultant to face difficult truths in ourselves, our community and our country, and this has had ramifications in all aspects of clinic life. We have re-evaluated the training and hiring practices at Kedzie, made changes to our training curriculum and created additional supports for trainees and new hires, with a heightened consideration for those on our team who are part of an underrepresented group. Most of our staff is English/Spanish bilingual, and we are fortunate to have partners who serve our Korean- and Gujarati-speaking residents. That said, while we do not offer therapy in languages we do not speak, we have offered educational programs with our partners to serve our refugee communities from Syria, Afghanistan, Myanmar, and the Congo. We hold a commitment to train graduate students who speak languages other than English and plan to serve those communities with the intention of expanding capacity to serve those underserved populations. In addition, our staff is also trained to be responsive to clients across the gender and sexual identity continuum, some of whom have

specialized training. Staff and students are regularly engaged in consultation along various diversity dimensions, including specific attention to immigration experiences and the intersectionality of race, class, gender, and religion/spirituality, among others.

In short, there are ways in which we could describe every client encounter as constituting a community partnership of sorts, as well as a partnership of a more personal kind. We all carry worlds within us, and our lives reflect this diversity of roles, needs and personal connections that are the building blocks of both character and culture. It is our task to cultivate these, so that our members can embrace and enrich the world around them.

V. Trauma-Informed Community Services

Mental health treatment works best when it adopts a general approach that aims to discover, along with the client, "*What happened to you, and how have you responded to it*?" rather than "What's wrong with you?" We believe that many of the symptoms and struggles people face arise out of their internal reactions to the life stressors they have encountered, and that our appreciation for the after-effects of trauma must be widened accordingly. In fact, there is no compelling reason not to view *every* clinical encounter through a trauma-informed lens. But while trauma has certain general effects upon mind, body/brain and spirit, it occurs in many forms, requiring specialized sensitivities on the parts of clinics and clinicians. Those who have endured single traumatic events will present differently than those who have come of age in traumatic circumstances, than those for whom the effects of specific events have compounded, and than those who have lived in the intergenerational shadows of their parents' shattering and often unspoken pasts. Trauma care must address the specific needs of children, for whom early disruptions can compromise futures, as well as youth sexual and social traumas and adult traumas due to immigration, poverty, racism, sexism and violence, among many others. It also must provide options for addressing mind and body simultaneously, offering groups that stress body-awareness, movement and mindfulness components, such as trauma-informed yoga, as well as other group, family and individual counseling-based modalities for healing.

Because the experience of trauma entails, at its essence, a shattering of the sense of safety, a trauma-informed clinic must provide, above all else, a safe and protected space in which clients can rebuild a sense of trust, both through the often slow and painstaking unfolding of therapeutic relationships and through group activities and opportunities for sharing and support. Building safety is a multi-faceted endeavor that includes the clinic's willingness to incorporate clients as full partners in the treatment planning and treatment processes, the maintenance of secure staff-client boundaries, the protection of confidentiality, and transparency regarding clinic policies and procedures, as a firm basis for cultivating agency, self-respect and hope.

VI. Consumer and Peer Involvement

Peer Services are an under-appreciated and under-used source of support and healing within a clinic's culture, yet a true community clinic can facilitate peer involvement along multiple axes, both inside the facility and in the world beyond its walls. Peers are perhaps a clinic's most powerful ambassadors, able to engage others with whom they share backgrounds and experiences, and to facilitate clients' introduction to unfamiliar clinic spaces. They can act as companions on the journey of healing and can provide the guidance of experience as well as insight, encouragement and faith in the possibilities for growth. Peers also have an essential role to play in building treatment equity, de-stigmatizing the use of clinic services and speaking up about needed services and blind spots in a treatment center's procedures, offerings and culture.

Group therapy participants essentially act as peer supports for each other, and participants often develop the courage to speak about their own experiences by hearing from others with whom they can identify, as the group itself serves to "hold" difficult emotions, memories and dynamics, distributing the intensity of feeling among the participants. This process is essential in allowing members to feel less alone, to gain new perspectives on their own experiences, and to watch how others develop alternative ways of coping and senses of self. At Kedzie, peer involvement has been especially important in our work with immigrant and refugee participants, in whom trust, cultural differences and language may be barriers to participation.

There are additional opportunities within the group structure as well. Many of the groups we hope to implement are made up of discrete, time-limited cycles that repeat several times over the course of a year. Those participants who feel that they are growing from a given group experience have the option to participate in additional cycles, as the group structure addresses both short-term and long-term needs and recovery plans. This presents an opening for "veterans" of specific groups to occupy a facilitative role, serving formally as go-to resources for their peers. As an example, we can look to Kedzie's Women's Support Group, which ran for more than five years, in which long-standing members became natural leaders in the group, gradually taking on more leadership in introducing topics, sharing resources and welcoming new members. In the same vein, Parent Peer Facilitators could occupy an important role in facilitating trauma prevention and family support. We would work to identify one or more candidates to participate in more formal Certified Recovery Support training in these areas to contribute to the life of the clinic and co-facilitate groups as well.

Our proposed LSAH clinic would also offer peers significant opportunities for occupying a more public role. Part of ensuring that our community mental health center is truly of the community involves the creation of Community Nights, in which our neighbors, including those who work in other organizations, as well as those who do not identify as having a mental health treatment need, are welcomed and engaged. Kedzie's series of Racial Healing Conversations, in which community members have been able to share their experiences and hear the experiences of Kedzie participants provide one example in which peers' voices have been essential.

Displacement, whether voluntary or forced, can be disorienting, frightening and traumatic, regardless of the events and situations our clients might have faced in their journeys. But "home" isn't merely the physical structures and landscapes in which we live; "home" is people most of all, who share a culture, a history, a language, a collective memory and even a collective trauma. As sensitive as we believe our clinical work can be, we cannot replicate the sense of trust and safety born of familiarity that peers from a common background can offer. It will be the people we serve, with our support, who will truly make our clinic a home.

VII. Evaluation of Services

The mission of EMHS of Chicago, NFP, is to provide accessible, culturally informed, quality mental health care to communities and their residents through the integration of clinical practice, education, evaluation, and the cultivation of community partnerships. Effective evaluation of our success in achieving this mission must take place along an array of axes. First, it is essential for clinic stakeholders to know how many clients are being served by its programs, and which clients are served by which programs. An accurate accounting of both the number of individuals in our programs and the number of clinical encounters they have had gives a snapshot of our role in the community, the size of our footprint. Included would be basic demographic data about our participants and in which modalities – clinic- and community-based individual, couple or family counseling, psychiatric services, participation in groups, and attendance at one-time workshops, parent education meetings, events and community nights – they were engaged. Further, it is essential to know how deeply these participants have been engaged, as reflected in treatment duration and the intensity of service use. Included among these metrics must be organizational encounters as well as client encounters, reflecting the number of organizations, schools and other community partners we have engaged, including with teachers, faith leaders and collaborative organizations, and the extent and nature of these engagements. We also track the number of students we have trained and their training outcomes.

Another essential measure of our success concerns the extent to which our programs have been of benefit. There are two aspects to assessing the effectiveness of clinic interventions: client progress and client satisfaction. These must be regarded as distinct; often, traumatized clients are most vocal about their grievances regarding treatment relationships, for instance, when they have come far enough in their therapeutic work to have the courage to speak up, sometimes for the first time in their lives. Client progress, the lessening of emotional pain, for example, is assessed by treatment providers, ideally in collaboration with their clients; whereas client satisfaction is assessed through structured opportunities for feedback, including likert-scale ratings of their experiences at intake, of the physical environment and reception, and of the quality and relevance of our programs as a whole. They also invite spontaneous input to staff, and suggestions for service improvement and service opportunities. A responsive clinic takes this client input seriously, replies to communications regarding it, and recognizes that client input is an essential part of resident ownership of the services they have authorized. Meanwhile, there are many standard instruments for measuring the well-being of clients, many of which go beyond the standard symptom checklists to assess the actual quality of clients' lives. These must include assessments of both their physical situations and their internal experiences, and include ratings created by clinic staff regarding the most meaningful parameters of personal, family and community functioning as well as more standard measures. In addition, our new programs are evaluated using a logic model that maps their inputs, activities, outputs, outcomes and impacts. We appreciate this evaluative structure because it tracks events and participants, the changes participants experience, and also community changes over a multi-year horizon.

Our annual program evaluations guide adjustments to our offerings, leading us to re-evaluate marketing, time options, barriers to care, and content. Once issues are identified and feedback is gathered, our team would meet to consider possible solutions for a pilot of adjusted programs. We solicit feedback from community stakeholders and residents to make our programs accessible, appealing and relevant. Because our programs are developed in response to community needs, we have had very few unsubscribed or under-performing Kedzie programs.

VIII. Budget and Narrative

The most essential ingredient of a successful community clinic is its staff. Most of all, we would plan to seek out clinicians who combine compassion, warmth and respect for others with clinical acumen and cultural sensitivity, and who share our vision of how vital a true community clinic can be. Because we offer opportunities for the sort of in-depth therapeutic resources that otherwise tend to be restricted to the well-resourced, we would want our team to appreciate the therapeutic journey involved in intensive, growth-oriented healing, and to have the capacity to think dynamically and interpersonally about clients within the contexts of family, community and culture. We would consider it essential that there be sufficient availability of staff who are able to speak the languages in which our client-base is most comfortable, and we would likewise require that members of our team be thoroughly familiar with the specific challenges that clients from diverse backgrounds, such as immigrants, LGBTQI+, young adults and minority groups, have faced, historically and ongoingly. Further, we would seek out staff who understand that effective community clinical work involves, in equal measure, working within and beyond the clinic walls, with individuals in intensive one-on-one counseling and with groups and community partners.

Our specific staffing requirements are informed both by community need and by the additional resources we bring in light of our existing structure. Our success in overseeing The Kedzie Center, and the fact that the LSAH and Kedzie catchment areas are contiguous and share many cultural characteristics and resources, allows our proposal to make use of existing capabilities to enhance the effectiveness of our staff and services. We envision a structure that would include two half-time positions to be shared across our two centers: An Operations and Finance Manager would supervise credentialing oversight, billing, insurance reimbursement and other financial concerns at the two sites, while the current and founding Executive Director of The Kedzie Center, licensed clinical psychologist Angela Sedeño, Ph.D. (see Appendix), would serve in the ED position over both programs to provide oversight and strategic leadership. In turn, a full-time Site Director would serve at each of the two clinics, and would report to the ED/CEO. We on the EMHS of Chicago NFP Board wholeheartedly endorse Dr. Sedeño for this position. She has been responsible for the lion's share of the Kedzie Center's success, including the creation of a welcoming mental health home for the community, a creative and dedicated staff, and a solid financial basis that includes commitments from large and small donors. Her oversight of grant funding and donations over the last three years has increased from 1% to 6%, and 12% to 15% of our total revenue, respectively, and has led to expanded options for Kedzie, over and above its EMHSP funding.

We have created a staffing plan that would allow us to provide a comprehensive foundation for multi-modal, flexible and intensive clinical work. Most of these positions would be FTE, with the exception of the Child and Adult Psychiatrists and the half-time ED/CEO and Operations and Finance Manager positions described above.

- Marriage and Family Therapist (MFT/LMFT)
- Early Child Development Therapist (MA)
- Staff Therapists (2) MA/LPC
- Clinical Social Workers (2) MSW/LSW
- Site Director/Clinical Supervisor, LCSW
- Child & Adolescent Psychiatrist (MD/APN)

- Adult Psychiatrist (MD/APN)
- Executive Director/CEO (HTE)
- Operations and Finance Manager (HTE)
- Administrative Assistants (2)
- Bookkeeper (PT)

Our experience with oversight of the Kedzie Center means that we have already-developed pathways and contacts for the recruitment of staff, as well as of trainees who can supplement our offerings. We have built strong relationships with diverse educational institutes that graduate excellent clinicians with a broad range of specializations, including:

- The Erikson Institute (early childhood education)
- Institute for Clinical Social Work
- Adler University (MFT, social justice)
- Northwestern University/The Family Institute
- Northeastern IL University Social Work
- Chicago School of Professional Psychology
- Chicago Center for Psychoanalysis
- Loyola University
- University of Chicago, Social Service Administration
- Roosevelt University
- School of the Art Institute

We have been able to locate strong candidates by posting on our website, on LinkedIn, at university job boards, through our colleague networks and community partnerships and on general job boards.

We believe that the provision of in-depth clinical work in a community setting requires a specialized expertise that has been too little supported in training programs and in most clinics. Thus, we view the training of students as both an obligation and an asset to community mental health. We have hosted some extraordinary clinicians-in-training who will, we are certain, go on to contribute greatly and pay our model forward, while our clients have benefitted from their enthusiasm and enhancement of our clinic offerings. These interns and externs have the opportunity to receive consultation both from staff members and from clinicians from across the city who are eager to volunteer their time in order to make a clinical contribution to Kedzie and its community.

Regarding our funding structure, we should note that we would plan to maintain two separate budgets for the LSAH and Kedzie clinics. But this is not to say that the two clinics could not benefit financially from their sibling status. We would expect there to be many advantages to operating the two centers with adjacent locations. Administrative, software and training costs could be reduced by sharing them across locations, and cross-training between the two sites could mean that the staffing burden of training could be shared, providing enhancement to the educational experiences of our trainees while allowing the flexibility to accommodate fluctuating staffing needs. The fact that we have Medicaid and insurance panels in place and have experience in obtaining Chicago Public School vendor authorization for in-school programs would expedite funding to the new clinic. And our already-developed relationships with

foundations, and the development of our dedicated and enthusiastic donor rosters could only be enhanced by our higher profile and greater geographical reach.

Meanwhile, we have experience in working within an EMHS funding context, and have been strategic and economical in our responsible use of funding. We have a history of targeting no less than 91% of our total revenue to direct program services, and 100% of the EMHSP funding to direct services. The funds in our budget that have been allocated to general administration and fundraising are raised through billing revenue and donations, which currently comprise 15% and 14% of total funding respectively. Grants for specific programs or general operations currently constitute 6% of our total funding. As you know, it takes years to cultivate the respect and confidence of granting agencies and major donors, and Kedzie's name has credibility both locally and nationally as a respected and responsible vehicle for those who want their contributions to make a meaningful difference. Donors recognize that the work we do is worth supporting both in itself and as a model that has informed and inspired others to follow the lead of the EMHS Act and its clinics in their own cities.

LSAH PROPOSED BUDGET FY 2021-22

Income	Program Expenses	Fundraising	Gen Admin	Total
Annual Fundraiser Campaigns (Spring 40)	$ 40,000	$ -	$ -	$ 40,000
Billing Revenue	$ 63,750	$ -	$ 10,000	$ 73,750
Bank Interest Income	$ 800	$ -	$ -	$ 800
Consultation/Workshop Revenue	$ 1,500	$ -	$ -	$ 1,500
Donor Contributions (EOY/Misc)	$ 5,000	$ -	$ -	$ 5,000
Foundation Grants	$ 10,000	$ -	$ -	$ 10,000
Governing Commission Direct Services	$ 758,200	$ -	$ -	$ 758,200
Total Income	$ 879,250	$ -	$ 10,000	$ 889,250
Personnel Expenses				
Total Salary Expense	$ 481,746	$ 4,779	$ 12,279	$ 498,804
Payroll Taxes				
SSI (6.2%)	$ 29,868	$ 296	$ 761	$ 30,926
Medicare (1.45%)	$ 6,985	$ 69	$ 178	$ 7,233
IL Unemployment (.675% on first $14,000) @11	$ 1,060	$ 11	$ 43	$ 1,114
Total Payroll Taxes	$ 37,914	$ 377	$ 982	$ 39,273
Total Payroll Expenses	$ 519,660	$ 5,156	$ 13,261	$ 538,077
Employee Benefits				
IRA (3%; estimate based on all employees)	$ 15,590	$ 155	$ 398	$ 16,142
Health Insurance Estimate 6,000 @10 FT employees	$ 58,200	$ 600	$ 1,500	$ 60,000
Guardian Insurance - Dental/STD/LTD	$ 9,175	$ 95	$ 230	$ 9,500
Total Employee Benefits	$ 82,965	$ 850	$ 2,128	$ 85,942
Contract Services - Direct Services				
Child/Adolescent and Adult Psychiatry*	$ 24,000	$ -	$ -	$ 24,000
Oth Providers (Group/Art Therapist, Yoga, childcare, inter	$ 15,000	$ -	$ -	$ 15,000
Total Professional Fees	$ 39,000	$ -	$ -	$ 39,000
Total Personnel Expenses	$ 641,624	$ 6,005	$ 15,389	$ 663,019
Non Personnel Expenses				
Advertising	$ -	$ -	$ 1,000	$ 1,000
Annual Fundraisers	$ -	$ 4,000	$ -	$ 4,000
Billing Bad Debt Expense	$ 15,800	$ -	$ -	$ 15,800
Contract Services - Indirect				
Accountant (Financial Audit)	$ -	$ -	$ 5,000	$ 5,000
Marketing/Branding Consultant	$ -	$ -	$ 3,000	$ 3,000
Board/DEI/ED/AD Consultant	$ -	$ -	$ 6,000	$ 6,000
Grantwriter/Program Evaluation	$ -	$ 5,000	$ -	$ 5,000
IT Consulting	$ 2,000	$ -	$ -	$ 2,000
Phones/Maintenance	$ 15,000	$ -	$ -	$ 15,000
Total Contract Services - Indirect	$ 17,000	$ 5,000	$ 14,000	$ 36,000
Depreciation	$ -	$ -	$ 3,500	$ 3,500
Dues and Subscriptions				
Books, Subscriptions NFG (2400),	$ 1,000	$ 1,500	$ -	$ 2,500
Continuing Education/Professional Devt	$ 1,000	$ -	$ -	$ 1,000
Membership Dues (IPA, ACEPT, CPS, neighborhood specifi	$ 1,000	$ -	$ -	$ 1,000
Total Dues and Subscriptions	$ 3,000	$ 1,500	$ -	$ 4,500
Equip, Rental and Maintenance				
Printer Rental (Zeaport)	$ 2,000	$ -	$ -	$ 2,000
IT Equipment - initial	$ 12,000	$ -	$ -	$ 12,000
Total Equip, Rental and Maintenance	$ 14,000	$ -	$ -	$ 14,000
Insurance				
Directors and Officers (Dasco)	$ -	$ -	$ 1,800	$ 1,800
Data Breach (USLI/Dasco)	$ 1,200	$ -	$ -	$ 1,200
General Liability/Umbrella policy (Travelers)	$ 2,000	$ -	$ -	$ 2,000
SAM Coverage (Insurers Review)	$ 1,600	$ -	$ -	$ 1,600
Professional Liability (Trust)	$ 4,200	$ -	$ -	$ 4,200
Workers Comp (Travelers)	$ 4,000	$ 80	$ 240	$ 4,320
Total Insurance	$ 13,000	$ 80	$ 2,040	$ 15,120

Operations				
Office Supplies/Therapy Supplies (3/5)	$ 7,200	$ -	$ 200	$ 7,400
Postage, Mailings	$ 300	$ 200	$ 100	$ 600
Software/HARDWARE	$ -	$ -	$ -	$ -
Therapy Notes	$ 5,000	$ -	$ -	$ 5,000
DOXY/ZOOM	$ 6,000	$ -	$ -	$ 6,000
Windows/2 DESKTOPS/12 LAPTOPS	$ 1,500	$ -	$ -	$ 1,500
Adobe + Norton	$ -	$ -	$ 500	$ 500
Mail Chimp	$ -	$ -	$ 150	$ 150
Quickbooks	$ -	$ -	$ 1,200	$ 1,200
Square Space Fees/Accelevents (280)	$ -	$ -	$ 500	$ 500
Total Operations	$ 20,000	$ 200	$ 2,650	$ 22,850
Miscellaneous Expenses				
Interest	$ -	$ -	$ 2,750	$ 2,750
Bank Fees	$ -	$ -	$ 300	$ 300
Business Registration Fees	$ -		$ 125	$ 125
Cash Variance	$ -	$ -	$ -	$ -
Donations	$ -	$ -	$ -	$ -
Licenses	$ -	$ -	$ 600	$ 600
Merchant Fees		$ -	$ 1,000	$ 1,000
Reconciliation Discrepancies	$ -	$ -	$ -	$ -
Total Miscellaneous Expenses	$ -	$ -	$ 4,775	$ 4,775
Programs and Community Engagement				
Community Nights/Events (6 x 50)/+MH FIRST AID	$ 1,400	$ -	$ -	$ 1,400
Groups (food and supplies; 10 x 10 wks x $30)	$ 3,000	$ -	$ -	$ 3,000
Bus Passes	$ 500	$ -	$ -	$ 500
Total Programs and Community Outreach	$ 4,900	$ -	$ -	$ 4,900
Space Costs				
Furnishings & Computers	$ 20,000	$ -	$ -	$ 20,000

Maintenance (5hrs @$20 *52 weeks) x2	$ 10,400	$ -	$ -	$ 10,400
Rent Estimate (4500X12)	$ 54,000	$ -	$ -	$ 54,000
Security System (Sentry)	$ 900	$ -	$ -	$ 900
Utilities	$ 10,000	$ -	$ -	$ 10,000
Total Space Costs	$ 95,300	$ -	$ -	$ 95,300
Telecommunications (AT&T, 300/mo)	$ 3,600	$ -	$ -	$ 3,600
Travel_Meetings_Meals_Events	$ 600	$ -	$ 200	$ 800
Total Non-Personnel Expenses	$ 187,200	$ 10,780	$ 28,165	$ 226,145
Total Personnel Expenses	$ 641,624	$ 6,005	$ 15,389	$ 663,019
Total Expenses	$ 828,824	$ 16,785	$ 43,554	$ 889,164
Net Income	**$ 50,426**	**$ (16,785)**	**$ (33,554)**	**$ 86**