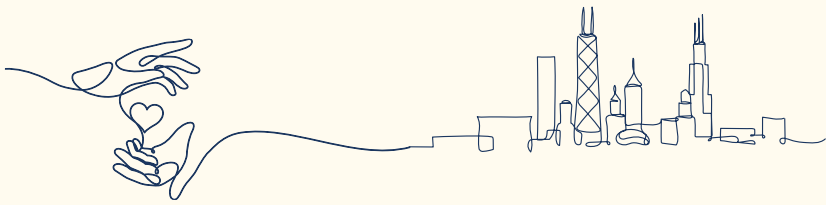
BEYOND CRISIS

SUMMIT REPORT

September 10, 2026

NAMI CHICAGO



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EXECUTIVE SUMMARY

A City That Goes Beyond Crisis

The current systemic approach to support in Chicago for individuals living with serious mental illnesses is a reactive, high-cost "crisis-only" intervention model that prioritizes short-term intervention over long-term stabilization. As a result, a portion of these individuals experience the city and its community through common encounters at hospitals, jails, and homeless shelters. A prior analysis by the University of Chicago's Health Lab of data from 2013 to 2017 estimates that there were 1,232 of these "cycling high users" who regularly experience all three of such encounters. What results for these individuals is the painful repetition of ineffective, inconsistent, and undignified care.

To achieve meaningful recovery, partners and collaborators across our city must pivot from managing acute episodes to architecting proactive systems of care. However, current modalities and resources available to providers and our communities are insufficient and ill-equipped to engage in such a shift on their own. Instead, policymakers, providers, advocates, and people with lived experience must coordinate and collaborate to develop proposed approaches that are sustainable and sensible for Chicago. Through an annual summit and ongoing coalition work, NAMI Chicago's Beyond Crisis initiative will provide the scaffolding and support that's needed for this integrated work so that it may occupy a dedicated space for these efforts.

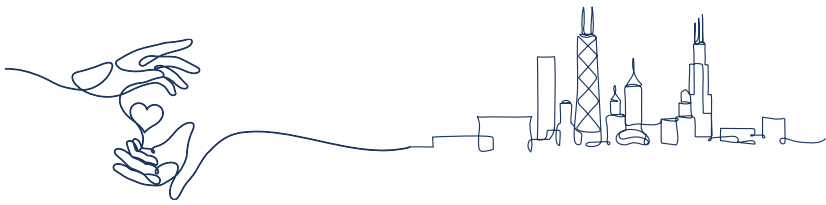
The issuance of this report follows the inaugural Beyond Crisis Summit and precedes the first Coalition meeting. As detailed herein, the Summit articulated this problem statement with a national backdrop provided by Dr. Tom Insel, former Director of the National Institute of Mental Health. Dr. Insel detailed how the current “triage” approach to these chronic conditions is not unique to Chicago but instead the result of a broader inequities and systemic missteps. Further, Dr. Insel equipped the audience and Coalition with a framework of “Three Ps” to adopt and install for its ongoing work:

People: Transitioning from "management" to relationship-centered care where someone continues to show up after the immediate crisis has passed;

Place: Establishing stable, safe environments that serve as the platform for all clinical interventions;

Purpose: Restoring identity through meaningful engagement, whether via education, employment, or community contribution. This shift values the expertise of those who have survived the gaps in our current system, using their insights to design a framework where recovery is defined by "learning to live again" rather than the mere absence of symptoms.

Following Dr. Insel, and at the center of the Summit’s agenda, was a panel of individuals with lived experience who have personally experienced the shortcomings and inequities of the status quo. Each panelist relayed their own journey of recovery in a city that is not otherwise equipped to meet individuals where they are and with what they might need. Each journey featured a distinct personal anecdote of the gaps in care that currently exist and how these systemic barriers have upended a person’s sense of belonging and worth.



The balance of the Summit was dedicated to exploring how Chicago can scale evidence-based solutions for this undertaking. The Summit uplifted existing strategies locally and nationally that support this work. Some presentations included:

- **The Clubhouse Model:** This "community as therapy" approach generates annual savings of $11,374 per member by mitigating isolation and high-cost healthcare utilization.

- **Street Psychiatry:** A concierge mobile clinic approach that provides psychiatric care to unsheltered populations, directly addressing the engagement failure by bringing the clinic to the client.

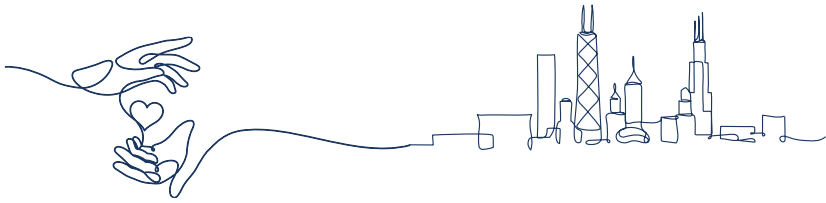
- **Single-Session Interventions (SSI):** Brief, barrier-free supports that mitigate the clinical harm of waitlists by empowering individuals at the first point of contact.

- **Early Psychosis Care:** A clinical model targeting the critical 5-year window of onset and integrating peer support for young adults experiencing early symptoms of serious mental health conditions

- **Dissecting Arbitrary or Systemic Barriers to Care:** Solutions for permanent supportive housing and peer-led stabilization so that individuals have a reliable home and sense of belonging.

The enclosed contents encapsulate more details about these topics and how they might inform the Coalition's ongoing work as well as where there is more opportunity for additional innovations and partnerships for consideration. The 2026 Beyond Crisis Summit served as the catalyst for building permanent collaborative infrastructure for this population. Now, the Coalition will leverage key learnings from the Summit as well as the expertise of people with lived experience to shape its objectives, structure, and priorities for the work ahead.

INTRODUCTION



Every day in Chicago, individuals living with serious mental health and substance use conditions experience cycles of repeated crises. While our public safety, healthcare, and housing systems all seek to intervene at the point of crisis to provide help, these stakeholders often fail to connect people with the specialized care and support they need to recover, which results in a cyclic system of ineffective and incomplete support. The result is a status quo where systems repeatedly intervene as crisis erupts while being unable to provide the timely treatment and supports necessary to support long-term recovery.

The number of individuals who experience a system of care through a crisis-only approach is knowable. In March 2021, the University of Chicago Health Lab released a report on the quantitative data gathered as part of their Roadmap Initiative. This effort was focused on so-called "high utilizers" and was designed to better understand the experience of people experiencing repeated crises and what barriers they encounter. The Health Lab analyzed data sets for years 2013-2017 from the Homeless Management Information System, Cook County Sherriff's Office, and administrative hospital records provided by the Illinois Department of Public Health (IDPH). Across all of these systems they identified a total population of 516,042 during the study period. 2,648 people were identified who interacted with all three systems, and of those 1,232 were labeled "cycling high users".

This study, and others like it, indicate that the number of people who find themselves in these repeated crisis cycles is relatively small. The research found that the population is predominantly male (86%) and Black (84%), most frequently accessed the hospital for causes associated with their mental health condition, and were most commonly charged with crimes related to substance use or survival. These findings reflect the deep persistent inequities within Chicago's health systems, and these neighbors are some of the most vulnerable members of our community.

Despite that previous study and years of efforts, there has been little progress in interrupting this cycle of repeated crises. NAMI Chicago’s Beyond Crisis work aims to build a shared understanding of the challenges we face and to identify proven solutions that can contribute to building the community-based systems of care and support that is needed to prevent, or mitigate, crisis and help people recover. The Summit convened a broad range of stakeholders including people with lived experience, providers, policymakers, funders, and community-based organizations.

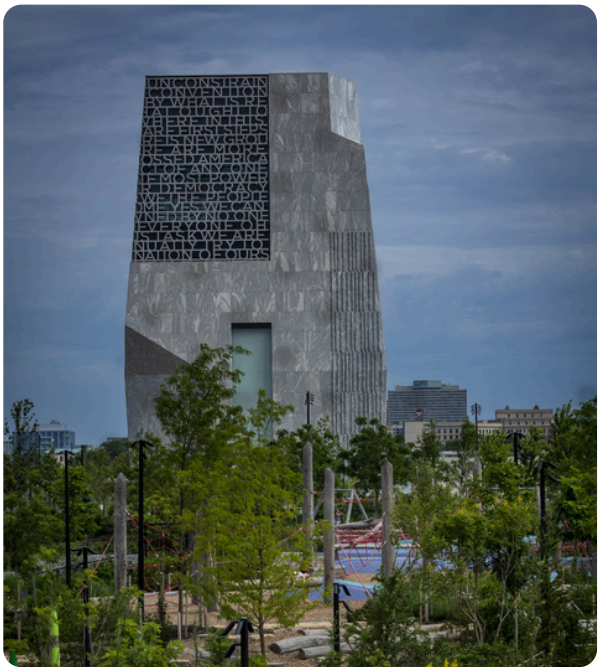
This report summarizes the key takeaways from the Summit that are foundational to the upcoming work of the Beyond Crisis Coalition. Presentation decks and other information are linked here for review. Citations can be found within the presentations along with more information than is summarized in this report.

Those interested in this ongoing work can learn the latest about the Coalition and sign up to participate at www.namichicago.org/beyondcrisis. All are welcome, and all are needed.

WHY DO WE NEED TO MOVE BEYOND CRISIS?

NAMI Chicago's Chief Executive Officer, Matt Davison, set the tone for the day, grounding the "why" of Beyond Crisis in the lived reality of Chicago's fragmented mental health system, particularly for people living with serious mental illness and co-occurring substance use challenges. Matt shared the story of a previous client who repeatedly cycled through psychiatric hospitals, homelessness, and eventually incarceration, illustrating how the current system often responds only when someone reaches a crisis point. Rather than receiving consistent, proactive support, individuals and families are left navigating these fragmented systems with limited resources, long after the individuals' needs have emerged.

Matt's remarks underscore that this status quo is expensive, heartbreaking, and incomplete. A crisis-driven approach can create a revolving door between emergency rooms, inpatient care, law enforcement, jails, shelters, and the streets without addressing the underlying conditions that contribute to repeated crises. He noted that while the status quo remains incomplete, it is fixable. Beyond Crisis is therefore positioned as an opportunity to move beyond this cycle, building a more connected, proactive, and community-centered approach to mental health that supports people before crisis becomes the only point where the system responds.



Together, the Beyond Crisis work is about:

- Exploring how we can go beyond the singular lens of crisis and create a system of care for serious mental illnesses further upstream, before individuals are left unhoused, untreated, and disconnected from their communities.
- Building a comprehensive approach on what to do after a crisis that supports sustainable and meaningful recovery.
- Making better use of our resources, precious public and private dollars are best spent in ways that support recovery and create true value for people living with serious mental health and substance use conditions.
- Valuing lived experience and empowering peer professionals to expand their work and create greater belonging amongst those impacted by serious mental health conditions and their families.
- Advancing policies and community-based care that's able to serve the entire City of Chicago.

Introducing the Beyond Crisis Coalition, Matt highlighted how the coalition is built on the belief that everyone has a role to play in supporting this population and everyone is welcome. NAMI Chicago recognizes that the work ahead is happening in a complicated and uncertain moment, especially as traditional sources of federal funding and support have become increasingly unpredictable, and in some cases, openly adversarial. At the same time, there is a growing rhetoric that frames incarceration and isolation as the simplest answers to complex mental health challenges.

NAMI Chicago believes there is a better way, and we cannot build that future alone. The Beyond Crisis Coalition brings together people with lived experience, providers, advocates, policymakers, funders, and community leaders around a shared commitment to reimagining what is possible. Together, we can build a system that meets people with dignity, connection, and meaningful support — not only when they reach a crisis, but long before it. There is a better way, and we will build it together.

KEYNOTE ADDRESS: DR. THOMAS "TOM" INSEL

Keynote Speaker: Dr. Thomas "Tom" Insel (bio)
Former Director, National Institute of Mental Health (2002-2015)

Co-Founder: Benchmark Health, Vanna Health, Humanest, NeuraWell, Mindstrong Health

Author: *Healing: Our Path from Mental Illness to Mental Health*

Dr. Insel's opening keynote provided national insights about the current care crises, including a call to action for a more holistic approach to behavioral healthcare. Much of his remarks can be found in greater detail in his book, *Healing: Our Path from Mental Illness to Mental Health*.
Challenging the room, Dr. Insel poses a critical question in the context of today's mental health crisis: With so much progress in science (neuroscience, psychological science, molecular biology, data science), why have we made so little progress in clinical psychiatry? Why are we in a national mental health crisis?

Dr. Insel identifies that the current crisis is the convergence of three distinct crises: youth mental health, serious mental illness, and substance use disorder. Rising youth suicide rates, a 20-year reduction in life expectancy, incarceration rates five times higher among people living with serious mental illness, and hundreds of thousands of overdose deaths in recent years demonstrate the profound impact of the mental health crisis across communities. Where these crises converge, is often where people find themselves in cycles of repeated crisis, ER boarding, or other dire outcomes.

Dr. Insel encouraged the audience to think of all of these as a care crisis, including:

- **Lack of Capacity:** States have drastically reduced the number of mental health hospital beds over the past 60 years. Within that time the number of people living with serious mental illness incarcerated in jails and prisons has drastically increased. The lack of capacity in our system for people with serious mental illness directly led to more criminalization and fewer opportunities for recovery.

- **Lack of Engagement:** About 52.9 million people in the US living with a mental health or substance use condition with about 15 million labeled “serious.” 40% of that group received services, 40% of those received minimally acceptable care and 33% benefit fully, 33% get some benefit, and 33% receive no benefit from treatment. Dr. Insel calls this the 40-40-33 rule. For kids, it worsens to the 20-20-33 rule.

- **Lack of Quality:** Less than 50% of patients were not seen 7 days after discharge from a psychiatric hospital, less than 50% of therapists provide evidence-based care, less than 50% of patients with depression or anxiety receive medication, and less than 50% of patients living with serious mental health and substance us conditions receive optimal recovery services.

- **Lack of Accountability:** Dr. Insel spoke to the promise of measurement-based care as a way to create more accountability for providers. He shared data that shows it remains underused with fewer than 20% of practitioners engaged in measurement-based care.

- **Lack of Equity:** Life expectancy, employment, rates of police use of force, and incarceration are all significantly higher for people with SMI than the general population.

In the face of these challenges, there are solutions. In the past five years there has been unprecedented public and private investment in our mental health system. New technologies present opportunities for innovation in research and early intervention. Dr. Insel advocated for a focus on recovery as the core solution to this crisis and delivering the "three P's" people, place, and purpose.

Although many of these problems can be defined as medical, the solutions need to be defined as social, environmental, and political. Recovery requires us to think beyond symptoms and invites us to redefine care, ensuring that everyone has access to the people, place, and purpose that fuel recovery. He identified integrated care, ACT teams, supportive housing, supported employment, family support, clubhouses, and more as existing models shifting our systems toward this recovery lens.

To conclude, Dr. Insel returned to the key question posed at the beginning of his keynote. *With so much progress in science (neuroscience, psychological science, molecular biology, data science), why have we made so little progress in clinical psychiatry? Why are we in a national mental health crisis?*

He answered it in three points:

- We need a different care model: focusing on the 3 P's and not just the traditional medical model.
- We need a value-based payment model: paying for the range of psychosocial rehab services that support recovery.
- We need a different public health model: focusing upstream to preempt crisis and downstream to prevent the next crisis.

LIVED EXPERIENCE PANEL

Panelists: Katherine, Stephanie, and David

Following Dr. Insel's keynote, NAMI Chicago team member, Brenda Bahena, CRSS, led a panel discussion with people with lived experience. The following is her reflection on that panel

It was a summer day in Chicago, one of those 100 degree days. All his belongings were in a trash bag, he had no ID, nothing else; only a will to survive. He reached out for help, in hopes this was the last time. Three years later, he found himself housed and on the road to recovery. He shared his story, alongside two other panelists at the Beyond Crisis Summit, this past July. Sharing your story is not easy, but it was one of the highlights that day.

Lived experience has a way of leaving you with more than information — they are stories that leave you with a feeling and a sense that you have been placed in the day and time of the storyteller. Collecting statistics and years of education can help us understand mental health, but lived experience testimony brings us face-to-face with what it actually means to live through a mental health crisis, navigate SMI), survive day to day, and finding the support needed beyond the initial call for help.

One panelist shared their experience living with a co-occurring mental health condition and substance use disorder, while also navigating seizures, other medical conditions, and prolonged periods of homelessness. Another spoke about living with a mental health diagnosis while experiencing homelessness, managing borderline diabetes, and grieving the loss of a parent. The third panelist shared the experience of being a mother to an adult son living with severe mental illness, whose symptoms disrupted his ability to function safely in daily life and ultimately contributing to situations that led to incarceration.

Seeking help looked very temporary at times. Despite their different circumstances, a common thread emerged: the crisis does not end when someone leaves the hospital, and the need for support does not end when the immediate danger has passed.

For some of the panelists, homelessness lasted more than five years. Managing medications, attending appointments, maintaining physical health, and meeting basic needs became significantly more difficult without stable housing, food, transportation, and a safe place to recover. Even when help was sought, the support often felt it had an expiration date. A person could go to a hospital, receive medication, be asked whether they were suicidal at that moment, and be discharged if they were not—then be expected to figure out how to obtain their next prescription, maintain their health, and navigate life while unhoused.

Even though housing was deemed significant by the panelists because of stability and a place to call home, it was not always available, or it was not the right housing and that matters. Stability is not simply about where someone lives, but whether the environment provides the support necessary to sustain recovery and prevent another crisis.

The panel also highlighted that having family support does not necessarily resolve these issues. The mother who shared her son's story described the challenges families face when an adult child is living with severe mental illness. Families may be expected to provide care and navigate complex systems, even when they themselves do not have the resources, support, or authority needed to keep their loved one safe and stable. When symptoms interfere with daily functioning, the consequences can extend into the legal system, including incarceration, rather than connecting the individual to the appropriate behavioral health supports.

They emphasized the importance of continued connection beyond crisis. A phone call, a consistent person to check in, can make the difference between simply surviving a crisis and beginning to recover. Someone who remembers their name. Someone who understands because they have experienced something similar. Someone who helps them navigate the next step rather than expecting them to figure it out alone. The panelists emphasized the difference it can make when someone continues to show up after the immediate crisis has passed. Recovery was not simply about getting through a crisis—it was about "learning to live again."

Today, the panelists expressed having more hope than they had in the past. At the same time, a feeling of waiting for the other shoe to drop. The experience of being helped for a short period and then left to navigate the next challenge alone can make long-term stability feel uncertain. Their willingness to share their stories was rooted in hope: the hope that another person will not become lost in the gaps between systems, services, and moments of crisis. Yet, at the same time, overwhelmed that someone was interested in their story. Since feeling like no one cared, in the past all of this still feels different.

The panelists were not simply sharing stories. They were bringing expertise to the table — the expertise that comes from living through crisis, navigating systems, surviving homelessness, supporting a loved one with severe mental illness, and finding a way forward. Their stories provided a human understanding of what happens before, during, and after crisis.

They were grateful for a seat at the table. More importantly, their stories reminded us that people with lived experience should not simply be invited to the conversation, they should help shape what happens next.

BREAKOUT SESSIONS

PRESENTATION: THE CLUBHOUSE MODEL WITH FOUNTAIN HOUSE (CONTENT PRESENTED)

Presenters: Ken Zimmerman, Chief Executive Officer, Joshua Seidman, Chief External Impact Officer, Faith Emmanuelle, Advocate

A clubhouse is a community-based location designed to support the recovery of people living with serious mental illness. Each clubhouse provides a restorative environment for people whose lives have been severely disrupted because of their mental illness. It all starts with the idea that "community is therapy."

Fountain House is a national mental health nonprofit fighting to improve health, increase opportunity, and end social and economic isolation for people living with serious mental illness. Founded in New York City in 1948, Fountain House pioneered the clubhouse model of community mental health, an approach shown to promote long-term recovery and thriving while reducing overall health care costs. Clubhouses provide the sense of community that can be the missing link between housing and health, creating the connection and support people need to recover and thrive. Today, Fountain House is leading a national movement to transform mental health care.

The Clubhouse model is:

- A voluntary, nonclinical, evidence-based approach for people living with serious mental illness
- Organized as an intentional community with a work-ordered day and needs members to operate
- Members and staff co-lead units that may include: Education & Employment; Housing; Governance & Leadership; Communications; Culinary; Research
- Fidelity and Flexibility: Core standards and local adaptation, formal accreditation process, and 12 international Training Centers (including Fountain House)

A former clubhouse member and advocate shared her journey to Fountain House, where she found community through affinity groups and the work-ordered day, ultimately reconnecting with advocacy and finding her voice to create change.

The former member's experience reflects what the data shows: clubhouses can reduce loneliness, improve quality of life, and generate significant economic savings.

- 58% of clubhouse members who scored 'lonely' on the UCLA scale became less lonely
- A clubhouse member with average needs represents an annual savings of $11,374, for the about 60,000 current members that represents an annual savings of $682 million. Expanding clubhouses to 5% of all people living with SMI in the US could save $8.5 billion annually.
- After one year of participation, members showed significant improvement across multiple quality of life domains.

Fountain House has been working to expand the model in Los Angeles as part of the Hollywood 2.0 ecosystem. They are tracking early success and believe this model can be adapted to the Chicago ecosystem.

Stay in touch with Fountain House's work in Chicago and learn more here.

PANEL: BUILDING FORWARD WITH RUSH STREET PSYCHIATRY AND NORTHWESTERN'S LAB FOR SCALABLE MENTAL HEALTH

Samuel Jackson, M.D., Street Psychiatrist and Dr. Jessica L. Schleider, Founding Director of the Lab for Scalable Mental Health and Associate Professor at Northwestern University.

This panel explored innovative, prevention-focused approaches to engaging individuals before a mental health crisis occurs or during the early stages of need. Panelists shared how their programs are pushing the envelope in outreach, relationship-building, and service design to better connect with individuals and communities.

Dr. Schleider presented on the work she leads at Northwestern's Lab for Scalable Mental Health, advancing single-session interventions to help bridge gaps in youth mental health ecosystems. These gaps remain significant, and provider shortages are only part of the story. Youth need mental health supports that :

- Are embedded in spaces where they already first seek help
- Empower youth to access care when and how they want it
- Are safe and better than nothing (the most common option) as per rigorous research many existing supports are not

The Lab's mission is to design, test, and disseminate brief, barrier-free interventions to reduce mental health problems at scale to establish a new layer of support for people. One type of intervention is a single-session intervention (SSI). These are specific, structured programs that intentionally involve just one visit or encounter with a clinic, provider, or self-guided program. These may be: accessed once or many times; self-guided or human-led; used in combination with other treatments or standalone; and accessed in or outside of healthcare settings. In all cases, SSIs challenge the often-false assumption that people will return and reinforce the belief that meaningful change is possible at any moment, for anyone.

There have been 24 systematic reviews and 415 clinical trials on SSIs with more than 50,000 participants engaged. In 20 of 24 systematic reviews, SSIs improved mental health or service use and generated notable impact when compared with multi-session therapies. They also demonstrated no differences in effects for online (self-guided), and human-delivered SSI. Dr. Schleider emphasized that SSIs do not replace other forms of mental healthcare, but they can bridge otherwise unfillable gaps in this ecosystem.

Dr. Schleider then reviewed a number of SSI projects currently underway across the globe. Train the trainer models are promising to expansion along with early results showing SSIs can mitigate harms of waitlists. The lab is currently working on implementation of YES 2.0 which is an anonymous and free online SSI toolkit. In Montana, the lab is partnering with and engaging local stakeholders to create and disseminate a toolkit to aid in implementation of the program. This is leading to more training of clinicians and engagement with the tool. More information can be found in the presentation.

Try or share the SSIs at: www.tryprojectyes.org/lsmh or www.schleiderlab.org/ssc.

Dr. Jackson presented on his work in Street Psychiatry and the details of the model Chicago is advancing. Dr. Jackson began by emphasizing that homelessness is fundamentally a housing problem. The lack of safe, affordable housing is a key driver of homelessness across the country. As median rents increase in a city or county, so does the number of people experiencing homelessness. That is not true of poverty rates and shows that this is a housing problem.

According to Chicago's annual point-in-time count, there were 6,527 residents experiencing homelessness with 1,641 unsheltered. Of those unsheltered, 23.7% live with a substance use condition and 27.3% with a mental health condition. Chicago's street psychiatry services span the continuum of needs to meet patients where they are. Low barrier and intensity clients are welcomed to walk-in clinics or engaged in street outreach. High barrier or intensity clients receive concierge psychiatry with two 25 patient teams conducting complete mobile outpatient clinics to help people engage in care.

Those who experience chronic homelessness have a unique experience. Half are living with a substance use condition, one-third live with serious mental illness, and on-fifth live with a personality disorder. The time spent experiencing homelessness is greater and has a higher likelihood of recurring for this population. These neighbors also incur 2.5 times the rate of annual healthcare spending compared to their peers who are housed and covered by Medicaid. Those experiencing chronic homelessness incur significantly more spending on inpatient, outpatient, and medications.

The Chicago Department of Public Health is working in partnership with Dr. Jackson on these efforts. Page 11 of the presentation lays out how this work is structured in the system of care, and lists partners and how they are funded. This ecosystem is designed to engage people, provide needed medications, reduce crisis, and ultimately help people find housing.

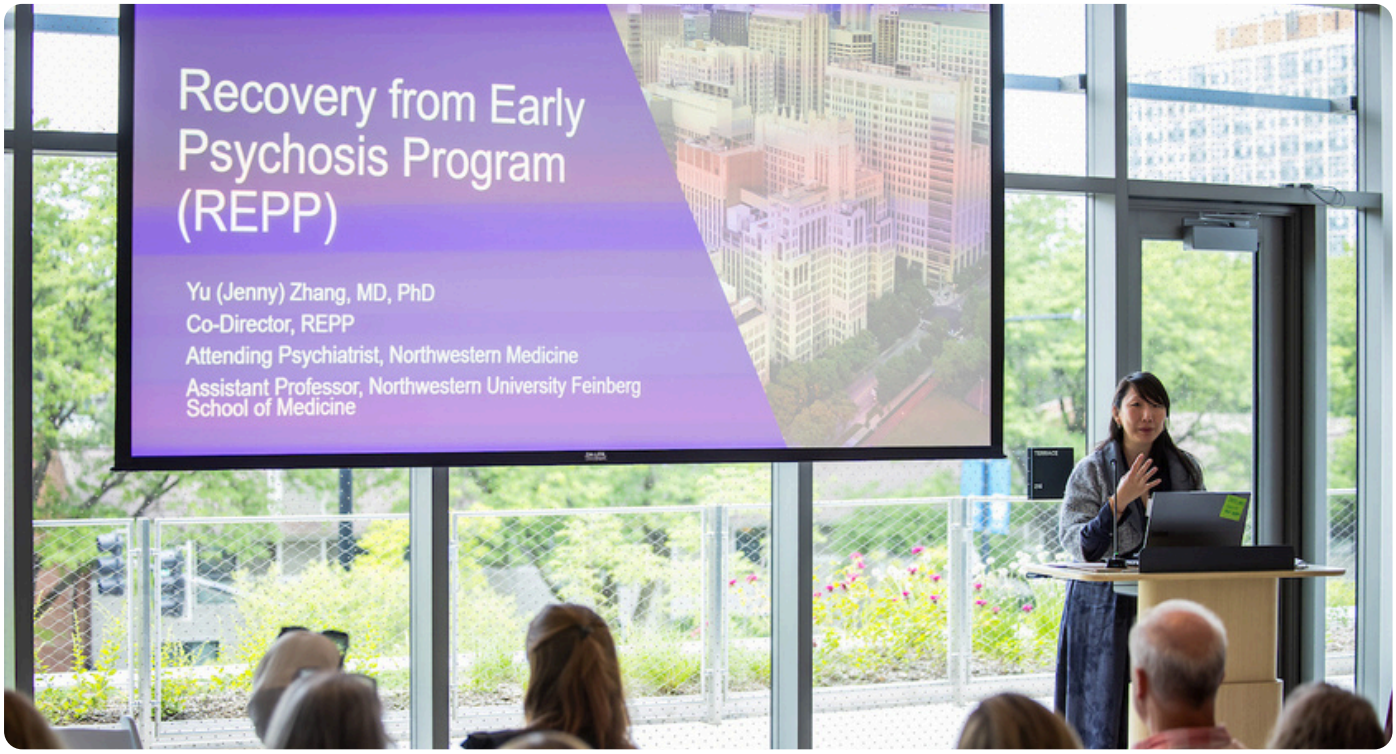
The program needs support from organizations, volunteers, clinicians, and donors who want to get involved. Reach out to samuel.wesley.jackson@gmail.com to connect with the program.

PANEL: EARLY INTERVENTION, FIRST EPISODE PSYCHOSIS WITH NORTHWESTERN MEDICINE AND YALE UNIVERSITY STEP LEARNING COLLABORATIVE

Panelists: Jenny Zhang, MD, PhD, Psychiatrist at Northwestern Memorial Hospital and Co-Director of Northwestern Medicine's Recovery from Early Psychosis Program, and Sumeyra Tayfur, PhD, Clinical Psychologist and Postdoctoral Associate in the Department of Psychiatry at Yale School of Medicine and Early Detection and Assessment Coordinator for the STEP Learning Collaborative

This panel discussed the critical importance of early intervention for individuals experiencing psychosis and how timely, coordinated care can improve recovery outcomes, quality of life, and life expectancy. Panelists detailed innovative models that connect individuals to specialized care within the first three years of diagnosis, pairing clinical treatment with wraparound social services to help reduce recurring episodes and break cycles of crisis.

Dr. Zhang presented her work as the Co-Director of Northwestern's Recovery from Early Psychosis Program (REPP). Founded in 2017 by Dr. Morris Goldman and Occupational Therapist Laruen Walker, the program strives to be youth-centered and developmentally attuned, focused on personal goals and strength, and helping patients be able to recognize signs and symptoms when they encounter challenges.



The program serves people 18-30 who experienced an onset of psychosis within the last 3 years. The conditions treated by the program include schizophrenia, bipolar disorder with psychotic features, schizoaffective disorder, and others. During intake, patients are assessed and connected with needed supports and treatment plans are updated every 6 months until graduation.

The components of the REPP program are listed below. They are funded through a mix of billable services and philanthropic funding.

- Occupational Therapy
- Individual and Family Therapy
- Peer Support
- Employment and Education Support
- Care Navigators
- Medication Management
- Crisis Management
- Family Education and Support
- Health Outcomes Coordinator
- In-house Referrals for neuropsych testing, intensive case management, substance use treatment, and metabolic clinic.

The REPP providers also uses engagement in art and other social activities for group-based therapies. Data is reviewed quarterly and leverages a feedback-driven approach to tailor programming to current participants, including symptoms, functioning, life satisfaction and recovery, utilization of care, and appointment attendance. Care navigators review data with patients and make shared decisions for steps forward.

REPP has served 206 patients since 2017 with 41 patients currently enrolled. Participants are on average 22 years old at the time of intake and currently are staying in the program for 1.28 years. Currently, wait times are 1-3 months from screen to intake and 2-4 weeks from the screening to the psychiatry appointment. 69% of patients are working and/or in school when participating in the program.

Dr. Tayfur presented on the Specialized Treatment Early in Psychosis (STEP) Learning Collaborative. Dr. Tayfur shared why early intervention is so important for people experiencing psychosis. Most of the impacts of the illness are experienced in the first 5 years. The longer a person experiences untreated psychosis, the more likely they become to have poorer outcomes.

Coordinated Specialty Care (CSC) is critical to early intervention. This team-based, recovery-oriented treatment model is evidence-based and proactive for individuals experiencing early course schizophrenia. This intervention emphasizes the importance of having a shared mission and population-specific care, including: young adult focus, family inclusion as standard, rapid access, and assertive engagement. CSCs are growing rapidly across the US, and there are about 350 operating currently.

The STEP Learning Collaborative is a statewide network of care for First Episode Psychosis in Connecticut. There are about 500 new cases of schizophrenia every year across the state. The collaborative works to improve access to care and improve outcomes through informatics, workforce development, stakeholder inclusion, and sustainability. People call or use their online referral form to connect with treatment. They serve anyone 16-35 years old within the first three years of the start of symptoms, regardless of insurance status.

Following the referral, a baseline assessment is completed with appropriate rapid referral to the local mental health agency within their goal of 7 days. Then ongoing collaboration throughout care.

Since February 2024, there have been 711 inquiries into the collaborative with 128 people deemed eligible and 103 admitted to care. 70% were engaged within 7 days, 82% within 2 weeks, and 76% were still engaged for 3 months.

Beyond direct service, the STEP Collaborative engages young people, schools, professionals, and first responders through community outreach, training, and education. They also advance peer support and elevate lived experience, including through their partnership with MindMap to share 24 stories of lived experience. Together, these efforts reduce stigma and help more people connect to timely, effective care and support.

PRESENTATION: IMPLEMENTING PEER AND VOCATIONAL SUPPORT SPECIALISTS IN COMMUNITY MENTAL HEALTHCARE WITH THE TEXAS INSTITUTE FOR EXCELLENCE IN MENTAL HEALTH

Presenter: Vanessa Vorhies Klodnick, PhD, LCSW, Texas Institute for Excellence in Mental Health : Vanessa Vorhies Klodnick, PhD, LCSW, Texas Institute for Excellence in Mental Health

This presentation examined the growing evidence behind the impact of peer support and community connection in mental health recovery, while examining the persistent policy and systems-level barriers that limit the expansion and sustainability of this work. The presentation highlighted strategies to advance funding, strengthen advocacy, and scale peer-led models of care, while addressing the challenges health systems face in integrating peers into professional care settings.

Dr. Klodnick is a Licensed Clinical Social Worker and implementation scientist with lived experience supporting a family member with mental health needs. Her research focuses on mental health and social services for transition-age youth, with an emphasis on multidisciplinary approaches and the integration of peer and social supports.

She began her presentation by engaging the group around their familiarity with the two peer roles at the center of her presentation: Peer Support Specialists and Supported Employment Specialists. Understanding these roles requires recognizing the value of the recovery model alongside the clinical or medical model. At its core, the recovery model is about helping people build a life worth living—not simply the absence of symptoms.

Dr. Klodnick presented the CHIME model of recovery which stands for Connectedness, Hope & Optimism, Identity, Meaning & Purpose, and Empowerment. Non-clinical recovery roles matter in community mental health because they promote recovery and community participation, address workforce shortages, and bring expertise, lived experience, and valuable perspective to the field.

In the traditional medical model, clinical care and the associated improvements to coping and decrease in symptoms lead to employment or social connection and thereby improve quality of life. Dr. Klodnick shared that the recovery model demands that employment and social connection be given equal status to clinical care. That holistic approach leads to improved outcomes.

Dr. Klodnick laid out the two peer roles at the center of her presentation and defined each:

- **Peer Support Specialist Role**
  - A Peer Support Specialist (PSS) is a non - clinical professional role that grew from the recovery movement following deinstitutionalization in 70s.
  - PSSs have Lived Experience: “Personal knowledge about the world gained through direct, first-hand involvement in everyday events rather than through representations constructed by other people.”
  - Peer Support is a practice model with national standards & certifications (SAMHSA, 2023; NRI, 2022).
  - Center for Medicare & Medicaid Services (CMS) recognized Peer Support as a Medicaid billable service in 2007 (MHA, 2017).

- **Supported Employment Specialist**
  - A Specialist who uses “Supported Employment” principles & practices
  - Supported Employment embraces the ideas that:
    - Every person diagnosed with a serious mental health condition can work
    - Extra job readiness training is unnecessary
    - Competitive employment is priority (i.e., at least minimum wage)

- **Individual Placement and Support (IPS) SE** is a “Place & Train” model meaning that people can be placed in jobs in the community with ongoing personal support. This is the most studied SE model. Pg. 14 of the presentation contains links to resources for this model and a list of benefits.

- **Supported Education (SEd)** is designed for post-secondary school engagement among individuals who have completed high school. The approach leads to an increase in access and retention along with improved long-term outcomes.

After sharing this foundational information, Dr. Klodnick underscored what organizations need for proper implementation, professional development, and funding mechanisms. As the field grows, more evidence and resources are available to support the inclusion of peers across systems of care. A key consideration is how to best braid insurance funding with other funding types to ensure the inclusion of peers is broad and sustainable across the field.

PANEL: OVERCOMING BARRIERS TO CARE WITH BRIDGES OF COLORADO, PEOPLE USA AND THRESHOLDS

Panelists: Jennifer Turner, Executive Director of Bridges of Colorado, Kimberly Wing, LCSW, Deputy CEO of People USA , and Mark Ishaug, President & CEO of Thresholds

This panel examined the complex barriers that can prevent individuals with serious mental illness from accessing and sustaining mental health care. Panelists examined how challenges related to housing, care access, system fragmentation, and unmet social needs intersect and impact long-term outcomes for this population. The discussion highlighted how organizations and providers are using care coordination and cross-sector collaboration to address these barriers, where progress is being made, and where gaps still remain.

Jennifer Turner, the Executive Director of Bridges of Colorado presented on their unique program. Bridges of Colorado was created by the Colorado State Legislature as an independent judicial agency. Their vision is for all individuals involved in the criminal justice system to be treated fairly and humanely, regardless of mental or behavioral health challenges. They promote positive outcomes for Coloradans living with mental or behavioral health challenges who encounter criminal justice involvement by fostering collaboration between both systems. They employ 100 liaisons who serve participants and courts across every judicial district. Their teams assess needs, connect individuals to services, and provide courts and attorneys with third-party expertise and expanded options.

In just one year, Bridges of Colorado served 5,746 participants, attended 20,911 court hearings, made 9,237 connections to services, and more for a cost of only $6.28 per participant per day. Bridges practices in a values-driven way that centers participants, recognizes the expertise of lived experience, and uses liberatory practices to promote equity in case management. Pages 10 and 11 provide information about liberatory practices in social work and in the workplace. These help address inequity and transform how care is provided within marginalized communities.

Kimberly Wing, LCSW, is the Deputy Chief Executive Officer of People USA, based in New York. Their continuum of care includes: supportive housing, employment counseling, crisis stabilization, care coordination, and more. People USA also operates Rose Houses, which are 24/7 short-term crisis respites. Guests can stay up to seven days, and they can come and go for appointments, jobs, and other essential needs. They are 100% operated by peers.

Pages 5 and 6 of the presentation share data from their dashboard showing the outcomes related to Rose Houses. The data show strong engagement with people experiencing a crisis, with 83.8% of those served reporting their needs met. People USA values this model because it:

- Builds relationship-centered care that goes beyond tasks and protocols
- Ensures that work is rooted in trust, connection, and consistency
- Honors lived experience and slows down to create emotional safety
- Replaces control with curiosity and builds trust rather than 'manages risk'
- Provides for support wherein peers and guests stay connected after the moment

Mark Ishaug, the CEO of Thresholds, presented on the organization's work to overcome barriers, a core component of their mission. Thresholds oversees over 1500 units in their housing program. These units are funded through a variety of sources, including specialized programs such as Safe Havens and low-barrier housing. They serve specialized populations and provide 24/7 onsite staffing, along with support from outreach teams. Thresholds provides a full spectrum of housing services designed to meet the diverse needs of their community members.

This includes outreach and engagement, emergency housing, permanent housing, and integrated services. Permanent Supportive Housing (PSH) combines long-term housing and wraparound clinical services for people living with serious mental health and substance use conditions. Among PSH residents, there is a 40% decrease in emergency room visits and 150% increase in engagement with behavioral health services. To connect individuals with housing, Thresholds leverages multiple approaches, including direct ownership, master leasing, Continuum of Care (CoC) subsidies, and Chicago Housing Authority (CHA) subsidies.

These programs face potential threats from proposed federal changes to the CoC program, the nation's largest investment in homeless assistance with 38,000+ units in Illinois. HUD is seeking to reduce funding for PSH in favor of less effective transitional housing models. At the time of this report, these changes are not yet in effect and remain under litigation. Amid these challenges, there are also opportunities for innovation. Thresholds recently opened The Glenn in Uptown, a 100-unit single-room occupancy (SRO) building that was preserved as low-barrier housing through an unprecedented public-private funding partnership.

There are three key actions that allow the community to impact Thresholds:

- Invest in permanent housing solutions
- Fund the support systems that make housing work
- Preserve and expand affordable housing options.

With sixty years of experience, Thresholds has shown that housing is where recovery begins. They recognize that access to housing ends the cycle of crisis, creates stability, and serves as a critical component of healthcare infrastructure.

PANEL: CCBHC'S POTENTIAL AND PROMISE WITH THRESHOLDS, TRILOGY, AND THE ILLINOIS DEPARTMENT OF HUMAN SERVICES

Panelists: Dr. Inger Burnett-Zeigler, Chief Behavioral Health Officer at the State of Illinois and Adjunct Faculty at Northwestern University, Sarah Fletcher, LCSW, CADC, Chief Clinical Officer at Trilogy Behavioral Healthcare, and Sherin Khan, LCSW, Chief Strategy Officer at Thresholds

Certified Community Behavioral Health Clinics (CCBHCs) were created to address longstanding fragmentation within behavioral health care by bringing together crisis services, treatment, care coordination, recovery supports, and community partnerships within a more integrated model of care. This panel explored both the promise and the realities of implementation in Illinois, answering "What's working? What remains challenging? And what does this model mean for individuals living with serious mental illness who often cycle through crisis systems, hospitals, homelessness, and the justice system?"

To begin the discussion, Dr. Inger Burnett-Zeigler presented on CCBHCs in Illinois. CCBHCs were established by Congress in 2014. In 2016, Illinois providers received some of the first federal CCBHC grants, alongside providers in 22 other states. Illinois launched its CCBHC demonstration program in 2024 with 19 sites. In 2025, an additional 10 sites became eligible when Illinois was awarded a three-year CCBHC demonstration grant.

CCBHCs are:

- Specialized clinics that provide a comprehensive, coordinated array of integrated mental health, substance use disorder, and primary care services.
- Required to serve anyone who presents for care, regardless of their ability to pay, place of residence, or age.
- Reimbursed under a Prospective Payment System (PPS) methodology to support the array of comprehensive services offered, which is more sustainable compared to traditional fee-for-service models.

There are nine core services that CCBHCs are required to provide. CCBHCs can provide these services directly or establish formal relationships with other providers, known as Designated Collaborating Organizations (DCOs). CCBHCs must directly provide at least 51% of the core services, excluding crisis services.

Dr. Burnett-Zeigler outlined both the strengths and challenges of the CCBHC demonstration. Among its key strengths is the strong statewide commitment to the model, supported by investments in training and technical assistance to help providers build capacity and implement the CCBHC framework. The demonstration has also expanded access to services and treatment modalities, while the Prospective Payment System (PPS) provides a more sustainable financing structure to support the delivery of comprehensive care.

At the same time, the demonstration faces several challenges. Workforce shortages continue to impact providers' ability to meet growing demand and deliver the full range of services. Questions around the level of fiscal investment and the long-term sustainability of funding also remain. Finally, the rapid pace of policy development and implementation has created broader impacts across the behavioral health system, requiring providers to continually adapt to evolving requirements and expectations.

BEYOND CRISIS SUMMIT TABLETOP EXERCISE

"A community is the mental and spiritual condition of knowing that the place is shared, and that the people who share the place define and limit the possibilities of each other's lives. It is the knowledge that people have of each other, their concern for each other, their trust in each other, the freedom with which they come and go among themselves." - Wendell Berry

Too often, social service systems are designed around programs with defined eligibility criteria, requiring people to fit within the boundaries of what already exists. When someone's behaviors, symptoms, identity, or circumstances don't fit neatly within those boundaries, they may be excluded from care and left at greater risk of experiencing crisis and of becoming caught in a cycle of repeated crises.

As so much of the Summit content reinforced, effectively supporting people with the greatest needs requires us to move beyond these silos. A person-centered, collaborative approach, one that brings together people with lived experience, providers, community organizations, policymakers, and other partners, is essential to building a system that can meet people where they are and support them before, during, and beyond crisis.

That's why, after a day of learning, reflection, and connection, NAMI Chicago brought the Summit community together to turn those insights into action.

The Recovery Model

NAMI Chicago's approach to mental health centers on what it means for all people to be well and to sustain that wellness every day. This is a shift from the traditional medical model, which focuses primarily on illness and treatment. Our model builds on the Substance Abuse and Mental Health Services Administration (SAMHSA) framework, which identifies Health, Home, Community, and Purpose as key foundations of wellness. We expand this framework by placing equity at the center, recognizing that access to housing, care, safety, and opportunity directly impacts a person's ability to be well. When equity is present across systems, wellness becomes possible for all.

The Wellness Wheel lays out eight dimensions of wellness. This tool helps us reflect on our wellness more holistically and highlights the broad range of needs that we all must consider to feel our best.

Both of these tools were essential to this exercise because supporting recovery and wellness requires thinking beyond the confines of the medical model and incorporating the things that truly help people feel whole.

The Wellness Wheel

Led by a facilitator from NAMI Chicago, each table received a persona, which described the characteristics and situation of an individual living with serious mental illness, and an activity board, on which participants wrote their responses. First, tables filled in the blanks of the personas and ensured they had a complete enough profile to find solutions. Participants were tasked with thinking of innovative solutions to prevent and break cycles of hospitalization and incarceration for their persona. To guide this process, the activity board was divided into the five dimensions of the recovery model: home, health, community, purpose, and equity.

RESPONSE REVIEW

The big question: How could we best support this person's recovery and wellness?

Review the personas

Each table's activity board was collected, and responses were reviewed and recorded. Tabletop facilitators from NAMI Chicago also shared notes about themes and experiences with the tabletop activity. The information collected through these activities informs this report and will serve as the starting point for the Coalition work. We will continue expanding and defining these dreams for a better system as our work moves forward.

PERSONA CLARIFICATIONS:

A NAMI Chicago facilitator asked each table to read through their assigned persona and to be curious about what additional information they need so they can create a complete picture of a person and inform what would support their recovery. The word cloud below shows how the different tables added to the assigned persona.

Beyond Crisis Summit attendees were certainly looking for more history than we could provide in a short scenario. Some tables decided on various details of their person's health or family of origin to inform their work. There was also a focus on strengths, behaviors, interests, and creating a more complete person to think about in the exercise. Overall, the group reflected back the core message of so many of the presentations at the Summit. Namely, that in order to truly support the recovery of people experiencing repeated crises, we must address not only the medical needs but think more holistically about those we seek to help and how we can best support them.

Once participants had a more complete understanding of their person, they proceeded to discuss each pillar of the recovery model and brainstorm what policies or programs would best support their recovery

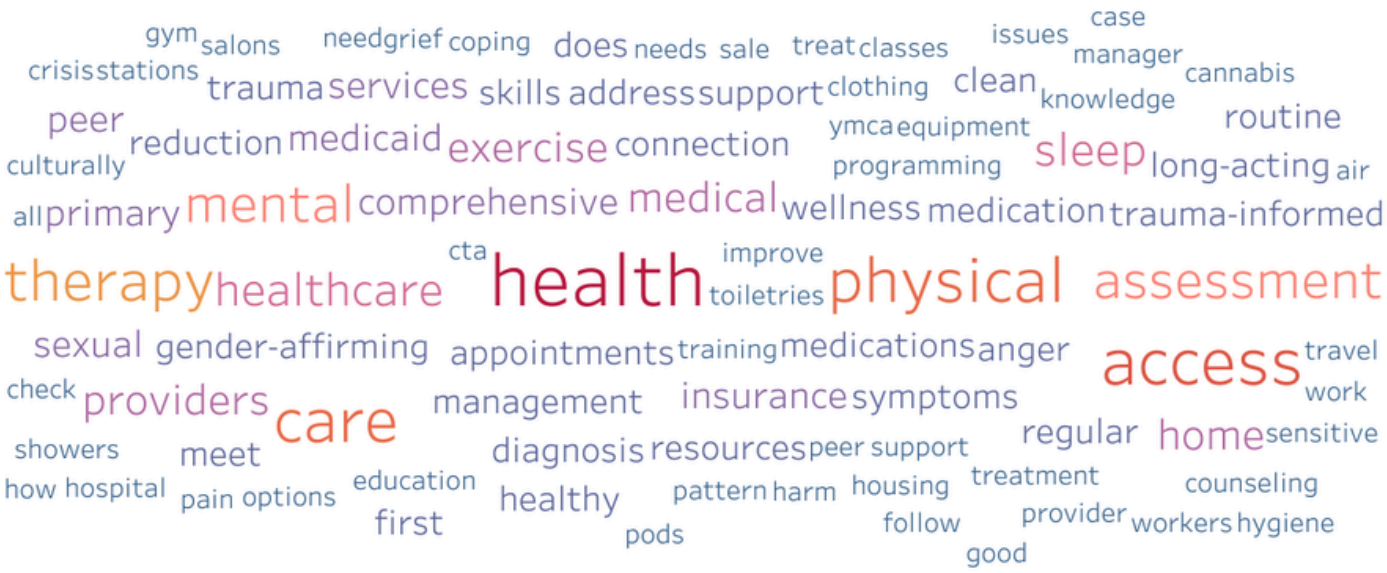
HOME

It seems obvious that housing is at the center of this word cloud. However, groups recognize that it is not simply having a roof over a person's head. The location of housing matters for access to healthcare, social, and other services, as well as a feeling of belonging in a particular community. Safety is also a key concern. If a person doesn't feel safe in their living situation or neighborhood, that drives the risk of falling back into a crisis or other negative outcomes. Tables also pointed to the importance of supportive and long-term housing options. It was important to many that people not simply be provided with a place to live, but that there were supports connected with that housing.

Eligibility was also a key concern. For many of our personas, they were experiencing symptoms or behaviors that might exclude them from available housing options. This is a barrier regularly encountered today that leads to repeated crises. Providing housing options that can properly support people with behaviors that are often excluded from other programs is a key consideration.

Options or choice also came up multiple times at various tables. Providing people with choices not only ensures a better fit, but also allows an individual to exercise their autonomy and feel a sense of ownership of their life. Often, systems will assign whatever unit is available in a kind of "take it or leave it" condition. This can be harmful and extend how long people experience homelessness.

HEALTH



As in housing, the biggest word in this group is health. As we consider the other words in the cloud, we see what groups believed would actually support health. Access to care is essential, of course, but not just any care. Tables pointed out the need for quality assessments, collaborative care models, peer support, and specialized medications like injectables. Groups also pointed to non-medical health supports that are needed. Access to clothing, transportation, laundry, and facilities to tend to personal hygiene were seen as important to supporting health.

Groups also identified the need for gender-affirming, culturally humble, and trauma-informed care. In crisis systems, we make an error when we treat everyone the same. We are, in fact, not the same. While evidence-based standards of care and best practices have to be present, tables highlighted that it is essential that systems be flexible and have enough resources to meet people where they are. Building healthcare systems that are flexible enough to affirm and provide the best individualized care is paramount to ensuring that all of our neighbors have the best opportunity to recover.

COMMUNITY

The work on the community pillar centered around a few different ideas. First, tables identified the importance of connection to friends and family as hugely important in this pillar. For so many of us, those are the primary support relationships we have and helping people reconnect or more deeply connect with their loved ones helps provide a sense of community. Family education is also important, so families feel like they are equipped to help their loved ones in crisis. Families empowered with greater education can be a key driver of moving our system from reactivity to proactivity, and provide greater opportunity for early intervention.

We know, though, that friends and family are not enough. Often, when people experience a crisis, systems will place the burden on family or other close friends to look after a person in the community. Most people don't know how to approach this and it can lead to recurring crisis or damage to social connections. Tables emphasized the importance of peer support in creating a sense of community. Whether at a clubhouse or somewhere in the community, peers help reduce stigma and demonstrate that healing and recovery are possible to achieve.

Tables also highlighted the importance of existing spaces in community where people might receive support.

Houses of worship, parks, salons/barber shops, and other community locations were seen as places where people might make connections. Building the confidence of these community anchors to engage with and support people living with serious mental health and substance use conditions can build a greater sense of belonging and grow the network of supports available. The investment in bolstering these community anchors to provide support, would allow for more prevention and support without the creation of new interventions.

PURPOSE

Employment was the central theme of the purpose pillar. Having work and income not only leads to greater financial security, it also uplifts our sense of purpose, and allows people the opportunity to grow. Advancing supported employment where people receive help getting started and persisting in work was broadly supported. Tables also identified training or volunteer opportunities as a way to provide a similar sense of purpose to those who are not able or not yet ready to work.

Tables were interested in expanding available opportunities to work. There can still be a significant amount of stigma among employers. Working collaboratively with employers across our economy to educate on the benefits of supported employment and create more jobs open for people experiencing a mental health or substance use condition can help open more options for job seekers.

Finally, tables called out the opportunity for social engagement and hobbies to also provide a sense of purpose outside of employment. In cases where a person is not yet ready or able to work, having community-based hobby and social opportunities is one way to provide a sense of purpose and belonging to people. The Clubhouse model provides some of these opportunities and was mentioned as a program that should be considered for Chicago.

EQUITY

Like the health pillar, access once again appears in equity. This is because of the profound access issues related to stigma and other forms of discrimination that impact how people with serious mental health and substance use conditions are treated. We see clearly that the criminal legal system creates a host of equity barriers for people experiencing repeated crises. Mainly, rather than be engaged positively, we too often rely on the negative reinforcement of courts or jail to create the space for treatment. Most tables indicated that supports were needed outside the court system to make care more accessible and move people away from incarceration or other legal consequences.

Transportation is another key equity concern. Chicago's transit and access to vehicles depends greatly on the neighborhood. For people without reliable access to transportation, engaging in recovery becomes more time-consuming and expensive. Providing transportation and other financial supports people need can reduce inequities and enable better engagement in treatment and supports.

KEY THEMES

When we consider the results of every table, key themes emerge that will serve as a starting point for the Beyond Crisis Coalition's work.

- **Access is essential.** If we consider the challenge of repeated crises in Chicago, we quickly see that accessible options are in short supply. The ability of people to access effective and quality specialized support must be at the forefront of this work. Cost is also a factor here and services must be no or low cost, particularly in the early stages, to ensure people do not encounter financial barriers.

- **Peer support must be included across the components of a successful system.** Lived experience has no substitute. Another person freely sharing what they have been through and listening to your story not only better supports the emotions of the person getting help, but also improves health, financial, and social outcomes. The clubhouse model made an impression on our attendees, but it is not the only model. The priority is to create a sense of connection and community to promote recovery and wellness. Sustainably funding and scaling peer support is essential to this work.

- **Education is fundamental.** Not only psychoeducation for the individual, but similar education for families, caregivers, and other providers as well. The groups believe that in many cases, people do not have the best information or a strong understanding of their diagnoses or what systems or supports are available. More regular education, particularly centered on the goals of the person or family is a need called out at many tables.

- **Building autonomy and encouraging people to act on their own behalf has to be prioritized.** The ability to make one's own decisions builds self-confidence and improves a person's engagement with recovery. For people experiencing repeated crises, systems often seek to remove autonomy to protect safety, limit liability, or ensure manageable operations. These actions are understandable, but can be harmful to people and even degrade trust and limit a person's willingness to engage in recovery. The focus on autonomy extended to acknowledging the need for gender-affirming and other identity-affirming care. Policies and programs that support autonomy to the greatest extent possible and extend dignity and respect to people can promote greater equity and increase the likelihood of engaging with care and supports.

- **Integrated or collaborative care was almost universally identified as the best option for providing care.** Given that many people experiencing repeated crises are experiencing physical health conditions, there is a need for comprehensive care and not simply mental or physical healthcare. Tables wanted more options where multi-disciplinary teams either work together directly or consult to ensure that a person is receiving a full range of support.

BEYOND THE SUMMIT: WHAT'S NEXT?

The Summit was only the beginning of the work of the Beyond Crisis Coalition. This Coalition will remain focused on community members who are experiencing repeated crises. Together, we will continue connecting with local and national experts to explore this topic and advance policy and program solutions that will reduce suffering and related costs across our systems. You can join the Coalition and stay connected to this work at namichicago.org/beyondcrisis.

At NAMI Chicago, it is a privilege to be able to connect and provide support to the mental health of our community. We are grateful to our sponsors for the Beyond Crisis Summit:

BEYOND CRISIS SUMMIT REPORT

Published September 2026

NAMI Chicago works to improve the lives of people affected by mental health conditions through support, education, advocacy, and community-based solutions.

Learn more: namichicago.org
Contact: info@namichicago.org
NAMI Chicago Helpline: 833-626-4244

224 W. Hill Street, Suite 410
Chicago, IL 60610

NAMI CHICAGO