Report & Toolkit

YOUTH HEALING CHI

A CALL TO ACTION FOR MENTAL HEALTH LIBERATION IN CHICAGO PUBLIC SCHOOLS

TABLE OF CONTENTS

WHO WE ARE

THE YOUTH HEALING CHI CAMPAIGN

The Youth Healing Chi Campaign is a citywide campaign created by young people, for young people. We are demanding a world that chooses care over punishment and healing over harm. We have an opportunity to develop a new vision of care and wellness outside of these carceral approaches by listening to, affirming, and following the lead of our young people and communities. Together, we are building the future we deserve.

Brighton Park Neighborhood Council (BPNC) is the leading organization for the Youth Healing Chi campaign. BPNC is an intergenerational community-based organization dedicated to equity and racial justice. Our mission is to improve the quality of life for the working-class and immigrant populations of Chicago's southwest side through grassroots organizing and providing free and accessible social services and quality programs for youth and adults. BPNC helped lead fights to get police out of Chicago Public Schools, fight for increased and sustainable funding for public neighborhood schools, and organize to reopen closed public mental health centers and establish a city-wide non-police crisis response. We will continue to lead fights alongside youth for an abolitionist future.

The campaign also includes the following organizations:

- **Asian Americans Advancing Justice Chicago (AAAJ)** builds power through collective advocacy and organizing to achieve racial equity, focusing on issues of education equity, immigration justice, and public safety.
- **HANA Center** is a community organization that empowers Korean American and immigrant communities through education, civic engagement, and advocacy.
- **Jewish Council on Urban Affairs (JCUA)** organizes Jewish communities of Chicagoland in pursuit for racial and economic justice.
- **Palenque LSNA** is a multi-issue community organization with a mission to create just and resilient futures through a focus on education, immigration, and housing equity.

The campaign is supported by **Advancement Project**, a racial justice nonprofit organization dedicated to building local power in communities of color across the country. We wholeheartedly believe in the genius of ordinary people to achieve lasting and permanent change and envision a future where people of color are free - where they can thrive, be safe, and exercise power. Our efforts to build power and dismantle racism focus on three issue areas: education justice, voting rights, and policing & decriminalization. One of the pioneers in the movement to end the school-to-prison pipeline, we fight for access to quality public education and police free schools.

REPORT AUTHORS

Noelia Rivera-Calderón (they/them) is an educator, movement lawyer, Practice Professor of Law and Director of the Law & Public Policy Program at Temple University Beasley School of Law. A former middle school teacher with nearly 20 years of lived experience of the mental healthcare system, much of their research and advocacy has focused on the intersection of K-12 education and mental health, particularly its impacts on those multiply marginalized. Noelia has spent their legal career supporting the development of abolitionist and liberatory mental health campaigns like the Youth Healing Chi campaign through education, research, policy development, and strategic support.

Hailey Collins is a law student at Temple University Beasley School of Law, where she serves as a Research Assistant to Noelia Rivera-Calderón and a Teaching Assistant in the Law & Public Policy Program. Her academic interests focus on constitutional law, democratic governance, and legal theory, particularly how foundational legal principles shape the design and accountability of public institutions. Through her work on this report, Hailey examines how those broader legal frameworks manifest in everyday systems such as public education, student safety policies, and access to mental health resources. Her contributions include legal research, policy analysis, data synthesis, and report design.

EXECUTIVE SUMMARY

As we write this at the end of 2025, our youth have just lived through months of Chicago under siege. They have seen their family members and community members attacked and kidnapped. They have come together in community to support each other, protect each other, and work for a better future–while finding healing wherever they can. We believe that our public schools, as a community institution and public good, are more than a place to receive instruction. We believe they must be sites of healing.

However, our analysis of Chicago Public Schools (CPS) crisis response policies found that these policies treat youth as risks–potential liabilities–more than they treat them as people deserving of self-determination and healing. District policies are designed to identify youth in need of intervention through both undefined screening procedures and the use of digital surveillance. The default response is then to initiate the SASS protocol (leading to psychiatric hospitalization) or involve law enforcement–even against the student or family's wishes. Against all evidence-based practice, hospitalization and policing become a first resort, not a last resort.

Part of the reason hospitalization becomes the go-to response is that other options are not widely available, including access to in-person 1:1 counseling. Students also lack access to the many holistic options that create a culture of healing, including opportunities for therapeutic arts and cultural programming and non-clinical peer support models. But there are not enough investments in those options; CPS instead views youth mental health as someone else's problem.

CPS has an opportunity to be national leaders for youth mental health liberation. The district has already made significant strides in ending school policing and the development of more "healing-centered" and holistic school safety policies is ongoing. It must now build on this by investing half of the past $30 million allocated to school police *yearly* in additional student mental health support: both clinical and holistic peer-led options. And it must ensure these efforts are not undercut by maintaining harmful, carceral crisis response policies.

This report analyzes current CPS crisis response policies and lays out a youth-led roadmap for mental health liberation. Beyond investments in youth mental health support, the Youth Healing Chi campaign calls for reforming the crisis response protocol and ending all policing in mental health crisis response. It also calls for a larger cultural shift in how we approach mental health: not through the lens of risk and liability, but through the lens of healing and self-determination for youth and families. It includes a toolkit so that students can protect their rights while, together with educators and community partners, they fight for systemic change.

KEY TERMS

CARES and SASS

Crisis & Referral Entry Services (CARES) is an Illinois statewide crisis hotline and the entry point to the SASS system. Screening, Assessment, & Support Services (SASS) is a statewide crisis care coordination system for children whose mental health crisis care will require public funding.

CIT (CRISIS INTERVENTION TEAM):

Also called the "Memphis Model," CIT is a model and training program through which law enforcement officers provide mental health crisis response with the goal of diverting from jail toward mental health treatment (including involuntary hospitalization). The total training for officers is 40 hours.

DIGITAL SURVEILLANCE:

In schools, this is the monitoring of youth behavior through digital tools. In this report we focus on tools like student monitoring software and systems, which can include social media monitoring and/or monitoring of school devices.

INVOLUNTARY HOSPITALIZATION:

The confinement of a person in a psychiatric facility or hospital psych ward against their will. It typically begins with a brief emergency hold period. The laws that allow for this are called "civil commitment" laws. This is also called: forced treatment, psychiatric detention, involuntary commitment. These terms are all used in this report.

PEER:

In the context of mental health, a "peer" is someone who has lived mental health experience in some way. Peer support as a model for mental health care is the result of longtime organizing and advocacy by movements of those harmed within the mental healthcare system.

SUICIDAL IDEATION:

Thinking about suicide. This can range from passing thoughts to more detailed plans.

CHICAGO YOUTH MENTAL HEALTH BY THE NUMBERS

CHICAGO YOUTH ARE SUFFERING.
IN 2023, DATA FROM THE YOUTH RISK BEHAVIOR SURVEILLANCE SURVEY (YRBSS)[1] SHOWS:

Youth most likely to experience hospitalization:[3]

- Youth 15-17
- Girls
- Black youth
- Youth using public funds (i.e. Medicaid)

40%

of Chicago high schoolers were persistently sad or hopeless

16%

of Chicago high schoolers seriously considered suicide

7%

of Chicago high schoolers attempted suicide

33%

of LGBTQ Chicago youth seriously considered suicide.

20%

of transgender Chicago youth attempted suicide.

53% of Chicago girls + **63%** of LGBTQ students

reported feeling persistently sad or hopeless.

50%

Mental health accounts for **half** of Illinois youth hospitalizations[2]

2,896 : 1

STUDENT TO FULL-TIME EQUIVALENT (FTE) SOCIAL WORKER RATIO IN CPS[4]

The national recommendation is 250 to 1. Some students prefer to speak to a social worker to get 1:1 mental health counseling, which is typically outside the scope of a school counselor's more academically oriented role.

WHAT LEADS TO CHICAGO YOUTH BEING HOSPITALIZED?

Illinois youth mental health hospitalizations are overwhelmingly for "mood disorders," *not* suicide attempts.[5]

Hospitalizations have sharply increased since before the Covid-19 pandemic, even with a 10% decrease in hospital beds. 10% of stays are longer than 2 weeks.[6]

Youth going through SASS (using public funds) are 3 times more likely to be hospitalized than youth with private insurance.[7]

The Illinois Department of Public Health acknowledges the rate of hospitalization does not need to be so high, but argues there are not enough outpatient options, so youth can end up experiencing unnecessary inpatient care.[8]

Meanwhile, many youth "in crisis" could benefit from having nonjudgmental adults who are there to listen and provide support. These may be in-school clinicians or those who provide holistic healing-centered programming.

The question must be, **"How can we support you?"**

HOW CPS DEFINES "CRISIS"

CPS defines crisis as a "traumatic incident that disrupts school functioning."[9]

School functioning is broadly defined. Rather than a focus on the individual's needs, the emphasis is on the functioning of the school as a whole and minimizing "disruption."

The examples of crisis include everything from deaths to natural disasters to medical emergencies,[10] all of which may require very different responses.

What is a School Crisis?

A school crisis is a traumatic incident that disrupts school functioning. Crises can be sudden, unexpected, or unanticipated. They can affect one individual or the entire school. Crises can occur before, during, or after school and on or off school grounds (Brock, 2002).

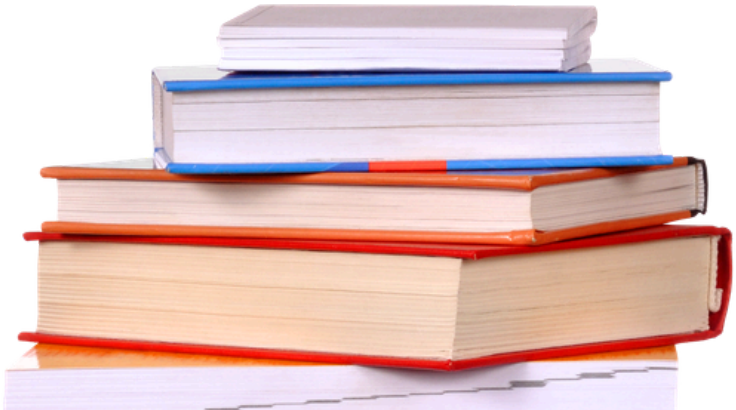
School crises affect all areas of school functioning including attendance, learning, and behavior. During a crisis, school resources can become overwhelmed and additional support in the form of "crisis intervention" might be required. Crisis intervention refers to a set of responses that schools can plan and implement to mitigate any disruption of school functioning caused by a crisis incident. These interventions are designed to address the emotional needs of the school community and facilitate a return to pre-crisis levels of functioning (Brock, 2002).

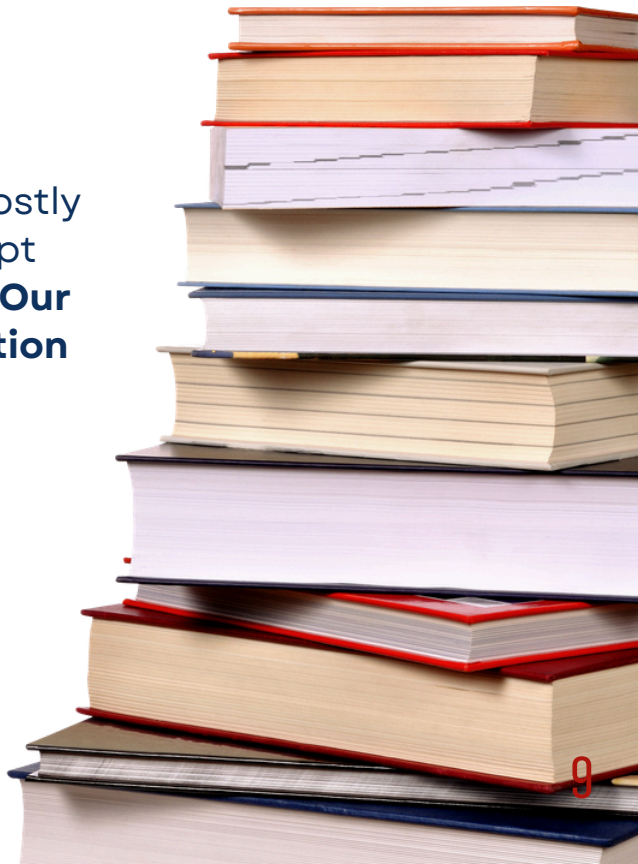
Examples:

- Student fatality or staff fatality
- Suicide ideation, attempt, or completion
- Homicide ideation, attempt, or completion
- Natural disaster
- Medical emergency
- Vehicular accident
- Abuse or neglect
- Non-fatal shooting

- Chicago Public Schools Crisis Management Manual (2024 Update)

But the crisis protocol itself—the rest of the interventions outlined in the guide—focuses mostly on **suicidal ideation** or (less commonly) attempt and, less so, on homicidal ideation or attempt. **Our analysis similarly focuses on the suicidal ideation or attempt protocol.**





REFRAMING "CRISIS"

ARE THERE OTHER WAYS TO THINK ABOUT CRISIS?

Movements of people who have experienced mental health crisis sometimes describe crisis differently: rather than a "return" to before the crisis, it can be an opportunity to break through the conditions that led to the crisis, with support. **What better place to give some of that support than an institution of education?**

> *The word "crisis" comes from a root meaning "judgment." A crisis is a moment of great tension and meeting the unknown. It's a turning point when things can't go on the way they have, and the situation isn't going to hold.* ***Could crisis be an opportunity for breakthrough, not just breakdown?*** *Can we learn about each other and ourselves as a community through crisis? Can we see crisis as an opportunity to judge a situation and ourselves carefully, not just react with panic and confusion or turn things over to the authorities?*
>
> - The Icarus Project, *Navigating Crisis*[11]

> *In spite of the fact that many traditional theorists have viewed crisis as an opportunity for growth and as an essential experience in the context of one's development (Erikson, 1976), we in mental health want to medicate it, lock it up, and restrain it. We have forgotten that perhaps there is something we can learn from this experience, something that will enable us to "do" it differently and understand ourselves in new ways... As people practice new ways of "being" through even the most difficult times, possibilities for breaking old patterns and creating new opportunities are endless.* ***Crisis then just becomes another word for redefining our experience and ourselves so that instead of needing to be locked up, we can begin to break free.***
>
> - Shery Mead, "Crisis as an Opportunity for Growth and Change"[12]

THE PROBLEMS: CPS MENTAL HEALTH POLICIES

PROBLEM 1: HOW SCHOOLS IDENTIFY STUDENT MENTAL HEALTH CONCERNS

Student mental health concerns can be identified by staff, online surveillance, or screening. Each of these processes leads to potentially harmful interventions.

Here's how they work.

IDENTIFICATION

Student mental health concerns can be identified through **staff, digital surveillance,** or **formal screening**. There is **no publicly available, comprehensive CPS-wide policy** that specifies which screening tools are required in each school, when they must be administered, or how results must be documented.[13] This means implementation varies widely by school, staff training, and interpretation. Open-ended identification pathways can lead to harmful interventions.

DIGITAL SURVEILLANCE OF STUDENT MENTAL HEALTH

In some CPS schools, students' online behavior is monitored by a private company called **Safer Schools Together (SST)**. This company conducts **Digital Threat Assessment (DTA)** on students' public social media activity.[14] This system was designed to identify possible safety risks. However, its methods and effects raise serious concerns.

HOW IT WORKS:

SST uses a method called **Digital Threat Assessment (DTA)** to review students' public social media activity. This includes content posted on platforms such as TikTok, Instagram, Snapchat, and Facebook. SST staff (Threat Analysts) are trained to look for signs of behavior they consider "worrisome."[15]

KEY POINTS:

- SST does not use automated software or artificial intelligence to flag posts. Instead, Threat Analysts use search filters and location tracking to review public posts.[16]
- Analysts apply a model called **Behavioral Threat Assessment (BTA)** to decide if a student should be labeled a **"Subject of Concern" (SOC)**.[17]
- While most SST flags relate to firearms, students are also flagged for categories like **"mental health concerns," "suicidal ideation,"** or **"non-suicidal self-harm"**.[18]
- SST does not explain which specific behaviors trigger these labels. There are no clear public criteria for what qualifies as a flag-worthy post.[19]
- Once flagged, a student's digital activity is used to create a "digital baseline" meant to track patterns over time, though the criteria for this baseline remain undisclosed.[20]

WHY THIS MATTERS:

Data from SST's 2023–2025 reports show that **Black, Latinx, and low-income students are flagged more often**, particularly in schools on Chicago's South and Southwest Sides.[21] Selective enrollment schools with majority-white or higher-income populations are flagged less often, despite comparable enrollment figures.[22]

REGIONS OF CHICAGO →

↓ SCHOOL DEMOGRAPHICS / (TITLE OF FLAG)

	South	SW	NW	North	Downtown	West
% Black/Latinx	98%	88%	74%	41%	40%	33%
% of Low Income Students	93	85	67.3%	50.5%	35%	39%
# Flags per School	8.0	6.7	4.7	1.5	2.0	0
"Mental Health Concern"	6	3	1	0	0	0
"Suicidal Ideation"	4	3	0	0	0	0
"Non-Suicidal Self Harm"	2	2	0	0	0	0
Totals:	**12**	**8**	**1**	**0**	**0**	**0**

There is **no publicly available CPS policy** that explains:

- When an SST-flagged student should be referred for support;
- Who decides the appropriate response or what that response will be;
- What behaviors justify escalation; or
- Whether the student has a right to know why they were flagged.

SCREENING

Student mental health concerns can also be identified through formal screening tools. While mental health screening will be offered to all children in grades 3-12 by 2027,[23] CPS does not currently have a publicly available, districtwide standard detailing which screening tools schools must use or how they should be administered.[24]

CPS provides **no transparent districtwide policy** identifying:

- which tools schools must use,
- how often screenings should occur,
- who is authorized to administer them, or
- how results should be stored or used.[25]

CPS also did not respond to an Illinois State Board of Education's request for information about the screening practices they use, but indicated "partial" screening implementation in a follow-up meeting.[26]

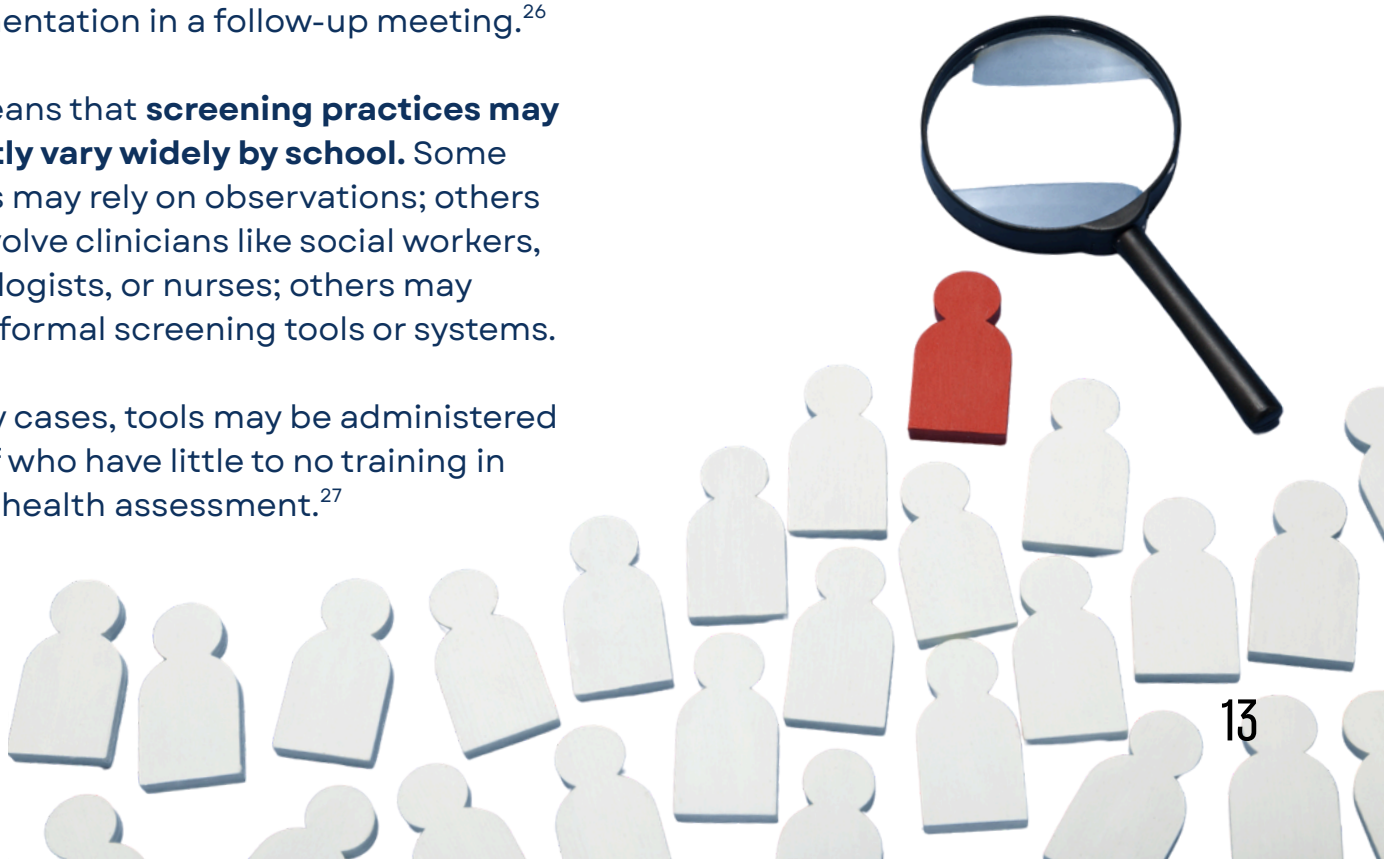
This means that **screening practices may currently vary widely by school.** Some schools may rely on observations; others may involve clinicians like social workers, psychologists, or nurses; others may involve formal screening tools or systems.

In many cases, tools may be administered by staff who have little to no training in mental health assessment.[27]

This inconsistency matters because screening tools carry different purposes, thresholds, and risks.[28] The lack of public knowledge of which screening tools are used is itself a concern.

Without clear CPS guidelines, any tools used may also be misapplied or used without adequate follow-up.[29] Mistakes in administration or interpretation can lead to **unnecessary referrals, inaccurate "risk" labels,** or even **escalation into crisis pathways.**

Where there is **significant discretion** in student mental health related identification, this discretion can often mirror existing racial discipline disparities and school surveillance patterns that shape who is screened, who is flagged, and who is pushed into crisis response.



PROBLEM 2: HOW SCHOOLS RESPOND TO YOUTH MENTAL HEALTH

CRISIS TEAM INVOLVEMENT

CPS' Comprehensive Mental Health and Suicide Prevention Policy, adopted by the Board of Education in 2022, requires schools to use the CPS Crisis Manual for suicidal ideation and attempt.[30]

START HERE:
WHAT HAPPENS DURING A CRISIS RESPONSE?

If school staff believe a student may be in danger or pose a risk to others, they might activate the **Crisis Team**. The crisis team includes school staff, but notably *not* the student in crisis or their family.[31]

UNDER THE CPS CRISIS MANUAL, THE CRISIS TEAM IS SUPPOSED TO:

- Evaluate the level of risk, including identifying "high risk individuals,"
- Stabilize the situation,
- Notify the parent or guardian, &
- Decide whether outside help is needed.[32]

THE OUTSIDE HELP MIGHT INCLUDE:

- Calling **CARES/SASS** – a state-run mental health care coordination line,[33] or
- Calling **911** for emergency services and **police support**.[34]

PARENT NOTIFICATION & ESCALATION

WHAT'S SUPPOSED TO HAPPEN:

Once school staff believe a student might be at risk or once a Crisis Team is activated, **parents or guardians *should* be notified**. They are supposed to be told:

- What the concern is ("suicidal ideation" or signs of self-harm),
- That the school believes a mental health evaluation is needed,
- And what the next steps might include (crisis screening or hospital visit).

But here's the issue: Parental consent is **not required** for the school to call the CARES crisis hotline, which may lead to a formal mental health screening.[35]

If a parent disagrees with the school's recommendation, they may be:

- Told to take their child to a hospital or mental health provider immediately,
- Warned that DCFS (Department of Children and Family Services) could be called for **"medical neglect"**[36] if they do not comply, or;
- Visited by police at home for a "well-being check."[37]

WHY THIS MATTERS:

Based on nothing but school staff's determination that a youth is at risk, parents are threatened with state intervention. Parents might be receiving urgent calls to act even when the student's situation may not require such a serious response.[38] Parents are not treated as partners, but as additional roadblocks to be managed–with policing if necessary.

This system leaves families with little agency and few protections.

CRISIS PROTOCOL, SASS, AND HOSPITALIZATION

WHAT ARE CARES & SASS?

- **CARES (Crisis & Referral Entry Services)** is a statewide crisis hotline.
- **SASS (Screening, Assessment, & Support Services)** is a "a single, statewide system to serve children experiencing a mental health crisis whose care will require public funding."[39]

HOW IT WORKS:

- Schools or families can call CARES if they think a student is in crisis.
- CARES will decide whether a student qualifies for a SASS evaluation.
- If so, a SASS worker comes to the school (or home) within 2 hours.
- The SASS worker asks questions and decides if the student needs counseling, outpatient services, or hospitalization.[40]

IMPORTANT NOTES:

- Parental permission is **not required** for the school to call CARES.[41]
- But parental permission **is required** for hospitalization[42]– unless someone initiates involuntary admission procedures.
- If a parent refuses recommended hospitalization, school staff may report the parent to DCFS for alleged "medical neglect."[43]
- The CARES/SASS recommendation itself **does not meet** the legal threshold for involuntary hospitalization, but can start the process.[44]

WHY THIS MATTERS:

The pressure placed on families when paired with threats of outside involvement can make it feel like there is no choice at all. Remember, most Illinois mental health hospitalizations are *not* for suicide attempts and in many cases outpatient options may be a better fit for the student's needs.

INVOLUNTARY HOSPITALIZATION

FORCED HOSPITALIZATION UNDER ILLINOIS LAW:

Under Illinois law, a child can **only** be hospitalized against their will if:

1. A **licensed psychiatrist or facility director** decides the child has a serious mental illness or emotional disturbance, **and**
2. Hospitalization is both **immediately necessary** and **likely to benefit** the child.[45]

HOW IT HAPPENS IN PRACTICE:

- A school staff member, parent, police officer, or **any adult** may initiate the process if the parent refuses or cannot be reached.[46]
- Once transported, the hospital has **24 hours** to determine whether the child meets the legal standard.[47]
- Youth **12 or older** must be informed of their right to object.[48]
- If the youth or family objects, the hospital must seek a court order within **15 business days,** and the child must receive an appointed attorney.[49]

THE REALITY:

In many cases, families don't know their rights and court hearings never happen. What is supposed to be a last resort often becomes the default response to crisis.

For Black and low-income students, the combination of vague screening tools, school pressure, and legal loopholes can fast-track them into hospitalization with **little oversight or accountability**.

IN THE HOSPITAL

Illinois and national reports document concerns with youth inpatient psychiatric units, including:

- **use of physical restraint and seclusion,**
- **lack of trauma-informed care,**
- **inadequate staff training,**
- **racial disparities in coercive measures,**
- **keeping children hospitalized beyond medical necessity, and**
- **reports of abuse or neglect in several Illinois facilities.**[50]

Youth hospitalized involuntarily are especially vulnerable because they have limited ability to refuse treatment, advocate for themselves, or access legal support.

RETURNING TO SCHOOL

AFTER A STUDENT LEAVES THE HOSPITAL:

- A school return plan (formally called a "reentry plan," calling to mind "reentry" from incarceration) **should** be created, but this depends on whether staff follow through.
- Parents are supposed to receive copies of assessments and discharge notes.
- Students may be asked to sign release forms or take part in new evaluations or safety plans.
- Students may be asked about counseling or medication use before returning.[51]

KEY ISSUES:

- There is **no standard or required return to school/"reentry" process** across all CPS schools.
- Not all students are given a full return support plan or support services they need.
- Students may feel stigmatized or closely monitored when they return, rather than supported.

WHY THIS MATTERS:

After a traumatic experience like hospitalization, what students need most is care, support, and a sense of safety at school. But in many cases, they are met with **surveillance and suspicion** instead. Without consistent return to school support, the system risks causing **more harm than healing.**

IN SUMMARY: INSTEAD OF HEALING, YOUTH EXPERIENCE HARM

The process that can begin with a flagged social media post can quickly spiral into a chain of decisions that deeply affect a student's life. Nearly anything can trigger the chain of surveillance, school disciplinary action, hospitalization, and even police involvement.

POLICING AS A RESPONSE TO MENTAL HEALTH CRISIS

POLICE AS FIRST RESPONDERS TO MENTAL HEALTH

In addition to the crisis procedures outlined above, CPS, like many districts, has a role for law enforcement in crisis response.

TYPES OF POLICING IN CPS CRISIS RESPONSE

Policing is more than the presence of actual police officers, though that is also at play. It also includes:[52]

- Calls to regular police officers or Crisis Intervention Teams (CIT)* trained police officers
- Well-being checks at a youth's home
- Police transport to the hospital via "protective custody"
- Reports of medical neglect
- Student monitoring software flags

*CIT = 40 hours of training in law enforcement crisis response.

IN PRACTICE, STUDENTS CAN BE:

- Flagged for a variety of behaviors,
- Confronted by administrators or school security, and/or
- Referred to police or emergency services when it may not be warranted.

These discretionary decisions often fall hardest on Black and low-income CPS students.[53]

CONCERNS INCLUDE:

- The CPS Crisis Manual does not indicate how social media surveillance may lead to a response.
- There is no definition or guidance on what counts as an "imminent risk" for which law enforcement must be involved.[54] This means school staff are left to **interpret** behavior without oversight or clear standards.
- Policing is detrimental to mental health. No one heals by force.

19 Number of times **police and law enforcement** are mentioned in the CPS Crisis Manual

16 Number of times "DCFS" is mentioned in the crisis manual for the purpose of reporting "**medical neglect**" if a parent refuses a SASS evaluation

13 Number of times a role for a **clinician (social worker, counselor, psychologist)** is mentioned in the crisis manual

0 Number of times words like "**autonomy**," "**healing**," "**choice**," "**self-determination**," or "**holistic**" appear in the Crisis Manual.

Aside from the Crisis Manual itself: even where CPS' Comprehensive Mental Health and Suicide Prevention Policy describes itself as "holistic" and "healing," it *still* includes law enforcement responses to mental health crisis.

THE PROBLEMS WITH LAW ENFORCEMENT INVOLVEMENT

Chicago schools operate within a broader **nationwide** pattern in which youth mental health concerns are addressed through **policing**, **surveillance**, and **coercive interventions**, rather than through care.[55]

The systems responding to young people in crisis were "built on carceral foundations," where those in need of help are controlled, punished, or removed–**not supported**.[56]

Without clear guidance to the contrary, across the country police officers are routinely called when a child is labeled "in crisis," suicidal, depressed, or emotionally overwhelmed. Officers conduct "wellness checks" at students' homes, and increasingly portray themselves as appropriate responders to mental health needs even though they are trained primarily to obtain compliance, not to provide care.[57]

This means that for many young people, the person who arrives in moments of vulnerability is a law enforcement officer, not a clinician, a peer, or a trusted person. There is currently **no evidence** that police-led responses improve mental health outcomes. Instead, the research shows that police involvement often increases fear, distress, and trauma, especially for Black, Latinx, and disabled students.[58]

POLICING MENTAL HEALTH MAKES STUDENTS FEEL LESS SAFE

Police responses tend to escalate situations rather than de-escalate them.[59] Officers have the authority to restrain, search, handcuff, or detain students. This power dynamic directly conflicts with the needs of young people in crisis.

When expressions of distress like crying, anger, withdrawing, verbalizing suicidal thoughts, or exhibiting disability-related behaviors are met with force, surveillance, or criminalization, we risk worsening the well-being of students and undermining the trust needed for genuine mental health disclosure.[60]

THE PIPELINE TO HOSPITALIZATION

Interventions like police transport to the hospital have the effect of making a student feel they are being punished–that they have done something wrong simply for being in a mental health crisis.

While hospitalization can be necessary in cases of injury or harm, it cannot be the first resort in every situation deemed a crisis, especially not against the youth's wishes and at the hands of police. Unwanted hospitalization *increases* suicidality and erodes trust in the mental health system.[61] This means that youth may not seek help in the future, even if they need it.[62]

HERE'S WHAT YOU NEED TO KNOW:

The following points summarize the key problems with CPS crisis response policies outlined in the preceding pages.

STUDENTS ARE BEING IDENTIFIED FOR CRISIS INTERVENTION–AND THE INTERVENTIONS CAN HARM MORE THAN THEY HELP.

1. Students can be labeled and treated as threats without warning.

Students may never know why they're being pulled into a meeting or confronted by school officials. "Concerning behavior" might mean anything from writing a song lyric to using slang or expressing emotion. And because these judgments are subjective, racial bias and misunderstanding can shape serious outcomes.[63]

2. Parents are often left out or pressured to comply.

While schools are supposed to contact parents when a student is in crisis, families can be shut out of the decision-making. Parents who refuse hospitalization or screening may be threatened with calls to child welfare. In many cases, they are told what will happen, not asked for their consent or guidance.[64]

3. State intervention is brought in quickly.

The moment a student is labeled a risk, a statewide crisis system is activated. Under CARES/SASS, workers can evaluate students on the spot and recommend hospitalization even if the student hasn't seen a mental health provider. There is no requirement that this process be trauma-informed, culturally competent, or medically necessary.[65]

4. Involuntary hospitalization can happen even when a child or parent disagrees.[66]

Illinois law allows children to be hospitalized without their consent if a doctor believes it's necessary. These decisions are made quickly and often based on incomplete information. Families may not know their rights, and many young people are admitted without any court hearing or legal support.

5. There is no consistent plan for what happens after.

After a hospital stay, some students return to school with little support. Others face new requirements, surveillance, or stigma. CPS does not have a uniform return to school process to help students reintegrate in a safe and affirming way.[67]

6. Youth needs and voices are missing from these policies and practices.

If we ask youth what support they need if they were to be in crisis, they have clear answers. Their experiences and stories must inform and shape policy.

YOUTH VOICES

"Honestly, in school I always felt like the support we got wasn't made for students like me. When I was struggling mentally, whether it was stress, burnout, or just feeling like I couldn't keep up, the only option school really pushed was talking to a counselor, who of course would probably tell our parents. ***There wasn't space to just talk or feel understood without it turning into a big deal****.* ***What I actually needed was someone to check in****, to listen without judgment, and to help me figure things out before it got bad.*

We're told to ask for help, but when we do, it's like ***the system doesn't know what to do with us****. Having people who actually get where we're coming from and listen to what we need would've made a huge difference."*

– Dalia Martinez, Youth Leader

"Students ***having a say*** *in their mental health care is a necessity. Many students go through tough times and don't know where to turn to for support and care. If we had more mental health resources in schools where students had a say in* ***deciding what made them feel better and how they wanted adults or others to support them,*** *that would make us feel like we had places to go.*

If we don't get support, our mental health will continue to struggle and eventually become a crisis that could have been avoided. In order to keep students and schools truly safe, all students need to have ***access to mental health care support and resources****."*

– D'angelo Reyes, Youth Leader

WHY WE NEED A RADICAL SHIFT IN HOW CPS APPROACHES MENTAL HEALTH

What's described as a safety measure or mental health response is often the **school to prison pipeline in another form**. With no consistent policies, no guaranteed protections, and no true oversight, this system puts students at risk of being misunderstood, mislabeled, and further from the support they actually need.

This isn't just about mental health.

It's about **how schools respond to young people in pain, in transition, or simply being teenagers.**
How schools respond can either **build trust or cause long-lasting harm.**

CPS' APPROACH TO MENTAL HEALTH IS **ANYTHING BUT HOLISTIC** or **HEALING CENTERED.**

School districts like CPS treat students like potential risks–liabilities–more than like people who need healing and care. This is why districts use student monitoring software, threat assessments, and involuntary "care." Youth not at imminent risk of harm will experience harmful consequences because of these mechanisms, while youth who need support won't get the help they need.

While CPS ended the school police contract in 2024,[68] it did not end school policing. Student surveillance is a form of policing. Forced hospitalization is a form of policing. Discriminatory threat assessments are a form of policing. This is in addition to actual police referrals and calls. Meanwhile, students who simply want 1:1 or group mental health counseling with a supportive adult and/or a peer struggle to get it.[69]

Across the country, states and cities–with federal approval and encouragement–are expanding forced institutionalization.[70] This is and will be used as an easy way to lock people up with little to no due process.[71] It is not a mechanism CPS should be funneling students toward, without parental consent, unless there is truly an imminent need.

None of these practices keep school communities safer–they add to student trauma and erode trust, keeping students from seeking help when they want it. Forced hospitalization increases youth suicide risk.[72] It also doesn't match the spirit of the law, which only allows forced care if the young person is "likely" to benefit.[73]

What if CPS did more to address some of the underlying causes of youth suffering? What if the district looked at the school policies and practices that keep young people in a state of trauma and worked to build welcoming, non-punitive, fully resourced schools where students who want additional support have the relationships and connections they need to receive it? What if CPS approached mental health truly holistically–as more than just calling a number and sending students to the hospital?

CPS has already begun the work of funding a "healing-centered" framework.[74] But this work will never fully succeed without changes to crisis response within CPS to end this policing. Chicago youth demand real healing, not criminalization.

THE YOUTH HEALING CHI CAMPAIGN

After a more than 5 year struggle to cancel the contract between the Chicago Police Department and Chicago Public Schools, the youth-led campaign CopsOutCPS won! The campaign secured an unanimous vote from the 2024 Chicago Board of Education, authorizing the removal of School Resource Officers from Chicago Public Schools. This win marked another step towards **fully removing policing practices from our schools,** and **investing in true systems of healing and care** for Chicago youth and families.

During the fight for CopsOutCPS, we made it clear: youth need more life-affirming resources including increased mental health support.

Despite the successful removal of School Resource Officers from schools, young people's mental health continues to be policed through:

- ✗ **surveillance technology**
- ✗ **the use of forced hospitalization**

These practices do not heal, they harm.

We have an opportunity to develop a new vision of care and wellness outside of these carceral approaches by listening to, affirming, and following the lead of our young people and communities.

Youth Healing Chi is grounded in three principles:

COMMUNITY CARE, CHOICE, AND CONFIDENTIALITY

CAMPAIGN PRINCIPLES

COMMUNITY CARE

Mental health is connected to access to basic needs like housing, food, and safety. In order to meaningfully address young people's mental health, we need to address their basic needs too.

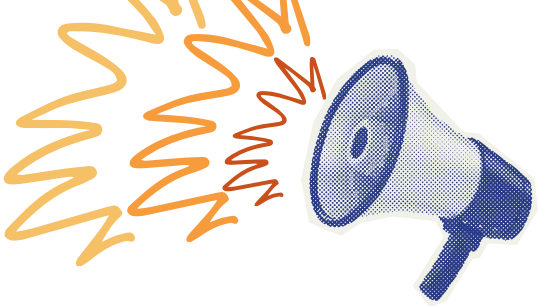
CHOICE

Everyone has the right to decide what is best for their own mind and body, including young people. No one should force you into a particular form of treatment or care.

CONFIDENTIALITY

Students' personal information must be protected. Schools should not share student information without permission, especially with law enforcement, Immigration and Customs Enforcement (ICE), and for-profit companies who do not have students' best interests at heart.

CAMPAIGN DEMANDS



ONE: $15 million for holistic healing programming & expanded mental health support staff.

In 2021, CPS announced an investment of $24 million (over 3 years) into a healing-centered and culturally responsive framework for school mental health support, including community partnerships and expansion of Behavioral Health Teams (BHTs) (see note 74). But our students need more. Today, there is not enough availability of adults whose role is to provide non-punitive, non-carceral mental health support or community-centered healing programming.

With the recent divestment of most of the yearly school policing budget ($30 million),[75] we demand what **our students deserve instead–an *additional* $15 million over the next academic year and every year following for holistic community-centered healing programming and mental health support.**

TWO: A new mental health crisis response protocol that drastically reduces the unnecessary and harmful use of involuntary hospitalization through overuse of SASS.

CPS is not living up to its stated "healing-centered" values or "holistic" approach to school safety when it comes to mental health crisis response. Because there is so much discretion in assessing students for suicide risk, there is an overuse of SASS, leading to forced hospitalization–sometimes without parents being contacted at all. Overuse of psychiatric hospitalization (and the many abuses leading to lawsuits against local hospitals) is already a huge problem in Illinois and these CPS policies allow that pipeline to continue unchecked.

We demand a new mental health crisis protocol: one that is healing-centered, student- and family-centered, and does not lead to calling SASS for everything and anything. Forced or coerced care is inappropriate unless injury or death is imminent. Otherwise, forced psychiatric detention actually increases youth suicidality. We demand all staff be trained in non-carceral crisis response.

THREE: Removing all policing and surveillance from mental health and crisis response.

40 hours (or much less) of training does not make cops mental health professionals. Mental health calls responded to by both Crisis Intervention Teams (CIT) and non-CIT officers in Chicago result in transport to a treatment center or hospital and even the use of force,[76] because that is the primary function of law enforcement in mental health response –to either arrest or transport to the psychiatric hospital.

Student surveillance software primarily used to monitor firearm concerns also "flags" mental health concerns with no transparent protocols for follow-up. Whether used by law enforcement or not, the use of surveillance technology is a function of policing that is inherently not healing-centered because healing requires relationships and trust.

For a truly healing-centered approach, **we demand an end to all law enforcement involvement in mental health response–whether through partnerships, referrals, or calls–and an end to the use of student monitoring software for mental health purposes.**

These resources are for students, families, teachers, school decisionmakers, and all advocates for mental health liberation.

Protect your rights, support each other, and create healing schools.

THE YOUTH HEALING CHI TOOLKIT

INCLUDING:

- **Know Your Rights: Involuntary Hospitalization**
- **Protecting Your Crisis Care Wishes Through Your IEP**
- **Safety Plans: Strengths, Supports, and Self-Determination (including sample Safety Plan)**
- **Guiding Questions for School-Level Policies and Programming**
- **Inspiration for Holistic Healing Programming**
- **Educator's Pledge**

KNOW YOUR RIGHTS: INVOLUNTARY HOSPITALIZATION

This factsheet (pages 27-28), while not legal advice, provides a practical guide to understanding and navigating Illinois law on youth involuntary hospitalization. Families may use it to prepare for meetings, crisis calls, or hospital interactions.

Does Illinois law ever require forced mental health hospitalization of children/youth?

No. Forced mental health hospitalization of children is never required by law. The law outlines the procedures through which a child *may* be admitted against their will, but nothing requires that the process be initiated except CPS policy.[77]

What is required for a child/youth to be hospitalized against their will in Illinois?

The essential requirements for admission provide that:
"Any minor may be admitted to a mental health facility for inpatient treatment upon application to the facility director, if the facility director finds that the minor has a mental illness or emotional disturbance of such severity that hospitalization is necessary and that the minor is likely to benefit from inpatient treatment" (emphasis added). Further, to be admitted against their or their parent's will, the minor must be "*in a condition that immediate hospitalization is necessary*."[78]

All requirements must be met. If the child is not likely to benefit and hospitalization is not *immediately* necessary, they should not be admitted even if they are diagnosed with severe mental illness.

For a law enforcement officer (like a police officer) to transport a minor for involuntary hospitalization, there is another requirement: the child must be *"in a condition that immediate hospitalization is necessary in order to protect the minor or others from physical harm"* (emphasis added).[79] If there is no actual threat of physical harm, police officers should not initiate hospitalization.

Who can initiate forced hospitalization of a child?

A parent or guardian, a person in *loco parentis* (this means someone acting as a parent, including school staff), any adult if the parent/guardian cannot be reached or refuses to consent, or a peace officer (like the police).[80]

What is CARES & SASS?

CARES is the statewide crisis line that screens youth who would use public funding (like Medicaid) for mental health hospitalization. If needed, they dispatch a local SASS clinician to evaluate a child at school or at home. Schools, parents, and guardians can call CARES; parental permission is not required to call.[81]

For the screening, the staffer inputs demographic information, parental information, a diagnosis, and the outcome. The possible outcomes are hospitalization, community stabilization, client refused services (18 or older), guardian refused services, or incomplete.[82] This screening by itself does NOT satisfy the requirements for involuntary hospitalization described above, but it can lead to someone starting the process.

HOW CAN YOU OBJECT TO HOSPITALIZATION?

A parent may refuse hospitalization of their child. However, in that case any interested adult can still pursue involuntary hospitalization of the child against the parent's wishes.[83]

A young person 12 or older is supposed to be given a copy of the **application for admission** and told of their **right to object to the admission**.[84]

- If a youth objects, they should be discharged **within 15 days** (excluding weekends/holidays) unless the facility files a petition with the court to keep them there.[85]
- After receiving this petition, a hearing should be held **within 5 days** (excluding weekends/holidays) and a lawyer must be appointed for the youth.[86]
- The court will order the youth released only if the standard for admission is not met, or if a less restrictive alternative is available.[87]
- Any interested adult (like a parent, lawyer, or youth organizer) can also submit a **written objection on behalf of a child** and initiate the same procedure.[88]

WHAT CAN YOU DO AS A PARENT?

1. **Get information.** Ask what triggered the call, take notes (names, times, statements), and request this information in a language you speak/understand.
2. **Request to be present for any evaluation** and state your preference (on-site at school or at home).
3. **Clarify consent**: For example, "We consent to an on-site evaluation and school-based support today. We *do not* consent to hospital admission."
   Note: Any adult may make the emergency petition to apply for hospitalization over the parent's objection if the parent cannot be reached or refuses consent.[89]
4. If admission occurs anyway, **youth 12+ may immediately file a written objection** and **request counsel and a hearing** within the statutory timelines outlined above.
5. **Get copies of these documents the same day:**
   1. CPS "Verification of Emergency Conference: Suicidal Ideation"[90]
   2. "Authorization for Release of Confidential Information."[91]
6. **Plan return to school:** parents can ask for a **written safety/support plan** and **check-ins** the next school day and the following weeks.

PROTECTING YOUR CRISIS CARE WISHES THROUGH YOUR IEP

If you are a student or a parent of a student with a disability, one way to safeguard your care wishes is through an IEP.

An **Individualized Education Program (IEP)** is a written plan outlining the specific special education services, supports, and goals a student with a disability needs to succeed academically and socially. It is developed for students between ages 3 and 21 who have been evaluated and determined eligible for special education services.

The IEP is created by a team, reviewed at least annually, and includes details like the student's strengths, needs, goals, and the services required, such as therapy or special accommodations.

You can learn more about the process of getting an IEP at www.cps.edu/services-and-supports/special-education/process

Note: An IEP is a **legal document** and schools ***must*** follow it.

BEHAVIOR INTERVENTION PLAN

A **Behavior Intervention Plan (BIP)** in an IEP can help prevent "crisis" situations by identifying triggers, listing prevention & teaching supports, positive reinforcement, and clear de-escalations before any external responders are called.[92] A BIP is developed by the **IEP Team** which includes the parent/guardian, special and general education teachers, a case manager, a Local Education Agency (LEA) representative, and relevant service providers.

A student's BIP is informed by a **Functional Behavioral Assessment (FBA)**, which is a formal evaluation conducted by qualified school personnel to determine the function of a student's behavior. An FBA may include observations, data review, and staff input and requires parent consent when conducted as an evaluation.

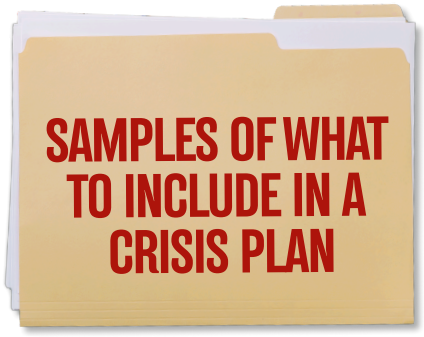
A **Crisis Plan** may also be developed as part of the IEP. It can outline what should be done in the event a crisis is already happening. Both the BIP and Crisis plan can be created together in a collaborative process with the IEP team, teachers, the parent/guardian, and the student.[93]

Request language (sample email to case manager/principal/IEP team):

"I am requesting a Functional Behavioral Assessment (FBA) to inform development of a Behavior Intervention Plan (BIP). Please provide consent forms and a proposed evaluation timeline. I request classroom observations and input from relevant school staff. I will provide documentation or recommendations from outside providers involved in my child's care for the IEP Team to consider."

These examples are designed for parents & caregivers to use during IEP meetings. This list is a guide to help families prepare questions, suggest supports, and ensure key elements are discussed and documented in the written plan. *These talking points and resources are not legal advice.*

1. **Background + What we know:** Student strengths, triggers, & early- warning signs.
2. **FBA hypothesis of function:** "When ___, student ___ to obtain/avoid ___ (e.g. attention/escape/sensory/tangible)."
3. **Prevention & teaching:** calming space, visuals, break cards, transition warnings, explicit teaching of replacement skills, short regulation breaks, academic "chunking."
4. **Positive reinforcement**: How/when replacement skills are acknowledged.
5. **Stepwise de-escalation** (least → more):
   - Offer choice of two calming options; reduce demands; one adult speaks; increase space.
   - Call trusted adult (include name/title).
   - Parent/guardian notification (who/when/how).
   - Initiate on-site Crisis Plan if needed



1. **Fill in the details in the Crisis Plan** about any steps you would like taken before further intervention. Examples can include sitting with the student in a quiet space with line of sight, walk with staff, hydration, co-regulation script, 1:1 counseling, or any other helpful interventions, with contemporaneous documentation.
2. **State that external responders are a last resort:** "*Call CARES or 911 only when there is an imminent risk of serious physical harm that cannot be mitigated on campus. Imminent means that the serious physical harm will occur before a parent can reasonably be reached to advise on their care wishes. Notify parent immediately and document legal basis and prior steps attempted."*
3. **Limits on restrictive practices:** State your wishes on any practices the student finds harmful; same-day incident notice to family; when the IEP/BIP should be reviewed.
4. **Return to school after crisis/hospitalization:** Meeting within 48–72 hours; temporary workload adjustments; scheduled daily check-ins; updating the plan.
5. **Data & review:** Specify what data is collected (logs, office referrals); who reviews; etc.

SAMPLE LANGUAGE FOR A BIP OR CRISIS PLAN:

Parent Notification & Participation

"School staff will contact Parent/Guardian at the onset of early-warning signs before contacting off-campus responders unless there is an imminent risk of serious physical harm. Imminent means that serious physical harm will occur before a parent can reasonably be reached to advise on their care wishes. Parent/Guardian may participate in problem-solving by phone or in person."

Least-Restrictive Crisis Response

"The team will implement and document at least two listed de-escalation strategies before considering external responders. External responders (CARES/SASS/911) will be contacted only when safety cannot be maintained on campus despite these measures."

Police/Transport Limits

"Police will not be contacted for a mental health crisis."

Staff Training

"All assigned staff (including substitutes) will receive training each semester on this BIP/Crisis Plan, disability-specific supports, and CPS de-escalation procedures. The case manager will maintain a training log."

Return to School

"Following any crisis removal or hospitalization, a return to school meeting will occur within 48–72 hours during which the IEP Team will put in place any needed supports, schedule check-ins, and/or temporarily modify workload."

SAFETY PLANS: STRENGTHS, SUPPORTS, & SELF-DETERMINATION

Whether they have (or want) an IEP or not, any student can have a personal "safety plan" that they can share with trusted adults. This is not a legal document, but helps youth reflect on the strengths, resources, and supports they already have and indicates their wishes for when they are struggling. This is something they can reference themselves and/or choose to share with a teacher, a counselor, a relative, a friend, or another trusted individual.

The sample "safety plan" on the next pages is inspired by the history of "mad mapping" done by peers who have organized against mental healthcare system harms, but is adapted for use by students.[94] It is a way to reclaim self-determination in healing.

_____'S SAFETY PLAN

PART ONE: FOR ME

I am strong, and I will feel good again.

What does it feel like when I'm doing well? *Examples: I have energy, I like trying new things, I want to spend time with friends.* _____

_____

_____

What makes me feel most alive? *Examples: When I play a sport, when I succeed at something after working hard, when I listen to music I love.* _____

_____

What are my strengths? *Examples: I am kind, I am sensitive, I can get through hard things.*

_____

_____

What are the most important things in my life? *Examples: My loved ones, activities I care about.*

_____

_____

_____

I have resources to lean on when I feel bad.

What ideas or beliefs help me in my life? *Examples: Faith in something greater than myself, faith in myself to overcome challenges, the idea that every person's life is important.* _____

_____

_____

What are some things I can do regularly to take care of my mental health? *Examples: Move my body, see a counselor, take medications that help me, spend time away from my phone.*

_____

_____

Are there any books, TV shows, movies, or music that always make me feel better?

_____

_____

What are my safe places? _____

_____

_____

Who can I talk to when I'm feeling bad? *Try to list at least three people and their contact info.*

1. _____
2. _____
3. _____
4. _____
5. _____

I have a plan for when I'm really struggling.

What does it feel like when I'm struggling? *Examples: I get irritated at everyone, I feel numb, I can't stop crying, I have panic attacks.* _____

_____

_____

What helps me when I'm struggling? *Examples: Talking to someone I trust, spending time alone, taking a day off from school, deep breathing, going for a walk, journaling.* _____

_____

_____

_____

How can people I trust best support me when I'm struggling? *Examples: Check in with me to see if I'm ok, bring me food, catch me up on any schoolwork I missed, say kind things to me.*

_____

_____

_____

What do I NOT want people to do when I'm struggling? *Examples: Don't call the police, don't tell x person, don't leave me alone.* _____

_____

_____

I can share this safety plan with people who care about me.

Show this plan to a couple people you trust, who care about you. Tell them to remind you to look at your plan when you're struggling. Do the things that help you, let others support you, and remember that you are strong, you are essential, and you will feel better again.

_____'S SAFETY PLAN

PART TWO: FOR MY TEACHER

I want to thrive in your classroom.

Here are some things that would make your classroom a safe and supportive space for me:

_____

_____

_____

_____

Here are some things that would NOT make your classroom a safe and supportive space for me: _____

_____

_____

_____

Here are some ways to support me when I am struggling.

When I'm having a bad day, please allow me to do the following:

- ☐ Put my head down on my desk
- ☐ Listen to music with headphones
- ☐ Write or draw in my journal
- ☐ Read a book
- ☐ _____
- ☐ _____
- ☐ Sit somewhere in the classroom where I can be more alone
- ☐ Go to (circle): the counselor, the nurse, the library, _____'s classroom, _____.
- ☐ _____

If you're worried about my mental health, please do NOT call the police or an SRO. Instead, please:

- ☐ Call _____.
- ☐ Ask me what support I need (counseling or other forms of help) and help me get those resources. ☐ Help me call [resource]: _____.
- ☐ Remind me to use my safety plan and get support from those I trust.
- ☐ _____

GUIDING QUESTIONS FOR SCHOOL-LEVEL POLICIES AND PROGRAMMING

Crafting school mental health policies should be a collaborative process involving students, families, community members, and educators. Our campaign demands are a district-level starting point, not an ending point, to support youth mental health in schools. These guiding questions can support in the longer-term process of developing more holistic, healing-centered policies beyond the initial adoption of the demands. They can also support schools in determining how to use any additional healing programming funds secured through this campaign.

1. Are the goals of [proposed policy] primarily to avoid district liability, or to support youth healing?

2. Does [proposed policy or use of funds] enable the "siloing" of mental health as something that is only the concern of mental health professionals? How do [proposed policies or use of funds] support a more holistic sense that youth mental health is all of our concern and that we all have a role to play to support it?

3. Does [proposed policy] act to *encourage* or *discourage* youth from seeking support? For example, is there a lack of protection of youth confidences or an open-ended pathway to forced care that would discourage support-seeking?

4. How have youth voices and self-determination been centered in the crafting of [proposed policies or use of funds]? How have youth been treated as partners in healing rather than objects of concern?

5. How do [proposed policies] address larger school-wide contributors to youth distress?

6. How do [proposed use of funds] tap into community and cultural resources that can support youth healing?

INSPIRATION FOR HOLISTIC HEALING PROGRAMMING

There are many ways in-school programming can support youth mental health. Many different approaches are needed and helpful! We don't have to only do what other districts have done, but can take inspiration from individual teachers, students, and community-based organizations too:

Peer Support Circles Facilitated by Teachers or Students
As a middle school teacher, one of our report authors started a peer support circle for students during advisory times. Students circled up and did discussion activities that helped them bond with each other and talk about what was happening in their lives. After they built trust, the circle was a practice they looked forward to every day, discussing serious challenges and supporting each other. Schools should support teachers seeking to adopt, improve, or train others in these successful practices.

Partnering with Community-based Organizations
Relying on a healing justice approach, in 2018 Los Angeles-based organization Project KnuckleHead brought beat-making and therapeutic music workshops to schools and youth centers serving unhoused youth and youth with mental health needs.[95] Their program focused on the arts and creativity as a form of collective healing and expression. This is an example of an approach that doesn't rely on the schools hiring practitioners directly, but partnering with a community organization that can bring a healing justice approach to schools. In a partnership like this, the school should work to provide any space/time/materials needed.

Supporting Student Ideas
One high school senior in Duluth, Minnesota, a member of the Red Cliff Band of Lake Superior Chippewa Nation, worked with her school district's American Indian liaison to bring a jingle dress workshop to her school.[96] A jingle dress is lined with hundreds of metal cones that mimic the sound of rain and is meant to bring peace and healing when used in dance. The student sought to use this dance to bring healing from the effects of the pandemic to her school. Cultural dances–whether performed for creative expression or through the lens of Dance Movement Therapy to address specific issues–are longstanding ancestral forms of healing with many benefits that can be brought to schools. This is also an example of healing practices coming from students themselves, rather than relying solely on outside practitioners.

The Importance of Arts Programming for Healing

One school in Queens, New York offered virtual art therapy during the pandemic.[97] The class was taught by a licensed creative arts therapist. Class would typically open by showing students different paintings reflecting different emotions and asking students to indicate which one they related to that day. Some days, the teacher would ask them to create a work of art on a specific theme, like something in nature surviving in a harsh environment or their perspectives on racist events–assignments that turned into larger art projects on their resilience and strength. Research indicates that art therapy can reduce children's feelings of anxiety, anger, and fear, while helping them come to terms with the sources of their trauma.[98]

Healing Justice Curriculum

Youth organization Detroit Heals Detroit offers a healing justice curriculum that they have worked with schools to implement.[99] Their approach to "trauma-informed" education, unlike many other approaches commonly used by schools, takes into account how racism causes trauma. It aims to develop youth into community organizers who work for collective liberation, not simply treating mental health as an individual concern requiring only individual "check-ins."

Are there teachers in your schools who do well at supporting youth mental health? How can the work they do be supported or expanded?

Are there students in your school with ideas for what would help students find everyday healing? Can they form a school mental health support committee and submit a proposal for holistic healing programming funds to make it happen?

Are there community based organizations who can be brought in for programming or who can develop healing-centered curriculum?

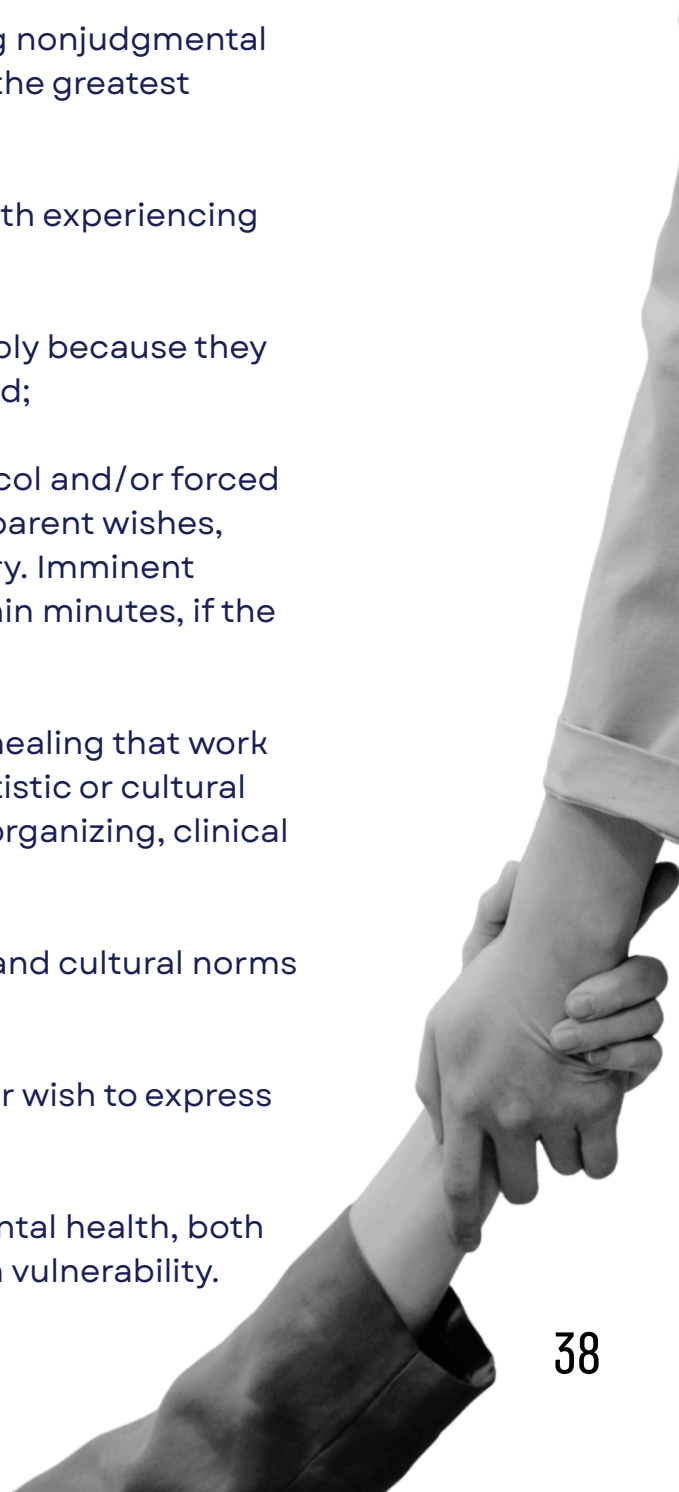
What abundance of resources is already available to us, just waiting for support that we would otherwise spend on surveilllance tech and policing?

EDUCATOR'S PLEDGE

Many educators are already showing up to support student healing in so many ways. This pledge is a commitment to either begin or continue this work, every day, to show up for youth in ways that center care and healing.

As a [Chicago Public Schools Teacher/Staff Member], **I affirm that our schools must be sites of healing for our youth. I pledge to support Chicago youth mental health by:**

- Being someone students can speak to, offering nonjudgmental support, and supporting youth care wishes to the greatest extent possible;
- Not calling law enforcement of any kind on youth experiencing crisis;
- Not reporting families for medical neglect simply because they do not want their child involuntarily hospitalized;
- Not referring students through the SASS protocol and/or forced treatment as a first resort, against student or parent wishes, when there is no imminent risk of physical injury. Imminent means the injury will happen immediately, within minutes, if the hospitalization protocol is not initiated;
- Supporting students in discovering modes of healing that work well for them: whether counseling, forms of artistic or cultural self-expression, community involvement and organizing, clinical options, a combination, or anything else;
- Working to change school policies, practices, and cultural norms that contribute to youth distress;
- Advocating for students who have expressed or wish to express their crisis care wishes through their IEPs; and
- Leading by example by supporting my own mental health, both individually and in community, openly and with vulnerability.



CREDITS

YOUTH HEALING CHI

Youth want mental health care rooted in healing and support, and are organizing a campaign for improved resources and responses around mental health care in Chicago Public Schools.

Thank you to the youth that organized before us and paved the way for Youth Healing Chi.

- Brighton Park Neighborhood Council
- Palenque LSNA
- Asian Americans Advancing Justice
- Jewish Council on Urban Affairs
- HANA Center

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May 2026

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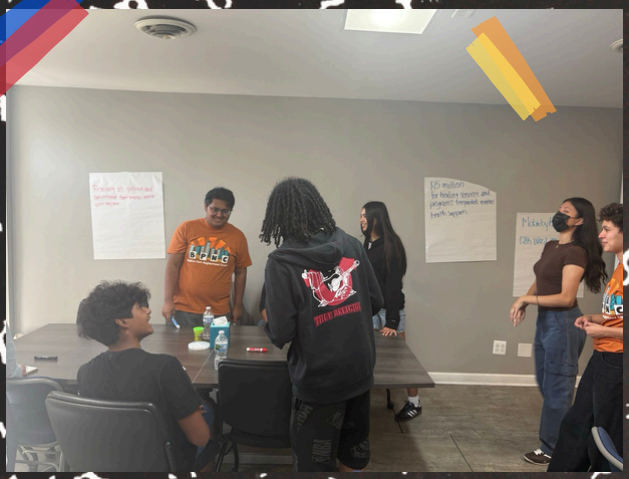

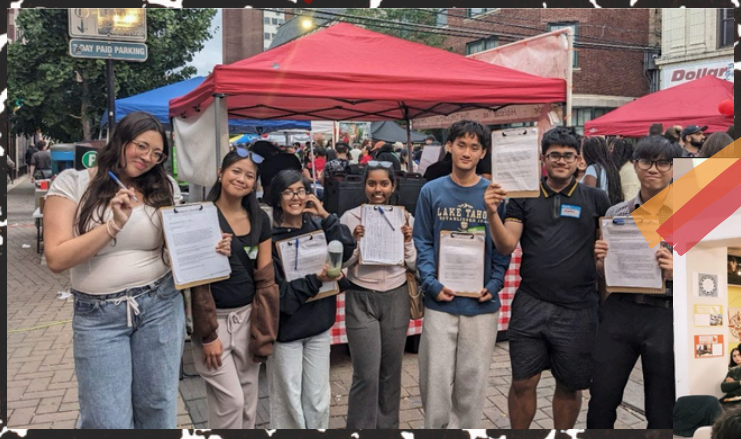
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