



Collaborative for Community Wellness

Asociación Colaborativa para el Bienestar Comunitario

## Mental Health Crisis Support in Chicago: Findings from a City-Wide Survey

### Introduction

In September 2021, the city of Chicago launched a Crisis Assistance Response & Engagement (CARE) pilot program in the Uptown/Lakeview/North Center and Auburn Gresham/Chatham community areas. Under this pilot program, select 911 calls received between 10:30am-4:00pm on Monday-Friday that are deemed to have a “mental health component” are diverted to a response team comprised of a police officer, paramedic, and mental health clinician, also known as a co-responder model.<sup>1</sup> While the Lightfoot administration touted the implementation of this pilot program as a historic moment due to the fact that the program “integrates health professionals into the 911 response system”<sup>2</sup>, there is an established body of research pointing to the concerns associated with including police on mental health crisis response teams. An analysis of the Crisis Intervention Team (CIT) model, a specialized police curriculum designed for police responding to mental health emergencies, found that CIT training did not have an effect on arrest rates when reviewing data across four Chicago police districts.<sup>3</sup> Furthermore, a systematic analysis of peer-reviewed research on the CIT model identified a lack of evidence showing that the CIT model is effective in decreasing arrests, use of force, or injury when CIT-trained police officers respond to mental health crises.<sup>4</sup> There are thus very real concerns that the inclusion of police on a mental health crisis response team will lead to tragic consequences including emotional traumatization, physical harm, and death. In 2020, the Collaborative for Community Wellness (CCW) introduced a council order calling for the creation of a non-police crisis response pilot after Mayor Lightfoot called for the establishment of a

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<sup>1</sup> City of Chicago (2022). Crisis Assistance Response & Engagement Program (CARE) Annual Report. Retrieved from <https://www.chicago.gov/content/dam/city/sites/public-safety-and-violenc-reduction/pdfs/CARE%202022-Annual%20Report-12-7.pdf>.

<sup>2</sup> City of Chicago (2022). Crisis Assistance Response & Engagement Program (CARE) Annual Report. Retrieved from <https://www.chicago.gov/content/dam/city/sites/public-safety-and-violenc-reduction/pdfs/CARE%202022-Annual%20Report-12-7.pdf>. p. 2.

<sup>3</sup> Watson, A. C., Ottati, V. C., Morabito, M., Draine, J., Kerr, A. N., & Angell, B. (2010). Outcomes of police contacts with persons with mental illnesses: The impact of CIT. *Administration and Policy in Mental Health and Mental Health Services Research*, 37, 302-317. Available at <https://link.springer.com/article/10.1007/s10488-009-0236-9>.

<sup>4</sup> Rogers, M. S., McNeil, D. E., & Binder, R. L. (2019). Effectiveness of police Crisis Intervention Training programs. *Journal of the American Academy of Psychiatry and the Law*, 47(4), 1-8. Retrieved from <https://jaapl.org/content/jaapl/early/2019/09/24/JAAPL.003863-19.full.pdf>.

co-responder pilot as part of her police reform package. Public pressure from the CCW during budget discussions within city council ended with an expanded pilot which added two non-police teams. While a non-police mental health crisis response team was added to serve the community areas of West Elsdon, West Lawn, Chicago Lawn, Gage Park, and West Englewood in June 2022, the lack of prioritization that the Lightfoot administration gave to the non-police team is reflected in the fact that implementation occurred nine months after the implementation of the police-involved teams. There is also no evidence to suggest that the Lightfoot administration sought community input to help inform program implementation. To help ensure that community perspectives inform future recommendations for the expansion of Chicago's mental health crisis response system, the CCW surveyed community residents across the city of Chicago to learn more about their vision for addressing emergent mental health needs. Highlighted below is an overview of our study methodology, key findings, and recommendations for implementing a mental health crisis response system that promotes long-term emotional well-being.

### **Study Methodology**

In October 2022, representatives from the Collaborative for Community Wellness with expertise in community-based research and survey design created an electronic survey consisting of closed and open-ended questions on the types of supports that should be available to individuals experiencing mental health emergencies, what a system of mental health crisis support should look like, and how it should be implemented. The survey was made available in both English and Spanish, and was distributed widely via an electronic link. A total of 652 individuals across all wards in the city of Chicago completed the survey independently between October 27, 2022 and April 15, 2023.

### **Demographics**

Every ward in the city had at least one respondent. The number of responses from each ward ranged from one to 36. Most respondents took the survey in English (602 or 92%); the rest (50 or 8%) took the survey in Spanish. Respondents' average age was 39.6; the median age was 36. The racial/ethnic breakdown was 49% white, 35% Latino/a/x, 14% African American, 6% Asian, and 5% other races/ethnicities.<sup>5</sup> The gender breakdown was 69% female, 23% male, 10% non-binary or gender non-conforming, and 3% transgender.<sup>5</sup> The vast majority (90%) had some form of health insurance. A sizable minority (20%) had experienced homelessness at some point in their lives.

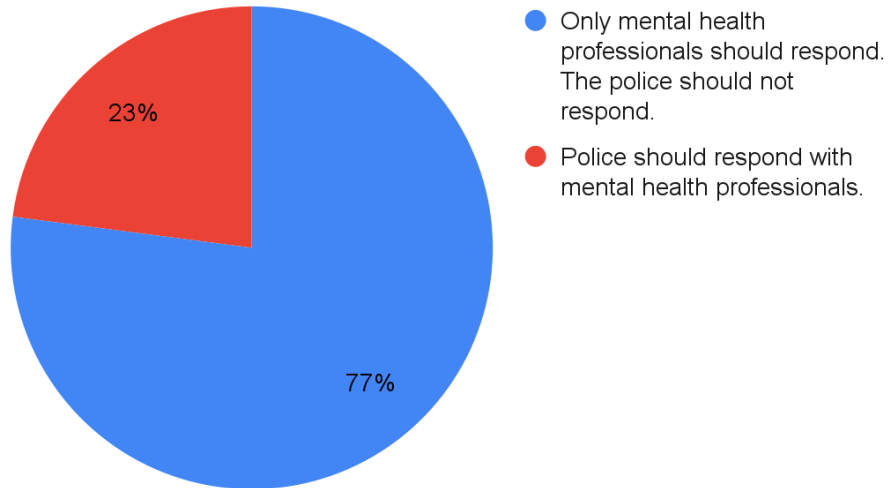
### **Key Survey Findings**

*Quantitative Findings.* The first question asked, "When someone is experiencing a mental health emergency and needs support, who should respond?" Over three-quarters (77%) of respondents said that only mental health professionals should respond and not the police, while 23% said police should respond with mental health professionals.

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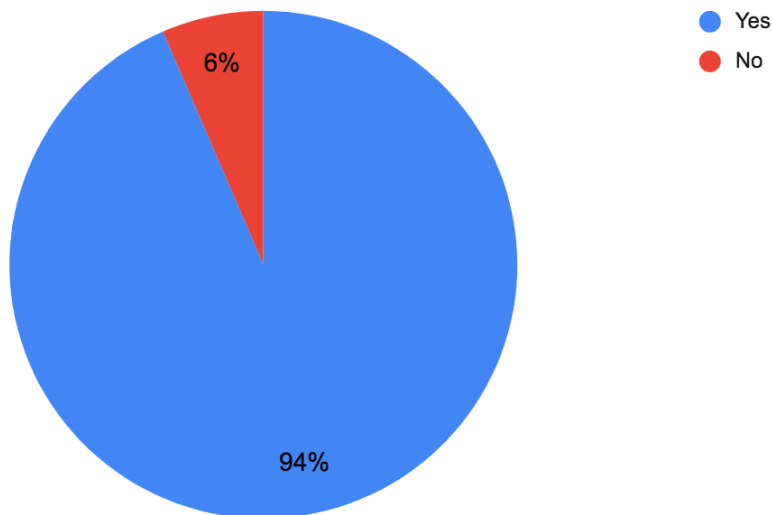
<sup>5</sup> Percentages add up to more than 100% because respondents could choose multiple categories.

### When someone is experiencing a mental health emergency and needs support, who should respond?



An ever larger majority (94%) said that a peer support specialist (someone with lived experience) should be part of a crisis response team, and just 6% said they should not be on the team.

### Should a peer support specialist (someone with lived experience) be part of a crisis response team?

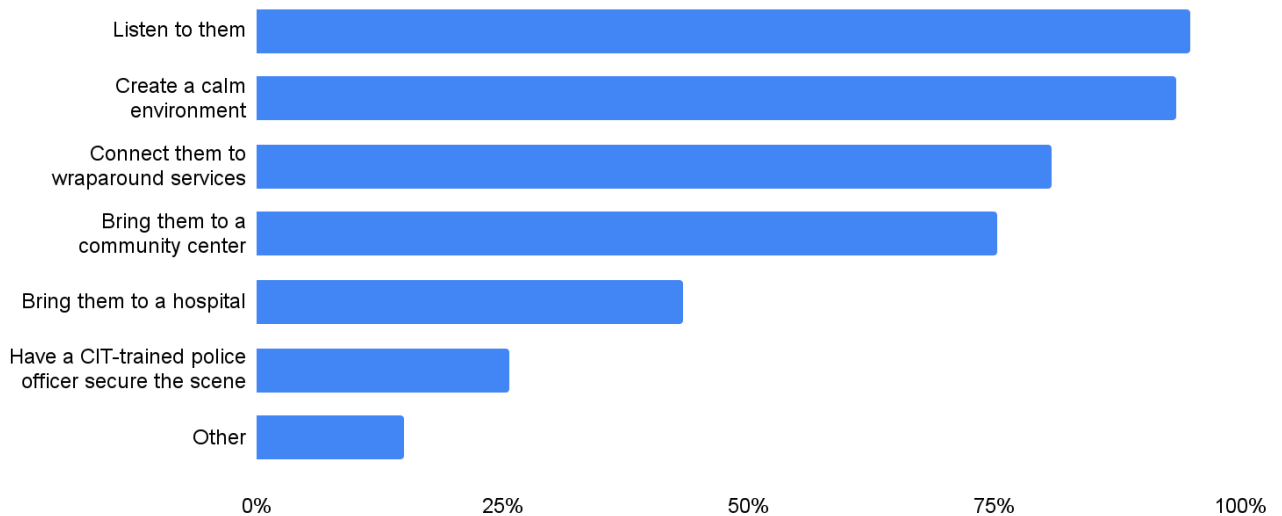


When asked how a crisis response team should support someone emotionally when they are experiencing a mental health emergency, most respondents indicated the team should listen to them (95%), create a calm environment (94%), and connect them to wraparound services (81%). More people said the person should be brought to a community center (75%) than to a hospital (46%). Just over a quarter (26%) said a police officer with crisis intervention training

should secure the scene, and 15% had other suggestions. These suggestions primarily focused on recognizing that there is not a “one size fits all” intervention for mental health crisis response and that the specific interventions that are utilized should be tailored to the unique needs of the individual. Respondents frequently noted that the individual should be asked what they need to help them cope with the crisis situation and that all interventions should be delivered with the individual’s consent.

## How should a crisis response team support someone emotionally when they are experiencing a mental health emergency?

Responses add up to more than 100% because respondents could choose multiple answers.



Regarding material items the crisis team could provide, there was broad support for transportation to an organization that could provide resources such as housing or domestic violence services (93%), food and water (88%), basic medical supplies (88%), personal hygiene supplies (79%), and clothing (74%). Two-thirds of respondents thought the teams should offer sleeping materials such as tents or sleeping bags, and 12% offered additional suggestions, including overdose kits with Narcan and other harm reduction supplies, resource lists, cash assistance, access to a telephone, and “comfort items” (i.e. stuffed animals, stress balls, art supplies). Survey respondents also frequently noted that individuals experiencing mental health crises should be asked if there are other material items that they need, and that crisis response teams should make reasonable efforts to obtain other requested material items that are not immediately available.

Most respondents (70%) thought the crisis team should wear a simple uniform of a t-shirt or jacket identifying them as part of the team. Smaller percentages thought they should wear a more formal polo or button-down shirt (12%), a uniform like a paramedic would wear (11%), or wrote in different suggestions (7%). Of the other suggestions, most recommended that crisis responders wear plain clothes so as to avoid a power differential, but have some type of

identification in plain sight (for example, a badge, lanyard, or hat) to reflect that they are part of the team and are a knowledgeable source of support.

Finally, respondents agreed that the crisis team should try to connect the person in crisis to longer-term services after a mental health emergency is resolved. These included long-term mental health services (96%), support for individuals who have experienced family or community violence (90%), medical care (85%), housing services (75%), employment and/or educational assistance (75%), and financial support (71%). Additionally, 12% wrote in their own suggestions, including social support/peer support groups and enrichment activities, connection to spiritual communities if desired, childcare support, public benefits assistance, food pantries, legal services, gender-affirming medical care, and substance use treatment. Many of these suggestions also noted that the type of support should depend on the needs of the individual. Survey respondents also noted that because many of the social service agencies in Chicago have lengthy waiting lists, there is a need for systemic change and ongoing advocacy to ensure that individuals are able to access the social supports listed above without encountering barriers such as waiting lists and limited organizational capacity.

*Qualitative Findings.* Survey respondents were allowed space to answer the following question in an open-ended format: "Please share more details about your vision for mental health crisis support in Chicago." A content analysis yielded the following themes across responses:

- ***Increased investment in preventative services is critical to addressing holistic resource needs before mental health symptoms reach a point of crisis.*** Survey respondents commonly identified that mental health crises could be prevented if Chicagoans had increased access to emotional support. Community members frequently cited cost, lack of insurance coverage, and lengthy waiting lists as barriers that impede individuals from accessing mental health services in their moments of need. Re-opening the closed CDPH public mental health centers was identified as being key to expanding access to free, long-term mental health services for individuals across Chicago and ensuring that mental health symptoms are addressed in a timely manner, before they escalate to a point of crisis. Additionally, survey respondents highlighted the interconnected nature of emotional and material resource needs. Facilitating access to affordable housing and ensuring living wages for all Chicagoans is also critical to promoting emotional well-being and preventing mental health crises.
- ***Traveling multidisciplinary teams of mental health crisis responders should be available in every ward in the city.*** In order to ensure that there is a timely response to all mental health crisis calls that are received, survey respondents commonly recommended that crisis response teams be housed in every community area of Chicago. It was also recommended that teams be available to respond to calls 24 hours a day, seven days per week. These teams should be comprised of mental health professionals, peer support workers, and medical professionals such as nurses. Survey respondents noted that they view the primary role of the multidisciplinary team as supporting with de-escalation, listening to the concerns of the individual and their family members, assessing for resource needs, and connecting the individual and their family

with the ongoing mental health, material resource, and medical services that are necessary to promote long-term well-being. A multi-disciplinary team consisting of professionals with specialized expertise in de-escalation, coupled with individuals who have had similar lived experiences and understand the cultural and community contexts where they are responding to emergency calls, is thus critical to creating a safe and calm environment that both addresses the immediate crisis at hand and connects the individual and family with the necessary resources to promote long-term well-being. Survey respondents additionally recommended that each crisis support team be adequately staffed to accordingly respond to the projected volume of calls in each community area, and also identified that crisis responders should be paid a living wage.

- ***Mental health crisis responders should be prepared to connect individuals with a range of resources to address their holistic needs in addition to providing immediate emotional support to de-escalate the situation.*** As noted above, survey respondents identified the interconnected nature of emotional, material resource, medical, and social needs. Providing de-escalation support to address the immediate crisis situation is therefore insufficient to prevent future crises if pressing resource needs are left unaddressed. Crisis responders should have supplies available to address immediate material resource needs (i.e. clothing, food, and water) and should also be prepared to connect individuals and families with organizations that offer long-term support in the areas of affordable housing, food security, education and employment assistance, medical care, and social support. Survey respondents additionally noted that individuals should be connected with accessible, long-term mental health supports, such as services through the CDPH mental health centers, to promote emotional well-being in the long-term. Crisis responders should thus be prepared to take on the role of case managers by facilitating warm handoffs with CDPH public mental health centers and other community-based social service organizations with whom they have established relationships whenever possible. In cases where warm handoffs are not possible, the crisis response team should follow up with the individual and their family to determine whether successful resource linkages have been made. As one survey respondent from the 48th ward noted: “It would be great if crisis response individuals could also be case managers who can help refer people to other resources after helping appease the crisis.” Survey respondents further emphasized the importance of this case management support for individuals who are unhoused.
- ***Individuals experiencing mental health crises should be treated with compassion and empathy.*** Across surveys, respondents commonly noted concerns about the criminalization of individuals experiencing mental health challenges and noted that within the current crisis response system, the voices and experiences of individuals experiencing mental health crises are ignored. Respondents thus advocated for a person-centered model of crisis response that treats individuals with dignity and recognizes that each individual is an expert in their own lived experiences. The aim of this approach is to listen to what individuals in crisis say that they need and to help them in developing a plan to connect with needed supports rather than immediately reverting to involuntary hospitalization. Individuals with lived experiences with mental health

challenges should also take on leadership roles in informing how an expanded crisis response system is developed and implemented in the city of Chicago.

- ***There is a need for more crisis care centers available to Chicagoans across the city.*** Survey respondents identified the need for more walk-in crisis care centers and living room spaces that are accessible to adults and youth in community areas across Chicago, regardless of insurance status. Survey respondents envisioned these centers as spaces where individuals can drop in proactively to seek social support from their peers, as well as speak with mental health professionals to receive emotional support and assistance connecting with resources to address their holistic needs. The centers could also serve as sites where traveling mental health crisis response teams could bring individuals to connect with additional support after the traveling teams complete their intervention. Survey respondents noted that an expanded network of living room spaces and crisis care centers would provide a much needed alternative to bringing individuals to a hospital emergency room.
- ***It is critical to ensure the safety of all individuals involved in a mental health crisis response interaction.*** While all survey respondents agreed on the importance of promoting the safety of all individuals involved in a mental health crisis response interaction, there were differing opinions regarding the measures that should be taken to ensure safety. As noted in our discussion of the quantitative findings, more than three-quarters (77%) of survey respondents indicated that police should not be present when responding to mental health emergencies. The majority of qualitative responses thus highlighted that including police on mental health crisis response teams only serves to perpetuate trauma and violence, and that safety can be promoted by removing police from the interaction. There was, however, a notable minority of respondents who expressed concerns about the safety of mental health professionals if police were not included on the team. The responses from this minority tended to focus on the fact that individuals experiencing distressing mental health symptoms could easily escalate to violence and would pose a threat to the safety of others at the scene. For this minority of individuals, it could be beneficial to develop educational campaigns that leverage both quantitative data and personal testimonies to challenge the narrative that police presence at mental health crisis calls promotes safety.

### **Implications and Recommendations**

Findings from this study clearly indicate that the vast majority of Chicagoans (77% of survey respondents) believe that police should not have a role in responding to mental health emergencies. These findings coincide with data from a national survey conducted through the National Alliance on Mental Illness in 2021, which found that 4 out of 5 U.S. adults believed that mental health professionals should be the first responders when an individual experiences a mental health crisis.<sup>6</sup> In accordance with the data at the national level, survey respondents

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<sup>6</sup> Ipsos, on behalf of National Alliance on Mental Illness (2021). NAMI 988 Crisis Response Research. Retrieved from <https://nami.org/NAMI/media/NAMI-Media/Public%20Policy/NAMI-988-Crisis-Response-Report-11-12-2021-For-Release.pdf>.

across Chicago thus identified that rather than implementing a police-involved crisis response model that perpetuates cycles of violence and trauma, the city of Chicago should invest in a system that provides compassionate, empathetic care to address the immediate crisis at hand and connects individuals and families with the long-term support that they need to promote holistic well-being and prevent future crises. Detailed recommendations of what this system can look like, based on a synthesis of the quantitative and qualitative survey data, are outlined below.

- ***Provide compassionate, empathetic, and person-centered care and de-escalation support to address the immediate crisis at hand.*** As indicated through the quantitative and qualitative data, survey respondents overwhelmingly reported that they believed teams comprised of trained mental health professionals and peer support specialists should respond to mental health emergency calls. They viewed the primary role of the crisis response team as listening to the individual experiencing a mental health crisis and creating a calm environment. Qualitative data further elaborated that individuals are experts in their life experiences and know what they need, and the crisis response team should thus provide a safe and supportive space that focuses on de-escalating the crisis at hand and talking with the individual and family to assess the supports that they need to promote well-being in the long-term. Recognizing that mental health professionals and peer support specialists are the best equipped to create a calm, safe, and supportive environment, we thus recommend that non-police crisis response teams be expanded to every community area in Chicago and that police co-responder teams be discontinued. Non-police mental health crisis response teams should operate 24 hours per day, 7 days per week, with adequate staffing to ensure that they can respond in a timely manner to the volume of incoming calls.
- ***Invest in long-term supportive services that promote holistic well-being in order to prevent mental health crises.*** Survey respondents overwhelmingly noted that it is not enough to simply de-escalate an immediate crisis situation. Instead, individuals and their families should be connected with the necessary resources to promote long-term well-being. Furthermore, the city of Chicago should invest in a comprehensive network of accessible mental health and social services to prevent such crises from occurring in the first place. Medical, material resource, and emotional needs are interconnected, and ensuring access to affordable housing, educational opportunities, employment that pays living wages, and high quality medical and mental health care is thus critical to promoting holistic well-being and addressing mental health symptoms before they reach a point of crisis. Expanding access to mental health services by re-opening the closed CDPH public mental health centers is an instrumental component of investing in a comprehensive network of holistic supports. Not only can the CDPH public mental health centers serve as hubs for mental health crisis response teams to connect individuals and families who are in need of long-term emotional and case management support, but an expanded public safety net also ensures that individuals can more easily access mental health services on a preventative basis before mental health symptoms become emergent.



- ***Decriminalize mental health emergencies and challenge the mainstream narrative that police presence at mental health crisis calls promotes safety.*** As noted above, the vast majority (77%) of survey respondents reported that they did not believe police should respond to mental health crisis calls, a finding that aligns with data at the national level. Among the minority of survey respondents who did believe that police should be present, their qualitative responses indicated that they believed police should be present to ensure the safety of other crisis responders in the event that the individual experiencing the mental health crisis became violent. However, research demonstrates that even when police have received training in mental health crisis response, they are not effective with ensuring safety and preventing violence. In fact, a systematic review of the literature on police officers who receive Crisis Intervention Training (CIT) found no difference between CIT and non-CIT trained officers with regard to arrest rates, use of force, or injury.<sup>7</sup> Because police officers are trained to respond to situations with force, there is a very real threat that police presence will only escalate a situation and lead to physical and emotional harm, rather than promoting safety. Furthermore, even though 23% of survey respondents believed that police should respond to mental health crisis calls alongside mental health professionals, 94% of survey respondents believed that the mental health crisis response team should create a calm environment. It will therefore be important to leverage research findings, coupled with personal testimonies, to educate the minority of individuals who support police-involved co-responder models about the fact that police presence runs the risk of creating more harm rather than promoting a safe and calm environment.

The City of Chicago has a historic opportunity to build a model of mental health crisis response that utilizes a compassionate, empathetic, person-centered approach to both address the immediate crisis at hand and promote long-term well-being. We urge the city of Chicago to establish a model that is informed by community recommendations and that ensures equitable access to both crisis care and long-term preventative services for all Chicagoans.

### **About the Collaborative for Community Wellness**

The Collaborative for Community Wellness is a collaborative that brings together mental health professionals, community-based organizations, and community residents to address the lack of mental health access and to redefine mental health to match the needs of the community.

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<sup>7</sup> Rogers, M. S., McNiel, D. E., & Binder, R. L. (2019). Effectiveness of police Crisis Intervention Training programs. *Journal of the American Academy of Psychiatry and the Law*, 47(4), 1-8. Retrieved from <https://jaapl.org/content/jaapl/early/2019/09/24/JAAPL.003863-19.full.pdf>.