WE GOTTA STOP CRIMINALIZIN' MENTAL ILLNESS

Experiences with Mental Health Crisis Response in Chicago

A Report by the UIC Community Research Collective

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EXECUTIVE SUMMARY

From July through October 2023, a team of sociologists from the University of Illinois at Chicago interviewed 23 residents of Chicago about their experiences with mental health crisis response. In partnership with the Collaborative for Community Wellness, we set out to learn about people's actual experiences with mental health services and crisis response in our city. During the interviews, people talked about access to mental health services, shared stories about mental health crises, and discussed their visions for a more just and effective mental healthcare and crisis response system. As this report makes clear, the current system is failing the people of our city.

Crisis Conditions

Decades of disinvestment from social services, including community-based public mental health centers, has created the conditions for mental health crises. By 2022, the City of Chicago invested 1000-times more money in the police department ($1.8 billion) than in mental health clinics ($1.8 million). When crises occur, people are often afraid to call for help because the Chicago Police Department (CPD) are the default first responders. Interviewees expressed a fear of police mistreating, harming, or killing the person having a mental health crisis. Despite this fear, many respondents explained that they often have to call 911 because there are no other options.

Police as First Responders

When police did respond, our respondents raised three major concerns about the police response. (1) Escalation: Police officers are quick to turn to an assertion of authority to reinstate order, violently if necessary. In doing so, they often provoke individuals experiencing mental health crises, escalating the situation. (2) Criminalization and violence: Respondents shared stories about personal encounters with police that turned violent as well as stories of other people killed during such encounters. Another form of coercion takes place when first responders describe a person in a mental health crisis as “a threat to themself or others” and involuntarily send them to prison or inpatient care. (3) Dehumanization and stigmatization: Respondents explain that police often treat people as “subhuman” during a mental health crisis.

The Aftermath of a Crisis

In the aftermath of a crisis, many of our respondents report further dehumanization and coercion at jails and prisons as well as hospitals and inpatient facilities. Respondents portrayed jails and prisons as environments that overwhelmingly exacerbate mental health conditions rather than providing care for prisoners confronting mental health challenges. Respondents also described coercive and dehumanizing treatment in hospitals and inpatient facilities, offering numerous critiques of “treatment” that was traumatic.

One of the primary critiques of hospitalization involves the deprivation of agency that takes place when a patient is described as “a threat to themself or others.” If a doctor deems the person a threat, they are involuntarily committed to inpatient care, even when they express disapproval. Much like their experiences with first responders, respondents report feeling dehumanized, stigmatized and devalued at medical facilities. As a result, inpatient facilities often fail to support healing.

A New Mental Healthcare[1] & Crisis Response System

At the end of each interview, respondents discussed their visions for an alternative mental healthcare system. The system would begin by addressing people’s basic needs. It would provide accessible, high-quality, community-based, destigmatized mental healthcare. And the crisis response system would prioritize non-police response teams and practices that are non-aggressive, collaborative, and center the person in crisis. Many respondents were emphatic that crisis response teams should not involve police, suggesting that mental health professionals and members of the local community would be better options. And they were adamant that responders refrain from criminalizing or stigmatizing the person experiencing a crisis. Interviewees envisioned two complementary ways to achieve this goal: (1) the person experiencing a crisis should be a voluntary participant in the process and outcomes, and (2) crisis response should be individualized and collaborative.

Conclusion

The main takeaway from this report is that we cannot continue relying on police to respond to mental health crises. The underfunded state of our public mental healthcare system is putting people’s lives at risk – both in the ways that people must struggle to access daily care and in the harmful, traumatic, and even deadly experiences during and after a crisis. There is much to be learned from community members who have firsthand experience with crisis response and who can imagine another way of caring for each other both within formalized systems of healthcare and within community. For the city to improve access to mental health services, city officials must prioritize those who are accessing care by collaborating with those seeking care rather than criminalizing them, cultivating communities of wellness rather than stigma, and offering individualized rather than dehumanized care.

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