WE GOTTA STOP CRIMINALIZIN' MENTAL ILLNESS

Experiences with Mental Health Crisis Response in Chicago

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A Report by the UIC Community Research Collective

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INTRODUCTION

In spring 2023, the Collaborative for Community Wellness conducted an anonymous survey of 650 residents across Chicago, asking people to describe their visions for an ideal mental health crisis response system.[1] The last question on the survey asked: **"Do you have a story that you would like to share about a past experience with mental health crisis response?"** From July through October 2023, a team of sociologists from the University of Illinois at Chicago - the Community Research Collective - interviewed people who offered to share their stories. We recruited additional participants through a flier in English and Spanish. Overall, we interviewed 23 residents of Chicago. Interviews lasted between one and two hours. We talked about access to mental health services, we listened to their stories about mental health crises, and we discussed their visions for a more just and effective mental health support and crisis response system. Some respondents shared stories about their own experiences; some shared stories about close friends, family members, or clients. See Table 1 for demographic information about our respondents.

Table 1. Respondent Demographics

Respondent Demographics						
Race				**Gender**		
Black	White	Latinx	Asian	Women	Men	Non-Binary
9	7	6	1	15	7	1

We set out to learn about people's actual experiences with mental health services and crisis response in Chicago. As this report makes clear, the current system is failing the people of our city. Decades of disinvestment from social services, including community-based public mental health centers, has created the conditions for mental health crises. When an immediate crises occur, people are afraid to call for help because the default first responders are police.

According to the people we interviewed, the police response: 1) escalates the crisis, 2) relies on criminalization and violence, and 3) dehumanizes and stigmatizes the person experiencing the crisis. In the aftermath of a crisis, respondents report further dehumanization and coercion at jails and prisons as well as hospitals and inpatient facilities. We focus on the critiques of hospitals and inpatient facilities. Our respondents

[1] For more information, see Collaborative for Community Wellness 2023a.

envision an alternative mental health system that addresses people's basic needs and provides accessible, high-quality, community-based, destigmatizing mental healthcare. Their vision for a new crisis response system prioritizes non-police response teams and practices that are non-aggressive, collaborative, and center the person experiencing the crisis.

CRISIS CONDITIONS

Over the last 40 years, business-friendly neoliberal policies that combine subsidies for corporations and elites with austerity for the working class have transformed Chicago into a deeply divided and unequal city marked by extreme inequality, racialized poverty, and militarized policing. The elimination of stable jobs, union wages, public housing, public education, mental health care, and other social services has deepened the everyday crisis conditions confronting Chicago's Black, Latinx, and diasporic working-class communities.

In 2012, the Chicago Department of Public Health closed 6 of the city's 12 public mental health centers as part of an austerity agenda. This marked an intensification of the disinvestment in public mental health that began in the early 1980s.[2] Over the same period, public funding for police departments has risen steadily. Like all neoliberal regimes, Chicago relies on police to contain crises, impose order, and suppress struggles for racial and social justice. By 2022, the City of Chicago invested 1000-times more money in the police department ($1.8 billion) than in mental health centers ($1.8 million).

With cuts to mental health services and increased police budgets, the Chicago Police Department (CPD) has become the city's first response to mental health crises. In December 2015, Chicago police responded to a 911 call from a man who requested help because his son, Quintonio LeGrier, was in distress. When police arrived, LeGrier's downstairs neighbor, Bettie Jones, opened the door as LeGrier came down from the second floor unit with a bat in his hand. The officers opened fire, killing both LeGrier and Jones. A review board determined that the officers were at a safe distance and ruled the shooting unjustifiable.

In response to incidents like LeGrier's murder, the CCW was part of a growing movement to demand changes to Chicago's mental health services and crisis response system. The city responded by initiating a "co-responder" pilot project, in which mental

[2] Collaborative for Community Wellness 2018.

health professionals pair with police to respond to mental health crises in four police districts. Although the pilot project has shown some promising results, it prioritizes police as first responders and does not address the broader disinvestment in public mental health centers.[3]

POLICE AS FIRST RESPONDERS

Within this context, mental health crises are inevitable. When crises occur, respondents explained that they are afraid to call for help because the first responders will be police. **When recounting their experiences, respondents often began with the caveat that they felt they had no other choice but to rely on police.** This suggests that people would be much more comfortable with a crisis response team that does not include police. In addition, respondents offered several explicit critiques of the ways that police react to mental health crises.

According to our respondents, police: 1) escalate crises, 2) rely on criminalization and violence, and 3) dehumanize and stigmatize the person experiencing a crisis. Very few respondents spoke about Crisis Intervention Training program. Overall, our respondents express skepticism at the capability of the Chicago Police Department to handle situations that require assistance, yet feel they have no other option than to contact the police.

1) FEAR OF POLICE, BUT NO OTHER OPTION

Throughout our interviews, respondents voiced fear at the thought of involving police in their mental health crises. These fears mainly pertained to an expectation of police response being dehumanizing, violent, or otherwise traumatic. Their fears stem from both personal experience with and awareness of harmful police encounters. Respondents expressed a fear of police mistreating, harming, or killing the person having a mental health crisis, which impacted how they chose to navigate their crises from start to finish (more on this below).

[3] In response to grassroots mobilizations, the city introduced one non-police crisis response team on the Southwest Side as part of the pilot project. But Mayor Lightfoot deprioritized the non-police option by launching the team nine months after the co-responder teams and by rejecting community input about its implementation.

Jessie, a white person in their 20s, explained that they were **hesitant to contact 911 because of the dehumanizing treatment they expected to receive from first responders: "One of the things that I dreaded the most was interacting with the first responders because I was like, you're already at one of your lowest moments, and then there's some people treating you like you're work that they don't wanna be doing. Or you're a nuisance or a bother."** Elizabeth, a white woman in her 50's, voiced similar fears of bringing police into a crisis situation. "I don't know what's gonna happen if a cop shows up at my door." Caroline, the mother of a Black child, explained, "I would never, ever call – unless my son's life was threatened. **Even if my life was threatened, I wouldn't call 911 because they're gonna send police. That's gonna make everything much worse."**

Anxiety about calling for support during a mental health crisis was commonplace across our interviews. Several people referenced high profile cases of police brutality used against Chicagoans who were experiencing mental health crises, including Laquan McDonald and Quintonio LeGrier, which ultimately led to their deaths. Others referenced racialized police brutality more generally as part of their fear. Because of both personally experiencing and socially witnessing violent encounters with police during a crisis, most of the people we interviewed were hesitant or afraid to involve police in the crisis response.

Despite this fear, many respondents explained that they often ended up needing to call 911 – either for themselves or someone else – because there are no other options. Some noted that they only call 911 as a last resort, for particularly extreme circumstances. Stella, a Black woman who is mother to a son with ongoing mental health symptoms, recounted a moment of intense crisis: "I was like, 'I don't wanna call the police. I'm very terrified to call the police, but I can't keep having this.'"

Caroline, the mother quoted above, shared a painful recounting of school staff calling the police on her young Black son, who was having a mental health crisis in class:

"Nobody in my mind should ever call the police on a seven-year-old. There's absolutely no reason. Period. I would say to them, 'Did he break a law?' No. He's seven. The reason was that they didn't know what to do. He was Black, and he was physically aggressive. He was physically aggressive towards his teachers. They did not know how to help him, how to support him. They had no, really, strategies. I mean, even

though, of course, we were in a million IEP meetings and everything, but there weren't any ways to support a child with his behaviors, so they just called the police."

2) MANAGING POLICE RESPONSES

Because of both the expectation of harm and the lack of non-police alternatives, many people we interviewed described the ways they altered their behavior to accommodate the presence of police. **Respondents described the lengths to which they were forced to go to manage their behavior while experiencing a crisis so as not to expose themselves or others to the potential danger of police dehumanization and violence.** Stella, the Black woman we quoted in the last section, recalled having to mediate how the police interacted with her son: "I was like, 'Look he's my son. He does not have a weapon. There's no weapons in the room. Hey, he's my son, I just need you to deescalate the situation. Please don't come in here and make it worse.'" Those we interviewed who had to call 911 for another person, often a family member, found themselves having to intervene to prevent the police from escalating the crisis by saying things like "don't kill her" or objecting to harmful acts like breaking down the door of someone in crisis.

Michael, a white man, spoke about how he had to learn to alter his behavior even during moments when he was experiencing a crisis: "I have to work hard to be - even when I'm in that state - I know that I need to be good to the police [laughter] because I know they can really fuck me up. You know what I mean?... When I'm in that state, I'm like, 'Don't fuck with me. Don't beat me up.'"

In our current context, where there are so few mental health resources and supports for individuals and families, people experiencing a crisis must thread the needle to present a situation that is seen as worthy of intervention while not inciting police officers to escalate the situation. In other words, people have to learn exactly how to leverage the system to get help without getting hurt. David, an older Black man who oversees the care of his sister through a legal guardianship arrangement, spoke about maintaining this dangerous balance when enlisting police support to ensure that his sister takes her medication:

> "She doesn't like takin' her meds so we have to call the police or fire department to get her to the hospital to take meds when it's time for her to take 'em. She has to take 'em every month because she has to get those long injection shots because she won't take oral medication. What I'm gonna relay to you is the fact that we gotta always talk to the police as though she's fightin' us or 'a harm to herself or others,' just to get this done. Because if you

don't say this, they won't come. What's bad about havin' said that, it makes them come loaded for bear. You know? **It's like you can't win. You don't want nobody to come shoot your sister or come ready to fight when there's no need of it. If you don't say those things, they won't come in the first place.** In other words, I know she will become a threat if I don't do some things, but I shouldn't have to say 'she's a danger to herself or others' at this point to access 911. When I got a whole history already of documentation and what have you to prove that if she don't get this treatment, she's gonna be a threat to herself or others. That needs to be a change. That's serious. Because, like I said, **I don't need nobody comin' to my house with guns blazin'. You see some of the results of that in the past where – a cop is a cop, they come like a cop.** If there's a crisis, they loaded for bear. That's not the case here."

3) POLICE RESPONSE

In many cases, the police are incapable of providing support that people need. Sarah, a 61-year-old Black woman whose daughter suffers from mental health symptoms, described the police as "not equipped" to handle her daughter's manic episodes. This was a frequent refrain among respondents, who often noted that police, in their experience, lack skill and training to handle mental health emergencies. Steven, a 31-year-old Black man, described police officers' unwillingness to provide assistance with his own mental health episode: "I'm having this episode, and my mind's spinning, and [my mom] calls the cops. They say because there's no domestic situation, because neither one of us have hit each other, they can't do much." Whether impeded by policy or lack of training, respondents consistently described police as unequipped or incapable of addressing citizen's needs.

When police did intervene, our respondents raised three major concerns about the police response. According to our respondents, police: 1) escalate crises, 2) rely on criminalization and violence, and 3) dehumanize and stigmatize the person experiencing the crisis.

A) Escalation

To begin with, respondents framed the ways that police respond as 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.

David described how police responses escalate his sister's mental health crises:

> "It's incredible. Sometimes you get four or five cops.... They can make this more simpler. They can have units that's already learned in this area and familiar with this type of response and don't have to come so deep, with so many people, as to alert the whole neighborhood that somethin's goin' on at my house....**It doesn't have to be like that. Because that's just really inciting the mental health person.** That makes 'em even more ready and willing to do things and say things that are outrageous. Because they're bein' stimulated by that process."

In this case, the manner in which police respond to the call escalates the situation as a matter of course. Multiple units with the sirens and lights create a stimulating environment for the individual undergoing crisis, escalating the situation for all involved.

Earlier, we shared a story about Steven, whose mother called the police during an argument, but the police were unable to help. Soon, the argument generated a mental health crisis. When the police returned, they escalated the situation. "They left, and so eventually [my mom] gets me to go outside, and then she closes and locks the doors. I don't know why, but I got mad, so I picked up a shovel. I smashed the window, I smashed the house window, I smashed her car windows, my car windows." After the situation reached a crisis point, the police came back.

> "That's when the police came runnin' back down the lane. We lived on a lane, so they came back runnin' down the lane. I got the shovel in my hand, and they were like hands on their tasers, and they were tryin' to talk me down... Basically what ended up happening was I put the shovel down. I walk up to them, and they are talkin' to me, and I don't know why, but I remember fighting them. Like I got into a fight with them, but I don't remember why. We were fighting, and then the next thing I know I wake up and I'm on the ground bein' handcuffed and there's like six other cops here."

As Steven makes clear, he had already put down the shovel when a conversation with police officers escalated the situation and led to his violent arrest.

B) Criminalization and violence

As the previous story demonstrates, escalation often leads to criminalization and the use of violence by police. Despite the fact that the person experiencing a crisis often does not pose a threat, first responders exhibit inexplicable levels of violence. In the most egregious example from our interviews, Kim, a 29-year-old Japanese-Filipina woman, was having suicidal ideations but was unarmed, naked, and taking a shower in a motel room when police intervened, handcuffed her, and strapped her down in an ambulance:

> "I had a motel room. I was showering. I hear a knock on the door. I'm like, 'What's going on?' because I think front desk called a wellness check on me. They were like, 'Open up. It's the cops, it's police.' I only have a towel on when I answered the door. **They dragged me out of my motel room naked.** I'm like, 'What the hell is going on? What the fuck is happening?' I was like, 'I get it. I'm planning on killing myself. I don't need this dramatic thing.' They put me in cuffs. They're dragging me out without telling me anything. They didn't tell me it was a wellness check. They didn't tell me. **They were like, 'Hey, it's the cops.' Then they just dragged me out of my motel room. Then they bring me downstairs. They load me up in the ambulance. They try to quickly throw a hoodie on me to cover up the fact that I'm naked only with a towel.** I'm like, 'Guys – This is cold. Really cold.' It was the middle of January, February. Apparently I was freaking out. I have very little memory of my psychosis. The memories I do have, I was angry. I was like, **'Why am I being strapped down? Why am I being taken like this?'** They took me to Northwestern for a psych eval."

The significant expectation of harm across interviewees, while partially mediated by broader contexts of highly publicized incidents of police brutality, was also a product of personal, familial, and community based experiences in which police had been violent towards them or someone they knew during a crisis. Michael, a mental health professional, told us: **"I'll be honest, we've had several clients who met up with police and they didn't survive."** Another explained that **Chicago needs to do something to ensure that "the police officers or the authorities or the first responders do not just hurry up and shoot or kill somebody who's having a mental episode, like I've seen happen."**

Another significant form of coercion takes place when first responders describe a person in a mental health crisis as "a threat to themself or others." Through this

designation, first responders strip away the person's agency and involuntarily send them to inpatient care or prison. We expand on this later in discussing what happens in the aftermath of a crisis.

Several interviewees remarked on being thankful that they and their loved ones were not harmed or killed by the police while in crisis. This survival gratitude was not just about surviving their crisis, it was about not experiencing police abuse in addition to the crisis. For instance, Steven, whose story we recounted previously, remarked: "You hear so many horror stories about Black men, Black women, and people dying at the hands of cops...The fact that I literally attacked the cop and survived, and they got me help afterwards, that's why I like—as much as I do think—I don't think all cops are bastards, but most cops are bastards. Yeah, **I was very thankful for that experience of living, I guess."**

When interviewees lauded positive encounters with police, their comments were hedged with assumptions of violence and the focus of their praise was typically about what officers did not do in the situation as opposed to what they did. Stella's explanation of the outcome of a police interaction involving her son, provides one such case: "The good thing is, they didn't harm my son. They were able to de-escalate because they basically just got him to leave the house." In this case, the respondent praises the police for not harming her son. She describes how they de-escalated the situation by removing her son from the premises, but this should be the bare minimum. Stella's son was provided with no mental health resources or restorative care. Comments like this do not point towards a desire for a police presence during moments of crisis, but towards the complicated, loaded, and primarily unhelpful impact that police have on people experiencing mental health crises.

C) Dehumanization and stigmatization

Another critique from respondents is that first responders dehumanize, stigmatize, and criminalize people. The treatment of a person experiencing a mental health crisis as subhuman runs through many of the interview narratives. In the words of Jessie, a white person in their 20s: "If you see it and experience it, the felt sense is you're treating this person like subhuman." Kim, the Japanese-Filipina woman, said:

> **"The cops were treating me like I was a piece of shit," and "We need people that will stay calm and not panic and not treat us like a fucking dog."**

Other respondents explain that dehumanizing treatment starts with centering the responders rather than the person experiencing the crisis. For some people, this critique extends beyond police to other first responders: "The EMTs were so condescending.... Don't have an attitude with me. Don't be too upset," Jessie explained. **"My impression is that there's something about the way that, currently, people interact with emotional crisis or mental health crisis that is very – I don't know – just very distant from the humanity of the person at the center."** They went on to describe an incident when first responders dropped them while they were on a stretcher. "People don't need to be super, super serious, and stone-faced all the time, but what are you doing dropping a teenager on a stretcher? That's a pretty significant mistake to make at your job. Also, laughing about it. Just making jokes like it's just casual, you're just on your shift."

4) CRISIS INTERVENTION TRAINING

Of our 23 interviews with people across the city of Chicago, only three spoke about Crisis Intervention Training (CIT). The CIT program provides 40 hours of crisis-response training to CPD officers on a voluntary basis. To access this service, residents must explicitly request a CIT-trained officer during a 911 call. Of the three respondents, one was a mental health professional who has trained CIT officers and had largely positive things to say. The other two were Chicagoans who had requested a CIT officer when someone else was experiencing a mental health crisis. Their views were significantly more critical.

Michael, the CIT trainer, explained the premise of crisis intervention and de-escalation.

> "I can't tell you how many times in my career I've talked people down like that. It's not rocket science. It's just being patient and listening. I don't know every situation, but being a cop is extremely challenging. But you just shoot? You just can't. We have to have a more humane way to do that. We've had amazing success sending out these – this pilot program – the response rate and people being willing to be worked with, it's amazing. We're gonna try and increase that, bring it into other situations. There's bad policemen. There's bad teachers. There's bad football players. People are people, so I'm not disputing that. I'm just saying because they're the first ones on scene, and then they see something that they don't quite [understand]. That's why we try and train them to understand what you're seeing and you're not in danger or maybe you are, but what to do if you are."

Sarah, a Black woman in her early 60s, described an encounter that involved a CIT trained officer: "I called the cops. There was a situation. They sent – whatcha call it – police officers that are like caseworkers or something. On the West Side. They had one cop that came who was like that. The other two [were] regular cops. The female wanted to go upside my daughter's head with a Billy club. I'm like, 'Nah, you not going to beat her up, because she's not mentally well.' They're not equipped to deal with it. They have a mindset of defense. They don't have a mindset, at the moment, to say, 'Let's take it back.' They're taught to aggressively handle the situation." Sarah had to handle the de-escalation on her own, despite the presence of a CIT trained officer.

Yolanda, a white woman from Rogers Park, was even more critical after her encounters with police officers who had CIT training.

> "It's not just like a regular cop. It's a cop who's been trained to help in these situations, but they don't do jack shit. They do nothing different, in my eyes. I kept trying to intervene, and I'm like, 'She's not gonna answer the door. You're banging on the door. Could you be a little nicer?' It was literally the same. And then, finally, she wouldn't answer the door, and he was like, 'Well, I'm gonna break down the door.' And I was like, 'Are you allowed to break – I don't think you can do that.' And they wanted me to leave. And I was like, 'I'm not fucking leaving.' So she's still super fucked up, and that made everything worse. I think it makes things worse, that I knew that this was a better option. And it still was terrible. **So if we're going to keep cops – which I hope, obviously, we don't – then they need to stop with the CIT bullshit."**

Just like Sarah, Yolanda was forced to manage the police and de-escalate the situation, even though a CIT trained officer was present. She highlighted the limits of training police in de-escalation tactics.

These interviews raise important concerns about relying on specialized training for police to handle mental health crises. The sharp contrast between the perspectives of the CIT trainer and the residents who encountered CIT trained officers indicates a likely disconnect between the ideal and the reality on the streets. Moreover, the perspectives of the residents align with the research literature, which has not produced evidence that CIT training reduces arrests, use of force, or injury to those having a mental health crisis.[4]

[4] Watson et al. 2010; Rogers et al. 2019.

THE AFTERMATH OF A CRISIS

In sharing their stories, many of our respondents discussed what happened after the crisis moment. In the aftermath of a crisis, respondents report further dehumanization and coercion at jails and prisons as well as hospitals and inpatient facilities. We begin with a short discussion of jails and prisons, but focus on the critique of hospitals and inpatient facilities because most of our respondents described experiences at these sites.

1) JAILS AND PRISONS

The criminalization of individuals experiencing mental health crises can land people in jail or prison. Three of our respondents described their own direct experience of incarceration or a family member's experience of incarceration. These respondents portrayed jails and prisons as environments that overwhelmingly exacerbate mental health conditions rather than providing care for prisoners confronting mental health challenges. Arrest and imprisonment were framed by respondents as inherently traumatic. The continued deprivation of liberty and the routine humiliations of prison life create the conditions for trauma and mental health challenges.

In the experience of our respondents, prison personnel prioritize a medical approach to mental healthcare. Angela, a middle-aged Black woman, has a son who is incarcerated and struggles with mental health symptoms. She shared with us that her son has displayed clear symptoms of depression, including an unwillingness to eat during his time in prison. Rather than address the underlying mental health challenges, the prison infirmary focused on the physical manifestation of the underlying mental health condition. The prison offered absolutely no mental health intervention for Angela's son.

When mental health interventions does take place, it is generally in the form of medication. James, a Black man in his 40s from Maywood, stated: "Anything dealin' with any sorts of mental illness, they wanna give you psychotropic drugs.... No counseling, no real one-on-one, not gettin' to the root of what it may be that's bothering and helpin'

you resolve it through cognitive behavioral therapy or something to that effect. No, they wanna offer you up a pill. A pill is the panacea to them."[5] Although counseling is technically available in some prisons, structural barriers – such as bulging caseloads and lack of privacy – prevent inmates from accessing this care in a meaningful way. James articulated his reluctance to disclose any degree of mental distress, saying: "If I'm not doin' well, I'm not gonna tell you I'm not doin' well in front of [my cellmate]."

James also described how prisons respond to inmates with mental health challenges by moving them to isolated confinement, or segregation.

> **"Those people who weren't able to get mental health treatment [outside of prison], bein' that the government, the state, in this particular case, of Illinois don't have the capacity to really treat them. What they do is they funnel 'em into prison. The prisons themselves don't have the capacity to treat people who have a mental illness. Therefore they send them to isolated confinement.** Well, I bear witness over years, I mean over years, of people bein' sent to solitary confinement for months, for years at a time."

Prisons are not designed for such patients, so as a rule, they are sent to isolated confinement. Their stay in isolation aggravates their mental health, worsening symptoms. The same applies to prisoners who fall into mental health crises while already in prison: instead of healing, they are sent to isolation. This quote from James encapsulates the criminalization of mental illness.

> "The people who get the worst, who suffered the worst from this are those with mental illnesses, because they don't possess the capacity themselves to obey the prison rules and guidelines. They always appear to be outside the guidelines and rules. If the prison don't have the capacity to treat them properly, what they do, they put 'em in a cell by themselves and they lock 'em away.... What isolation finally does to people in general, a person who doesn't have a mental illness, solitary confinement, isolated confinement, for a period of weeks, even months, they will develop symptoms of mental illness. **If you put somebody who already has symptoms of mental illness or who are mentally ill in solitary confinement for weeks or months, it's gonna exacerbate their mental illness. I be a witness to this."**

[5] For more on the use of medication in carceral facilities, see Hatch 2019.

Respondents also described how the concentration of individuals dealing with mental health challenges and/or coping with past traumatic experiences created an added layer of trauma for inmates, which sowed seeds of conflict and prevented access to care. This occurred via exposure to traumatizing events such as suicide and violent conflict. One respondent described witnessing two suicides in prison. James described the cycle of violence that can occur when people with mental health struggles are placed in cells with people who do not have the skills to handle those interactions and who likely have their own trauma. In one particular incident, a man assaulted his cellmate, who had an unknown mental health condition, and then both men were sent to isolation for 30 days as punishment for fighting. "He gonna be punished for bein' a human punchin' bag… Then, after his 30 days up, he gonna be released back in general population and put in a cell with somebody else who don't have the skills or capacity to deal with it. That's what's gonna happen, and it's gonna repeat, unfortunately."

2) HOSPITALS AND INPATIENT FACILITIES

Most of the people that we interviewed discussed experiences at hospital emergency rooms and inpatient facilities in the aftermath of a mental health crisis. Even in these settings, they also experienced coercive and dehumanizing treatment. Our respondents offered numerous critiques of "treatment" that was traumatic.

A) Deprivation of agency

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"* and their agency and autonomy are stripped away. If a doctor deems the person a threat, they are involuntarily committed to inpatient care, even when they express disapproval.

Jessie, a white transgender person in their 20s, described an experience at an emergency room after experiencing suicidal ideations. Jessie wanted a referral to an outpatient mental health center. Instead, the ER staff committed them to an inpatient facility against their will.

> "There just was no wiggle room of trust. There was no, it sounds a little corny, but there's no spirit of collaboration. It was just sort of like, 'Well, we can't believe you. We can't trust you because you did this thing.' Which, it always pissed me off, too, because I hurt myself. Can't trust me to do what? Not that it's not serious, but I'm like, at the end of the day, it is my life and my body. You don't trust me to do what? It just feels strange to be like, 'Because we don't trust you to keep yourself safe, we're gonna remove your agency and autonomy and send you to a place that you can't leave, and you [don't] have

control over your circumstances, your situation. You don't have any privacy. Someone's gonna watch you shower, watch you use the bathroom because we're so worried about you.' Whatever. I thought I wanted to kill myself before and now I can't even pee with the door closed. That's really not making me feel a new lease on life. A new zeal for life. We would joke about that, but it's very real. How is it you're like, 'Okay, you've hit this real low point. You survived. As a consequence of that, we're gonna make the next two weeks of your life a nightmare.' Nothing that's comfortable around, nothing, no one familiar. You have limits on how long you can see friends, family. It's very, I don't know, very weird.... It's like, hey, you're in crisis. Do you wanna go somewhere where you have no autonomy? You have to get naked and have someone check your body. All of this stuff that just is not, why would that inspire healing for someone?"

Jessie went on to describe the feeling of not having a choice about their own treatment:

"I went to seek support, and they basically had twisted my words or misinterpreted my words to be like, 'Oh, this person's paranoid for no reason, and they can't keep themselves safe. They're a threat to themselves.' They were like, 'We're sending you to inpatient.' I'm like, 'How did we get there from what I'm saying?' I specifically was like, I wasn't really physically all that harmed. I was like, 'I don't wanna go to inpatient.' I was like, 'Could I just do outpatient?' Because I had something, because of some concern for my safety with myself or whatever, they were like, 'If you come to the ER for suicidality, suicide attempt or whatever, you have to go to inpatient before you can go to outpatient.' It's the thing where there's not really a choice."

The lack of agency is exacerbated by a lack of explanation or communication. Lola, a Black woman in her 20s, explains how lack of communication took away her ability to properly consent to care. When Lola was experiencing a mental health crisis, her friend called 911. An ambulance took her to the emergency room, where doctors involuntarily admitted her to an inpatient facility. She woke up in the ER highly disoriented. Lola recounted, "I was just very confused. I was like, 'What's going on?'" She was having trouble understanding what she had experienced. She explains, "I think I didn't really understand the gravity of everything that had happened." Her confusion continued as she waited for the next steps in her care. She had limited access to her family and providers were asking her questions.

They suggested that she needed further care, which she accepted because she understood it would be helpful. **She thought that she was agreeing to communicate with a therapist, after which she would go home. Instead, she was transferred to an inpatient facility in the early morning, around 3:00 am and she was very confused and scared when she arrived. She wasn't sure if her family knew where she was. She was finally informed of where she was and why she was there by a nurse at 9:00 am.** Her experience demonstrates the confusion, fear, and general discomfort that someone in crisis faces when they are not involved in making a plan for their care, and illustrates how lack of communication leads to involuntary treatment.

Finally, the deprivation of agency exacerbates many people's symptoms, as was the case for James and Jessie. "Bein' under the total control of someone else and someone else bein' a stranger, that has a way of makin' a person – it affects your self-esteem," James explained. Jessie added: "I hadn't been suicidal when I entered that [inpatient] facility, and then being there, I was extremely suicidal because I felt trapped. I felt like I didn't know how I was gonna get out. I was just being triggered and disrespected constantly."

B) Dehumanization and stigmatization

Much like their experiences with first responders, many respondents shared stories of dehumanization and stigmatization at hospitals and inpatient facilities. Mental health patients are often denied their rationality as reasonable human beings.

Their behavior is reduced either to their age (teenagers who are "dramatic or hormonal"), a mental health condition ("crazy"), or presumed criminality ("looks like a criminal"). More than one respondent discussed the similarity of these three positions – **child, crazy, and criminal** – and explained that the attitude of care providers is to treat them as "subhuman." As Jessie explains, these three groups of people are subjected to treatment that is "otherwise seen as unthinkable or just something we wouldn't do to people. If you're a child, if you're a prisoner, or if you're crazy, suddenly, tying people up, drugging people, beating people" becomes acceptable.

Beyond these three categories of particularly dehumanized individuals, however, respondents also report feeling devalued by hospitals and inpatient facilities. James explained, **"You don't really feel as though you have any value within that system. To understand that they give you this pill because it's the least expensive thing that they can give you to help treat you, it further goes along with the narrative that you are of low value."** Elizabeth, a white woman in her 50s, described an instance where she received a letter explaining that her treatments would not be covered. "I got this letter in

the mail. I remember I got it. I read it. I set it down. I went up the street to my paid therapist and told the front desk I wouldn't be coming anymore because I didn't deserve treatment, then went and canceled my gym membership because I figured I wasn't worth that either. That's how traumatic that experience was. I stopped all treatment because I got that letter basically saying I wasn't worthy of treatment." Although this happened to Elizabeth outside of the United States, her experience of feeling devalued aligns with the experiences that other respondents reported having in Chicago.

Patients also describe feeling dehumanized through the medicalization of their individuality. **For example, some hospital and inpatient facility staff describe trans identity or non-binary pronouns as part of a mental illness. "[They] mocked my identity as a transgender person," Jessie explained. They went on to say, "I was just being triggered and disrespected constantly. I tried to tell them and correct them about my pronouns and my name. They laughed in my face and were just very, 'We don't do that here,' sort of implying it was part of my mental illness and they weren't gonna enable me."** In other words, during the whole mental health journey, patients go through a process of dehumanization wherein aspects of their identity or humanity are stripped from them.

The reliance on medication within hospitals and inpatient facilities also contributed to the feeling of devaluation and dehumanization. Lauren, a white woman from the North Side, described her experience at an emergency room: "They didn't give me any type of treatment other than to sedate me." Caroline, another white woman living on the North Side, discussed a similar experience that her son had at a local hospital. "They were just stupid, like they didn't help him. Everything was medication, medication, medication. I truly, strongly believe in medication, but there is a person in there that you need to acknowledge and recognize. You can't just throw meds at somebody." Elizabeth shared, "I ended up self-harming in the emergency room when they weren't looking, and then they babysat me for three or four days. It was terrible. They shot my ass full of Valium and Ativan. They basically just drugged me out." The emphasis on medicine reduces individuals to their symptoms and fails to engage with their full humanity.

Respondents discussed a host of practices in inpatient facilities that stripped away their agency, humanity, and individuality: a lack of privacy (even in the bathroom), staff monitoring of phone calls, bans on music and social media, and limited activities other than TV. None of those practices are conducive to healing. As Yolanda explained, "They [monitor phone calls] so that you can't tell anyone, and you can't escape. But again,

it depends on the frickin' individual. There is a person, right, if they talk to a friend, or if they get on social media, they're gonna get worse. But some people need their friend. It just needs to be individualized."

The result of these practices is that inpatient facilities often fail to support healing. In fact, some respondents explained that they felt it necessary to lie about their "healing" so that they could leave inpatient care sooner rather than later. As Jessie explained,

> "They won't let you leave if you are still saying, 'Yeah, I'm still having suicidal urges.' It doesn't even have to be all that long. Even if you've said no for two days, that's usually okay. Then you also just have to – they do check-ins. Usually, multiple times a day, they do these little check-ins. The check-ins are your progress report, your status report. That's what I mean where I saw people be like profoundly dishonest. I, myself, have been dishonest because what else are you supposed to do? People, to us, would be talking about how nothing has changed. That when they got home, they were gonna go back to the shitty boyfriend that made them in such a low place that put them in there in the first place. They were gonna continue with drinking or drugs. They were gonna continue self-harming. They were going to try and kill themselves again."

In other words, the deprivation of agency and dehumanization that respondents experienced in hospitals and inpatient facilities did not promote effective healing. Instead, these practices lead people to conceal their ongoing symptoms so that they could simply leave the facilities.

Some respondents discussing the aftermath of a mental health crisis drew explicit comparisons between the conditions in jails, prisons, and inpatient facilities. Describing conversations with friends who had been incarcerated, Jessie explained:

> "I've had so many conversations where our experiences in inpatient facilities and psychiatric facilities in a prison are so similar. The feelings I had [in an inpatient facility] are so similar to some of my friends who have experienced incarceration. Either just temporarily in jail or serving time. There's just this way that staff talks to you that is just, they don't give a shit about you. … It's just literally a cocktail of environmental factors that actively make people unsafe emotionally, and mentally, and physically. That's a place that is

supposedly supposed to be about healing. Or, in the case of prisons, it's allegedly supposed to be about safety, public safety."

James and Elizabeth also discussed similarities between the inpatient experience and carceral punishment. Stripped of their agency and subjected to stigmatizing and dehumanizing treatment, our respondents insisted that hospitalization and incarceration are closely related.[6]

A NEW MENTAL HEALTHCARE AND CRISIS RESPONSE SYSTEM

At the end of each interview, respondents discussed their visions for an alternative mental healthcare system. In this section, we explore the core aspects of a more just and effective mental healthcare system as described by our respondents. The system would begin by addressing people's basic needs. It would provide accessible, high-quality, community-based, destigmatized care. And the crisis response system would prioritize non-police response teams and practices that are non-aggressive, collaborative, and center the person in crisis.

1) MEETING BASIC NEEDS

When discussing their visions for a more just and effective mental healthcare system, many respondents argued that care begins with meeting people's basic needs for stable housing, nutrition, job training, and healthcare. Elizabeth, a white woman in her 50s, explained:

[6] For more on this theme, see Ben Moshe 2014, 2020; Thuma 2019; and Daley et al. 2019.

> “**Mental health is about community. It’s about socialization. It’s about physical health. It’s about harm reduction…It is about people having access to exercise, childcare, food. Hierarchy of needs here.** People can’t focus on their mental health if they’re dehydrated. People can’t focus on their mental health when they’re unable to feed their children. People can’t focus on their mental health if there’s no one helping them with their children’s mental health.”

2) ACCESSIBLE, COMMUNITY-BASED, HIGH-QUALITY CARE

Respondents outlined the core elements of a vision for accessible, community-based, high-quality mental healthcare without stigma or criminalization.

A) Accessible and community-based

Respondents envisioned making the mental health service sector more accessible and community-centered. Accessibility here refers to location, affordability, information, staffing, and timeliness.

Community spaces for healing, where people can care for each other, were consistently mentioned as priorities. Adding elements of community-centered care increases accessibility for residents. Justine, a Mexican American woman living in Brighton Park for over 25 years, explained what supports were needed: “I would say spaces. **Spaces for us to talk about this type of stuff…so it’s not such a ‘I’m alone in this’**…If you know you have a space that you can go to that is there to support you regardless of who you are, regardless of all different walks of life. Having that support I think is more than valid.” Carla, a 44-year-old Latina resident of Chicago Lawn, echoed this need: “Now I recognize my symptoms. **If I can find a place just for five minutes to calm myself down, that would be perfect**…. Why don’t we have safe space, calm spaces?” Community members imagine “living room” spaces sprinkled throughoutB Chicago that offer a safe, soft, and quiet environment to talk to volunteers and trainedB professionals about their experiences and needs on a walk-in basis.[7]

Respondents also discussed the benefits of group therapy or support groups withB individuals who have similar mental health experiences and challenges. Kim, a 29-year-old Japanese-Filipina woman, said: “Going to group therapy has helped me feel not aloneB in my struggles, has helped me arm myself with tools like Cognitive Behavioral Therapy,

[7] See Collaborative for Community Wellness 2023b for more on the “living room” model.

and art therapy." Michael, a white mental health professional, shared: "When people come to our support groups, you'd be surprised. People go, 'I didn't know there was so many people like me.' They love the connection." Group therapy and support groups may also take place in living room spaces. In alignment with the principles of an autonomous and destigmatized collaborative planning process for mental healthcare, these community spaces will serve as preventative care so that individuals like Carla can find support before escalating to a crisis. Further, these recommended spaces can also serve as connectors to high-quality mental health centers that ensure patients are treated with full respect.

Several interviewees noted the need for public mental health centers to be re-opened or established in underserved communities. Sarah, a Black woman in her 60s, shared that such services had previously been available and extremely beneficial to their community – both during crisis situations and for general wellbeing and preventative practices – but they no longer exist. She explained:

> "**Well, they definitely need to start puttin' more facilities on the South Side.** I was there when they removed the mental health clinics from the South Side, and there is a big difference. People relied on that clinic, over here, to go get their medications, to get their wellness, even for female care and your kids. It was a great place. You can get a WIC program there. It was an all-in-one service, and they took it outta the community like they always do. They take things out, and when people start actin' up and goin' elsewhere and clownin', then they wanna say, 'Oh, they're a bunch of criminals,' when the fact is that you have taken everything."

Others noted that telehealth appointments or free transportation services were extremely helpful in overcoming certain geographic barriers to accessing mental healthcare. Financial accessibility was frequently noted as a barrier to folks accessing any mental healthcare, let alone quality care. As Michael stated, "In a best-case scenario, nobody in the city is worried about paying for or worrying about having access to [a mental health center]." Others noted that insurance tends to limit access to care rather than enable it. Kim explained how her insurance only covered her medication needs after a crisis took place, even though access to medication beforehand could have prevented the crisis. "Now I can afford it because I went through a crisis and now I have health insurance because I had the crisis." Overall, respondents called for a removal of socioeconomic barriers, eliminating eligibility requirements by insurance companies, and ending healthcare that is "based on profit." All of this suggests the importance of publicly

funded mental health centers that provide universal care without conditions.[8]

Another way to make mental health centers more accessible is to ensure the widespread availability of information regarding locations and resources. Respondents discussed how calling 311 often left them feeling more confused or helpless. Several turned to Google, also leaving individuals unsure where to go. Some noted possible solutions such as a clear online database of mental healthcare facilities on the city's website, with details about the services and mental health needs that each location can support. Others noted that city-wide campaigns with visible posters, signs with hotline numbers, or even booths at public events are all ways in which mental health services are more likely to be seen and known by the public.

Finally, several respondents noted that sufficient staffing and extended opening times are needed for mental health centers to be accessible. Respondents explained that facilities were often overbooked or wait times were too long to treat needs at appropriate times. Some centers were open at inaccessible hours and individuals experiencing a crisis late at night or early in the morning were left with no choice but to visit an emergency room for care. In the words of Lauren, a white woman living on the North Side, the courage to seek care in times of need should be met with care, not further traumatization: "Just picking up the phone to call – that should be all it takes. It takes a lot just to do that and to continue to have to call and call and be told, 'No, that we're not open,' that's not good. People need support right away. We need to know that we have somebody when we need somebody."

To further expand community-based, accessible mental healthcare, respondents also called for establishing comprehensive mental health services in schools in order to reach young people in the community. According to respondents, schools should provide and ensure social workers are available and trained to connect students and their families to proper mental health services. Elizabeth called for: **"Normalizing it, for one thing. Making it accessible from such a young age and making it accessible in schools more."** Sarah called for more one-on-one special education options. Finally, respondents also discussed the need to provide more services for currently and formerly incarcerated populations. Folks imagined mental healthcare facilities and supports as an alternative to carceral systems. Recognizing the criminalization of mental health, respondents are clearly advocating for preventative care and meeting basic needs which has the potential to eliminate the need for a crisis response that results in trauma, stigmatization, and criminalization.

[8] See Collaborative for Community Wellness 2023b for detailed proposals that align with this vision.

B) High-quality, destigmatized mental healthcare

In addition to accessible facilities, respondents called for transformation *within* facilities, or an audit of current mental health service staff and the establishment of best practice training and guidelines to ensure staff treat patients with full respect and decency.

Consistent across all of our respondents is a call for destigmatizing and decriminalizing people with mental health challenges, not only in hospitals, inpatient facilities, and among first responders but within communities. Angela, who works for a mental health organization, explains that this can help create a norm of accessing mental healthcare. **"Well, definitely get rid of the stigma...I would hope that we would have easy access to care.** Easy access to mental healthcare, because it's big. It's big now, and Black people, as a norm, try not to engage in mental health dialect or things of that nature." James, himself an advocate of social justice, said **"I think first we gotta stop criminalizin' mental illness.** That's the very first thing that needs to be done. You can limit the amount of people who goin' to prison just because they have a mental illness, that'd be a big step in the right direction."

Inherently connected to the recommendations to integrate multiple forms of mental health support is an effort to destigmatize mental healthcare. By making care more accessible, respondents envision the normalization of talking about and seeking support. Kim expressed a positive experience with therapy which led to her family moving beyond stigma: "They have become more involved in my life. They are more concerned about me whenever I'm having emotional moments. They ask me about how therapy is going. They ask me, 'How are you doing mentally?' I feel like because of me they're more aware of other people's mental health needs as well." Respondents overwhelmingly advocated for a more just healthcare system grounded in community healing and responses to mental health crises which center their personhood and cultivate a calming environment.

Community members are asking for a collaborative and participatory planning process for their own care as autonomous agents which centers the principles of decriminalization and destigmatization. To meet this vision for destigmatized care, respondents shared specific best practices they would like to see in mental healthcare facilities. All of these practices contribute to an overall vision of a participatory, collaborative approach, wherein individuals are enabled to act for themselves, verbalize their needs, have their wishes respected, and receive care specific to their mental health needs.

- ***Autonomy and self-sufficiency*:** First, respondents expressed that care models should promote independence and encourage patients to take care of themselves as

much as they are able, rather than assuming deficiency or inability. Jessie shared their ideal for what mental health should look like: “Mental health means that…you’re able to take care of yourself for the most part. Or for most of the time. Or at least that your mental health is not a barrier to that, to you taking care of yourself, even if there are other barriers.”

- ***Basing care on patient’s verbalized needs*:** Second, even amid a mental health crisis, patients should be allowed to verbalize their needs to providers. Many called for more collaboration and participatory planning between staff and clients to determine a plan of action towards healing. Lola, a Black woman in her 20s, discussed knowing they needed a therapist, but never having the opportunity to express that need. **“I think just honoring what people want as well and listening to them would also be an ideal aspect of a perfect mental health response system.”** When Lola finally obtained a therapist, her experience was positive due to the patient-participatory model of their meetings. “I think having a therapist who meets you where you’re at and almost doesn’t push you to feel or believe or make a decision that’s based on what they want or based on what maybe the world would think is a good decision. … Really, having a therapist who understands that, ‘Maybe right now, I don’t wanna make the best decision for myself. Maybe I wanna keep doing the harmful thing, but I wanna do less of it,’ and having a therapist who’s okay with that, instead of just having one that’s like, ‘No, you need to stop doing the harmful thing and just become this perfect good person.’”
- ***Matching care to specific mental health needs:*** Several noted ways in which their care felt like a homogenized protocol for mental illness broadly and often had nothing or little to do with their specific needs. As Elizabeth, a white woman in her 50s stated: “There’s no nuance. It’s all very black and white, but mental health is not black and white…One person’s cancer is different from another person’s cancer. Why are we treating mental illness the same. There’s so many shades.” Jessie also noted: “The Western medical process of it’s all linear, and we identify the problem and try and solve it with this thing. We’re trying to trim the edges so it fits in the medical system. It doesn’t. It just doesn’t fit.” Elizabeth also expressed a positive experience working with a program that “let [them] develop as a person” by connecting them to mental health and other social services that could help them with their personal goals for stability.
- ***Reform and funding for mental healthcare workers:*** Respondents called for an overall reform and audit of current facilities and staff, and a re-establishment of these participatory planning practices. As stated by Michael, “Let’s fire everybody in there who isn’t kind or compassionate or helpful. We’ll get them all out. We’ll bring in new people. The culture needs to be changed in order to – it starts at the top, so it’s not just that worker, but he’s been getting away with it. They’ve been created over time.” While many of these requests are tied to the comportment and best practices of staff,

they also imply the need for more funding to employ and train mental healthcare workers in order to eliminate overworking and underpaying staff. Respondents relayed that facilities with frequent turn-around of staff lead to unhelpful or negative relationships with service providers. In addition, respondents of color expressed the need for more diverse mental healthcare workers that can share similar backgrounds and identities as their clients.

3) AN ALTERNATIVE CRISIS RESPONSE SYSTEM

Respondents shared a variety of ideas to improve the response when crises occur. The calls for change break down into three main areas: 1) the composition of crisis response teams, 2) practices that are collaborative and non-aggressive, and 3) centering the person in crisis.

A) Crisis response teams

Many respondents were emphatic that crisis response teams should not involve police. Our respondents suggested that mental health professionals and members of the local community are better options. Very few respondents were in favor of either CIT trained police or a co-responder model that included police along with mental health professionals. Significantly, each of the respondents in favor of a police presence have either current or previous experience working alongside the Chicago police.

Most respondents were insistent that police should not be involved in mental health crisis response. This aligns with the findings from the CCW's 2023 survey, in which over three-quarters (77%) of respondents said that only mental health professionals should respond to mental health crises and not police.[9] As documented throughout the report, respondents shared negative personal experiences with police, either from their own mental health crisis or that of a family member or friend. Respondents were explicit in their stance. Yolanda, a 56-year-old white woman living in Rogers Park, stated that no police presence was desirable and CIT training was "bullshit." Lauren, another white woman living on the North Side, recognized that having training for police officers would be an improvement, but clarified that in an ideal situation police would not respond to mental health crisis situations at all. Carla, a Latina who works in non-profit community services, shared: **"We don't need police. You know? We need someone who can calm us with words, or breath, or [through] just staying by [our] side."** Lola, Elizabeth, and Caroline, all expressed similar opposition to police involvement.

Many of these respondents envisioned locally staffed crisis response teams and teams composed of mental health professionals.[10] Jessie explained that a response by people who

[9] Collaborative for Community Wellness 2023a.

[10] See Collaborative for Community Wellness 2023b for detailed proposals that align with this vision.

are from the community is valuable because they are familiar with the person experiencing a crisis, and their first interaction is not during the charged crisis moment. Multiple respondents wanted crisis response to involve mental health professionals trained to handle crisis experiences. Michael, a mental health professional, described successful experiences talking people down from crises. Lauren pointed out that an important part of crisis response involves being able to evaluate and de-escalate the situation. She thinks that mental health professionals will be able to do that better than a police officer carrying a gun. Lola, a Black woman in her 20s, shared a similar idea. “I think that the people who step in should be people who are trained to deal with mental health crises. People who are therapists, or people who are medical professionals, mental health professionals who might just be better equipped to deal with that.”

No respondents thought that police should be the only or even the primary first responders for any mental health crisis. Respondents with current or prior experience working alongside the police were more invested in continued police involvement in crisis response. Michael, a mental health professional involved in training police, felt that circumstances where there is a gun or other weapon might justify police involvement. Yet he insisted that police must be properly trained if they are going to be involved in mental health crisis response. He described a successful interaction he observed with a CIT trained police officer who was able to be non-threatening, which allowed a conversation with the person in crisis to take place. David, a former DCFS investigator, also saw a role for police in crisis response. But he felt strongly that police should play a supporting role: “Mental health people, the social workers...they can be the professionals there and guide the police as to how they need to interact or not interact.” Kim shared this view, explaining: “If there’s gonna be a cop, there should also be a mental health professional.”

B) Transforming responder practices

The people we interviewed shared several proposals to improve how responders address crisis situations. Interviewees want first responders to focus on de-escalation and take a non-aggressive approach. And they are adamant that responders refrain from criminalizing or stigmatizing the person experiencing a crisis as they manage the situation.

Two respondents shared stories of de-escalation. Stella, a Black mother, described a positive experience where police were able to de-escalate a situation involving her son. This was critical because it kept him from experiencing a violent response from the police themselves. Sarah, another Black mother, talked about her fears that police would carry out an aggressive response to her daughter. She assessed that one of the police officers

officers who had responded to a crisis was seeking to hit her daughter's head, so she had to step in to de-escalate the situation and prevent that outcome. Responses that did not involve successful de-escalation put respondents and their loved ones at risk. Respondents perceived that the aggression inherent to policing was detrimental in crisis situations. Sarah concluded that the police are "not equipped to deal with [crisis situations]. They have a mindset of defense. They don't have a mindset, at the moment, to say, 'Let's take it back.' They're taught to aggressively handle the situation."

The widespread preference for decriminalized and destigmatized support has been explored in detail throughout the report. The people we interviewed were clear that these desires extend to first responders at the moment of crisis itself. The following remarks exemplify these ideas. Lola shared her hope for a decriminalized crisis response. **"The biggest change to the approach for mental health in the city... is that there needs to be another option than dialing 911, and then this whole crime response happens. Because having a mental health crisis is not a crime, and I think it's treated that way a lot."** Steven, a 31-year-old Black man, condemned stigmatization of those in crisis and imagined a more supportive response. "You see people on the news walkin' around butt naked, talkin' to people, yellin' and stuff. They put them on the news, and they blast them in one of the worst times in their lives. It's just like, we could do so much better for these people. We can literally help them and give the support they need so that they can be better."

Demanding that first responders prioritize de-escalation and recognize the humanity of the person experiencing a crises, rather than stigmatizing or criminalizing them, reinforces the conclusion that police should not be involved in the response.

C) Humanized, individualized approach that centers the person in crisis

As we explained in the preceding section, respondents seek an approach to crisis response that is decriminalized and destigmatized. Respondents articulate a clear path to achieve this, through two complimentary objectives: 1) the person experiencing a crisis must be a voluntary participant in the process and outcomes of crisis response, and 2) crisis response must be individualized and collaborative. These two asks from respondents are indicative of the overwhelming desire for crisis response to humanize and center the individual experiencing a crisis. According to our respondents, crisis response should treat each individual experiencing a crisis as a unique, valuable human being, which would require respecting their consent and their particular needs rather than committing them to dehumanizing inpatient facilities.

Respondents advised that crisis response must involve the consent of the person experiencing a crisis. This was critical to the encounter concluding in a positive, productive manner. Some respondents expressed that involuntary commitment or detention as part of a crisis response was harmful and not productive. During their experience with inpatient treatment, Jessie observed that some people are not able to heal in the in-patient setting. Elizabeth had a "terrible" experience where she was sedated for several days while in an inpatient facility. During inpatient treatment, she "[didn't] have access to any of the things that [she] needed to feel safe and comforted." She has resolved to self-manage the way she seeks help during future crisis moments, so that she is not exposed to another involuntary, negative, unhelpful crisis response.

Ricky, a 66-year-old Black man shared multiple experiences at local hospitals where he was involuntarily released from care. He had an experience like this at Mercy Hospital. When he was informed by a nurse that he was okay to leave, Ricky objected to that assessment and asked for resources. The nurse told him, "we're not equipped with that. You'll have to go to this program or go to that program or go to this program." He expressed that he could not coordinate that on his own, and that he was concerned about his suicidality. The nurse said that there was no assistance available, and he was forced to leave. After having this experience, Ricky refers to the hospital as "No Mercy." Ricky did not consent to the termination of crisis support and having the situation play out without his consent left him in a vulnerable state and at risk of further crises. When individuals do not consent to the content or duration of the crisis response, it is not conducive to helping them heal. Voluntary participation is important for achieving crisis responses that offer suitable support and resolve the crisis with a positive outcome.

Respondents urged that the steps taken in crisis response be individualized for the person experiencing a crisis. This is evident in the diversity of specific ideas and personal strategies that respondents shared, which were particular to their own context and experience. Respondents wanted their specific needs to be considered by crisis responders. Sophia, a 29-year-old woman living in Rogers Park, breaks it down simply. She wanted her feelings to be important to the police officers who responded to her crisis. Instead, she explains, "I just didn't feel like it really mattered what I was going through mentally."

To prioritize the needs of individuals, respondents envisioned that the person experiencing the crisis would have agency as a collaborative participant in the crisis response process. Elizabeth explained, "there needs to be someone, not showing up to shut someone down, but to get them to maybe open up a little bit... 'This is you and

me,' whereas [with the cops] it's 'You versus me,' as opposed to working with me." Jessie explains that a cooperative format that promotes agency is key to avoid criminalization, dehumanization, and stigmatization. They imagine, "something that is more collaborative and more participatory so that... when you're in crisis, you're not suddenly treated... [as] if you're crazy or a prisoner or something, [and like] it's okay to treat you any type of way because you're whatever, you're not sane, or you're a danger to yourself or others. There's just other ways to approach that, I think, than through physical force [or] through the removal of your autonomy and agency." Respondents imagine an ideal crisis response situation to involve clear, timely communication with the individual in crisis and their support persons. David, who has guardianship over his sister, is often left out of the loop when she is in crisis. This lack of communication lessens the quality of care his sister receives. David explained that if he were promptly contacted, he would be able to inform the facility about his sister's needs and share details of her prior care, which would improve the quality of their response. In summation, respondents want individuals experiencing crises to be treated as fully human actors who can and should be involved in making decisions about their own care. They expect crisis responders to respect the unique personhood of individuals in crisis and engage them collaboratively.

CONCLUSION

For years, there have been calls to re-open the public mental health centers closed in 2012 (and in previous years), and to fully re-imagine the way our city supports residents with both daily mental healthcare and crisis care. To do that re-imagining, there needs to be an understanding of the current contexts in which Chicagoans are living and navigating access to mental healthcare.

With our interviews of 23 individuals who've had or dealt with a mental health crisis in the city, three primary themes have emerged. First, people experiencing mental health crises and seeking help frequently rely on 911 despite the fact that it is an inadequate and often traumatic route for accessing care only because they have no other option. Second, when people call 911, the subsequent response can often lead to criminalizing, dehumanizing, and depersonalized treatment at the scene of the crisis, in a hospital or inpatient facility, and/or in a jail or prison. Third, to make the system work better across

the city, our mental healthcare and crisis systems must be more collaborative, individualized, and community-based while also rooting out stigmatizing, dehumanizing, and criminalizing aspects of the system.

While ideas for how to change the system among our interviews were diverse, the main takeaway is that we cannot continue relying on police to respond to mental health crises. The underfunded state of our 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 and often traumatic experiences during and after a crisis. People experiencing a crisis have been made to feel less-than-human, out of control, confused, and ultimately worse – arguably the opposite of our city's goals for mental healthcare. This can be changed in part by introducing a transformed system of mental healthcare that collaborates with those seeking care rather than criminalizing them, that cultivates communities of wellness rather than stigma, and that offers individualized rather than dehumanized care

We believe that these personal perspectives of transforming our mental healthcare system also hold true for the guiding principle by which the city chooses to transform mental healthcare in Chicago. For the city to change access to mental health services for the better – both in quantity and quality – city officials must prioritize those who are accessing care. 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 as a way to privilege healing and mutual aid. Drawing on the lived experiences of this collective of individuals allows us to see the spaces where needs are not being met and the knowledge that lives within those most impacted by these systems of harm. Most importantly, it allows us insight into the alternatives that can and should be created instead.

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