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Emergency Response to Mental Health Crises: A Case Study of Bloomington, Illinois

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Abstract

This research project examines Bloomington, Illinois's emergency response system to mental health crises. Through a review of the emergency response resources at the national, state, and local level, this capstone identifies where Bloomington has been successful and where there are still gaps. In response, this study offers recommendations for how Bloomington can address those gaps and how other cities can analyze their mental health emergency response system similarly. Finally, limitations and future research are discussed.

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Introduction

After the police protests that defined the summer of 2020, it is challenging to decouple any review of police practices from those calls for reform. After the murder of George Floyd, protesters made demands ranging from "Reform the Police" to "Defund the Police" to "Abolish the Police." These protests were only the peak of these movements, which have been quietly bubbling in the background for years (McDowell & Fernandez, 2018). Beyond the mistreatment of African Americans and other minorities, activists and academics have noted the broad powers the police hold. This is directly in response to the growing size of problems we expect the police to solve. Through a patchwork of policies, police have had to become social workers, therapists, case workers, advocates, etc., on top of their first and foremost task of "serve and protect" (Rubin & Poston, 2020). The movements to reevaluate the jobs of the police - from "reform" to "abolish" - all come down to the desire for more targeted and research-based approaches to addressing community issues.

One such area that has been gaining attention in the past few decades is addressing how police interact with people with mental health problems, especially when addressing people experiencing a mental health crisis. People with mental health problems have unique needs and often act in ways that may seem illogical or even dangerous. This can be challenging for police officers, who must balance aiding the individual and protecting the public. Moreover, people with mental health problems are more likely to be the victims of crime than people without mental health issues (Watson et al., 2001). Despite this, police are more likely to stereotype people with mental health issues as more dangerous and are more likely to use force against them (Gottfried & Christopher, 2017). Ultimately, many police officers do not have adequate training to interact with people with mental health issues, which is a glaring concern considering the

higher instances of violence against this group. This has led to a push to 1) train police officers to interact with people with mental health issues and 2) hire mental health professionals to work alongside police (Steadman et al., 2000). These interventions have looked like Crisis Intervention Training and Crisis Intervention Teams for dealing with mental health crises.

These programs have popped up in cities around the country, with different approaches and varying success. One such city is Bloomington, Illinois, where I worked for the past year. In 2015, Bloomington created a 20-year Comprehensive Plan. This plan outlined the city's goals, with specific actions to take, ways to measure progress, and a listing of potential partners. One of the many goals was to "Investigate the possibility of screening the behavioral health-related calls and dispatching a crisis intervention team." I decided to research Bloomington as a case study to better understand how cities decide to develop and continue to grow, maintain, and improve programs to address mental health crises. After reviewing the literature on this topic, I outline the various steps taken in Bloomington to reform how mental health crises are treated. Next, I discuss how these approaches stack up against the research on this subject and suggest how other cities may review their mental health crisis response similarly. I finish with a discussion of the limitations of the research study.

Background and Literature Review

Currently, the most widely discussed model of reforming how police interact with people experiencing a behavioral crisis is the Crisis Intervention Model, often referred to as "CIT" (Rogers et al., 2019). There are several variations in implementing the Crisis Intervention Model, but these reforms generally consist of police departments having staff, often cops, who are trained in Crisis Intervention and are the primary first responders to behavioral crises. The Crisis Intervention Model was first started in Memphis, Tennessee, in 1988 after the police fatally shot

an individual experiencing a behavioral health crisis (Watson & Fulambarker, 2012). This event spurred several community organizations, including the Memphis Police Department, local universities, and community organizers, to convene to discuss how best to reform how the police department handles behavioral crises. This group developed the first Crisis Intervention Model, now called the Memphis model, which has since become the most widely used form of Crisis Intervention. In 2019, it was estimated that about 2,700 police departments in the United States had adopted Crisis Intervention Training, which is about 16%[1] of police departments in the country. CIT has also spread beyond the United States to countries such as Canada, Australia, and the United Kingdom.

There are several critical aspects to the foundational Memphis model. Firstly, officers volunteer to get a 40-hour crisis intervention training. Emergency call dispatchers also receive training to recognize calls best suited for CIT-trained officers to send the appropriate units. A psychiatric emergency drop-off site is the primary location for officers to bring people experiencing a behavioral health emergency. Through these changes in police department practices, it is expected that there will almost always be officers trained to handle behavioral health crises. They can provide appropriate care and, when necessary, help get these individuals further care from the designated psychiatric facilities or other relevant community resources (Watson & Fulambarker, 2012).

Research shows that this model has some positive effects, such as an increase in the likelihood that a person experiencing a behavioral health problem will be referred to mental health services after interacting with first responders (Compton et al., 2014) and an improvement

[1] This number may seem somewhat small, but it likely underestimates the impact for two reasons. Firstly, this is likely an underestimation as it only counts official Memphis-model CIT programs, which isn't the only way to implement CIT, as we'll discuss later. Secondly, large cities are overrepresented in this percentage, so their programs would impact a more people than small towns with smaller populations.

in police officers' perceptions of individuals with behavioral health problems (Ellis, 2014). However, it also has its limitations. For example, research is scant due to variations in the implemented programs and varying levels of compliance (Watson et al., 2017; Lloyd-Evans et al., 2020). There has been minimal evidence that it significantly impacts some important long-term factors, such as health outcomes for these individuals after police interaction (Gatens, 2018; Lloyd-Evans et al., 2020).

Due to the high emphasis on working with the community, CIT should change to suit the unique needs of different communities. However, over the years, three major variations of CIT have formed. The first category is "police-based specialized police response," which consists of departments training sworn police officers to interact with people with behavioral health problems. The second category is "police-based specialized mental health response," which consists of departments providing non-sworn police department employees with mental health training to assist sworn police on the job. The last category is "mental-health-based specialized mental health response," which consists of police departments coordinating with mental health systems to allow mental health professionals to lead efforts to handle cases involving people with behavioral problems (Hails & Borum, 2003).

Before analyzing the effectiveness of CIT, it is crucial to recognize how these programs have historically been measured. Originally, the goal of those Memphis community members who initially developed CIT was to reduce the number of people with behavioral health problems killed by police. According to press reports in 1999, only two people with histories of mental illness had been killed by police since CIT had started in 1987, down from an annual average of seven police-involved deaths of people with behavioral health problems (Sweeney, 1999). While in no way a bad measure of success, this is a very limited view of the issues people with

behavioral health problems face when interacting with police. Other studies suggest some alternative goals communities may want to strive for in addition to reduced rates of police-involved deaths of people with behavioral health problems, such as fewer incidents of police violence overall, better short-term and long-term outcomes for the individuals who interact with police, and fewer arrests of people who need behavioral health treatment (Pollack & Humphreys, 2020). Assessing police reforms in a broader sense, communities may also want to consider the effect these programs have on people with behavioral health issues when interacting with police for a reason other than a behavioral health crisis or how these programs affect people without behavioral health problems.

The research on CIT and CIT-adjacent programs is not overly conclusive. Regardless, CIT has been designated "Best Practice," as well as "Evidence-Based," though that is only for specific outcomes, and even then, there is still debate (Watson & Fulambarker, 2012; Watson et al., 2017). Focusing on what CIT is generally effective at, some of the significant positive outcomes are that CIT reduces officers' negative perceptions of people with behavioral health issues, lessens rates of violence by police against individuals with behavioral health problems, and increases collaboration between police agencies and health agencies (Watson & Compton, 2019; Wei, 2021). However, due to the unique implementation of CIT in different cities, it remains unclear how consistent these outcomes are across police departments. Additionally, dilution is also expected with the widespread adoption of a program. While optimal conditions may consist of 24/7 access to CIT-trained officers, strict adherence to Crisis Intervention Training, and immediate access to psychiatric and community resources, these are not possible in all districts. If certain program aspects are not met, positive outcomes can severely diminish. For example, some communities only provide Crisis Intervention-Trained officers or Crisis

Intervention Teams and psychiatric and community services during the day. This can prove insufficient, especially considering that most behavioral health emergencies occur late at night or in the early morning (Wei, 2021).

When CIT is implemented, there are still two major criticisms. Firstly, there's a question by some researchers and activists on whether police should be involved at all when responding to behavioral health crisis calls (Balfour et al., 2021). As discussed, people with behavioral health problems are more likely to be shot or assaulted by the police. Even without outright acts of violence, interacting with police can be a traumatic experience. Some communities have successfully established programs where exclusively behavioral health professionals address these calls. However, most programs still include at least one police officer, if not exclusively police officers, for these calls, often arguing that these calls may be too dangerous for non-officers. The other major criticism of CIT is the overwhelming focus on addressing people in behavioral crisis without attempting to address any of the problems that lead to that type of crisis or improving conditions after the crisis. Importantly, research does not show that CIT reduces the number of behavioral health crisis calls and improves the long-term health outcomes of individuals who have experienced these crises (Lloyd-Evans et al., 2020). Yet, studies demonstrate that Crisis Intervention Training does increase the number of community members police divert to behavioral health services, but, reasonably, these effects remain minuscule in areas that lack adequate access to behavioral health services (Watson et al., 2011). These criticisms are not necessarily criticisms of CIT but rather a complaint of police departments and communities that consider CIT to be the only necessary change when trying to improve the interaction of police with people with behavioral health problems.

As a response to the same issues that led to CIT and as a response to the limitations of CIT itself, new approaches have been suggested. These new approaches cannot be neatly summed up into a single method; rather, they represent a push for a more comprehensive framework for addressing behavioral health crises. These approaches can generally be divided into three broad categories (Pollack & Humphreys, 2020). The first category is prevention, focusing on both prevention of a behavioral health crisis occurring and adverse police responses. In terms of programs that aim to prevent behavioral health crises, there are indirect and direct programs. The direct programs target at-risk individuals and include identifying and providing care to them. Direct approaches include identifying and providing care to high-risk individuals (Tentner et al., 2019) and taking steps to reduce strain on police so that police are in the right mindset to handle more difficult community members (Violanti et al., 2017). These programs can also have more indirect programs and policies, benefitting those beyond just the high-risk demographic, such as those that reduce rates of crisis for both individuals with behavioral health issues and those who don't, like taxes on alcohol and reducing access to firearms (Crifasi et al., 2015).

The second category is police interaction, where CIT would fit (Pollack & Humphreys, 2020). The last category is the longer-term management of people with behavioral disabilities in the criminal justice system. Programs in this category include Critical Time interventions, Assertive Community Treatment (ACT), and 24/7 Sobriety. These programs attempt to address the underlying behavioral health issues and provide easy access to the resources necessary for these individuals to manage their behavioral disabilities, whether through treatment of the underlying problems or just management of the symptoms.

Because this approach doesn't provide a specific outline for what programs or reforms to implement, it is difficult to evaluate the effectiveness of this approach. Therefore, it is essential to look at the strengths and limitations of each program individually. The approach is strong from a theoretical standpoint. It acknowledges the complexities of the issue and attempts to look at the problem from a systematic framework. From there, it breaks the process into more manageable parts, with each piece claiming a variety of approaches to try. However, the limitation of this approach is that there is yet to be a clear guideline for how best to tackle each part of the problem.

There have been a few attempts to create comprehensive toolkits for governments wishing to improve their mental health crisis response. The best toolkit so far is designed by the Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA has created a Best Practice Toolkit titled "National Guidelines for Behavioral Health Crisis Care" (Substance Abuse and Mental Health Services Administration [SAMHSA], 2020). This toolkit defines national guidelines in crisis care, provides tips for implementing care that aligns with federal guidelines, and provides tools to evaluate the alignment of systems to national policies. Much of the advice in this toolkit centers around the idea that services need to be for "anyone, anywhere and anytime." This relates to the City's "no-wrong-door" approach, which is also recommended within this toolkit.

Much of what the toolkit outlines align with best practices discussed in the literature, but I will summarize some keynotes here. Firstly, the toolkit outlines three core elements of a Crisis System - a regional crisis call center, a crisis mobile team response, and crisis receiving and stabilization facilities. The toolkit also lists minimum expectations for these elements and additional best practices. For call centers, in particular, the toolkit recommends basing practices

on those of Air Traffic Control (ATC). ATC has two vitally important objectives for avoiding tragedy -

> "1) Always know where the aircraft is (in time and space) and never lose contact; and
>
> 2) Verify the hand-off has occurred, and the airplane is safely in the hands of another controller".

In this scenario, the "aircraft"/"airplane" is the individual in crisis, and the controller is another mental health crisis care provider. The toolkit also highlights the importance of communication between organizations working in this field and the ability to serve "anyone, anywhere, and anytime."

In summary, there are several evidence-based approaches to addressing behavioral health crises. CIT provides a clear framework for improving police relations with people with mental health issues and redefining who should even be in charge of helping people in a mental health crisis. However, CIT is only a bandaid. Funding preventative measures, providing options for specialized care depending on the type of crisis, and funding long-term care after a crisis event are essential for creating a comprehensive care system. However, this requires many organizations working together and a holistic approach to helping people with ongoing or temporary mental health issues. Through my research, I provide a reference guide for cities on how they can implement the most current research to provide the best results for addressing behavioral health crises. I do this by looking at a case study, Bloomington, Illinois, and outlining how it has addressed the problem, what it has done well, and how it can continue to improve.

Methodology

My analysis consists of an in-depth review of the emergency response practices in cases of behavioral crises in the City of Bloomington, Illinois. I chose Bloomington because of my

position as a graduate student at Illinois State University in the Applied Community and Economic Development (ACED) fellowship program and as a fellow working for the Bloomington City Government. I worked within the Community and Economic Development Department on several projects related to the goals outlined in the City's Comprehensive Plan. One of the goals of the City's Comprehensive Plan is to "investigate the possibility of screening the behavioral health-related calls and dispatching a crisis intervention team." For this research, I wanted to answer the following questions:

a) How did Bloomington first approach the decision to establish some reform on addressing mental health crises?

b) What programs are available within Bloomington (all programs operating within the city, not just programs provided by the city)?

c) How do those programs interact with each other?

d) How is the success of those programs, and the ecosystem of programs as a whole, measured?

e) Are there gaps in the provided programs? If so, where and how might Bloomington fill those gaps?

To answer these questions, I started with a full review of programs that operate within Bloomington. I began with reviewing federal programs, then funneling them down to state, county, city, and local level programs. For each program, when possible, I outlined how the program began, what it does, how they measure its success, and how successful the program is. To find this data, I searched government websites for information on all behavioral health programs and criminal justice practices - for the federal government, the State of Illinois, McLean County, Bloomington, and the neighboring town of Normal (since it works closely on

many programs). I searched both behavioral health and criminal justice sections of government websites due to the differences in how organizations choose to address the topic. If applicable, I searched specifically for planning documents, grant programs, partner organizations, assessments, and laws. After looking through the available data on government websites, I followed the listed grant programs and partner organizations to the websites of other organizations working in this area to review the available programs outside government operations.

For this study, I generally relied on organizations to define for themselves what a "behavioral health crisis," "mental health crisis," behavioral health emergency," or "mental health emergency" was. This refers to an event where an individual needs immediate attention for a primarily mental health-related issue. This could be co-occurring with or independent of a physical health risk. The most obvious example is likely suicidal ideation, but it could include events such as hallucinations or psychotic episodes, either drug-induced or otherwise. It could also involve circumstances where the police are called for something a person with a mental health issue has done that may be a direct result of their mental health issue, but that may also be illegal or suspicious, such as loitering, stealing, yelling, possessing a weapon, etc.

Additionally, I briefly explored programs that address everyday interactions between people with mental health issues and the police. Mental health emergencies are only a small subset of these interactions. People with mental health issues interact with the police for events other than those directly related to their mental illness, though their mental illness may still be indirectly related. Either way, people with mental health issues may have unique needs that the police should know.

Finally, I finish my discussion by exploring where there are gaps in the programs available within Bloomington, how other cities might do their analysis or learn from what Bloomington has done, and the limitations of this research.

Research

Federal & National Level

The concept of mental health emergency care is relatively new, with mentions of it only popping up within the last century (Wellin et al., 1987). Three frameworks for addressing mental health emergencies - are the psychiatric hospital, the emergency ward of the general hospital, and the community mental health movement. First, psychiatric hospitals have been around in the U.S. since about 1752, starting with the Quakers in Philadelphia (Ozarin, 2017). To address ongoing mental illness, some psychiatric hospitals began to create "after-care" programs in the 1930s. These programs allowed prior patients to get immediate short-term care for issues that arose post-release. Concurrently, some general hospitals added a psychiatric wing to their emergency departments to address the increasing volume of mental health emergency cases (Wellin et al., 1987). The third framework was the community mental health movement, which came out of the "third mental health revolution," a social movement that pushed for the humane and research-based treatment of people with mental health issues. No single program was comprehensive, but all three frameworks laid the groundwork for our current mental health crisis response.

As mental health care continued to improve around the country, the federal government took notice. Leading this push for greater national policy were World War I and World II veterans and veteran advocates who were fed up with the lack of mental health care soldiers and veterans received from the federal government (Brand, 1965). In 1946, President Truman signed

the National Mental Health Act, which led to the creation of the National Institute of Mental Health (NIMH) three years later. The National Institute of Mental Health would be one of the first four institutes to make up the National Institute of Health (NIH). At the request of NIMH, Congress passed the Mental Health Study Act in 1955 to determine the current state of mental health care in the United States, and in 1961 the "Action on Mental Health" was published. Based on the recommendations in this report, President Kennedy signed the Community Mental Health Act (1963) into law. This Act shifted funding and services from institutionalized settings to community-based behavioral health services. The Community Mental Health Act led to significant deinstitutionalization, intending to reimagine what mental health care looked like. Unfortunately, the resulting Community Mental Health Centers were severely underfunded, with only half of the planned facilities built and no money for maintenance (Erickson, 2021). With the rapid decline in psychiatric hospitals and a lack of a real replacement, mental health care fell to periphery organizations, such as hospitals, homeless shelters, veterans organizations, prisons, and the police. Since then, each administration has shifted approaches to general mental health (National Institutes of Health, 2021).

Mainly, this has influenced mental health crises and affected how much funding and focus states and local governments spend on this issue. The National Institute of Mental Health and the SAMHSA have funded research and mental health emergency programs around the country. Additionally, SAMHSA has created a "Best Practice Toolkit" for "National Guidelines for Behavioral Health Crisis Care" (SAMHSA, 2020). The most significant federal policy regarding mental health crisis management is the designation of the new 988 dialing code. This step was a long time coming, with Congress first appropriating funding for a suicide prevention hotline in 2001. SAMHSA worked with national organizations to develop a network of crisis call

centers. By 2005, the National Suicide Prevention Lifeline was launched, with the Lifeline expanding to include different languages, specialized services for Veterans and disaster victims, and a text line. In 2018, Congress passed the National Suicide Hotline Improvement Act to perform a feasibility study designating a three-digit dialing code for a crisis and suicide hotline. In 2020, Congress passed the National Suicide Hotline Designation Act, requiring all U.S. telecommunication providers to activate 988 for all subscribers by July 16, 2022 (SAMHSA, 2022). According to SAMHSA, the National Suicide Prevention Lifeline is "a phone chat and text service that provides free and confidential support to people in suicidal crisis or mental health related distress 24 hours a day, 7 days a week, across the U.S.".

Outside the federal government, some national organizations and networks are also available. For example, the National Alliance on Mental Health and Mental Health America promote awareness of mental health issues and provide resources on what to do if you or someone you know are experiencing a mental health crisis (National Alliance on Mental Illness [NAMI], n.d.). Additionally, organizations like the Criminal Justice Coordinating Council address this issue from the police reform side, working within communities. Not all divisions address how police handle mental health emergencies, but it is a growing focus (The Justice Management Institute, n.d.).

State of Illinois

In the decades following the Community Mental Health Act, the State of Illinois began developing its solutions to mental health problems. The Illinois Department of Children and Family Services (DCFS) started funding programs for addressing mental health emergencies for children (Illinois Department of Healthcare and Family Services [IDHFS], 2018). This work complemented the work of the Illinois Mental Health Planning and Advisory Council (IMHPAC;

now a part of the IDHS), created in 1992, and the Illinois Department of Human Services (IDHS), formed in 1997 (Illinois Department of Human Services [IDHS], n.d.a; IDHS, n.d.b).

In 2004, the Illinois Congress passed the Children's Mental Health Act. This Act set broad goals for the state to address adolescents' mental health. This Act created the Illinois Children's Mental Health Partnership, which published the first Children's Mental Health Plan in 2005. The Illinois Children's Mental Health Partnership comprises each child-serving state agency and 25 experts. The Children's Mental Health Plan was updated in 2022. The Act also required the IDHFS to screen Medicaid youth before inpatient psychiatric hospitalization (IDHFS, 2018). As a result, IDHFS, IDHS, and IDCFS collaborated on two major crisis response systems to achieve this goal. The first is the Crisis and Referral Entry Service (CARES). CARES is a telephone service, similar to other crisis and suicide hotlines, that is specifically designed to ensure children get access to crisis services in the most appropriate setting, through the second system created by this group, the Screening, Assessment and Support Services (SASS; IDHFS, n.d.). SASS is a statewide 90-day crisis program for youth, with services ranging from immediate crisis intervention to outpatient care.

In 2015, Governor Rauner signed Executive Order 14 (2015), establishing the Illinois State Commission on Criminal Justice and Sentencing Reform (Illinois State Commission on Criminal Justice and Sentencing Reform [ISCCJSR], n.d.). The Commission was created to develop comprehensive, evidence-based strategies to reduce Illinois' prison population by 25 percent by 2025. In 2016, the Commission provided its Final Report, which, among other recommendations, recommended that the Illinois Criminal Justice Information Authority (ICJIA) establish county-based Criminal Justice Coordinating Councils (CJCC). Following this recommendation, ICJIA awarded five counties technical assistance grants to develop CJCCs.

Those five counties included Lake, McHenry, McLean, Winnebago, and St. Clair Counties. At this point, McLean County had already established a CJCC and used this money to expand its work (McLean County Criminal Justice Coordinating Council, 2017). Specifically, the McLean County CJCC used the grant to further data analysis and collaborate with the Department of Justice.

The Illinois State Commission on Criminal Justice and Sentencing Reform identified two approaches to reducing the prison population - decreasing prison admissions and the length of stay (ISCCJSR, n.d.). To address the first approach, the Commission recommended reducing recidivism with evidence-based programming in diversions, in prison, during reentry, and in the community. Local CJCCs have practiced this recommendation through increased mental health crisis response efforts, which can divert people struggling with mental health issues away from prisons and to mental health treatment facilities. Additionally, proper mental health care can reduce the chances of a person committing crimes in the future.

One of Illinois's earliest emergency mental health services providers was PATH. PATH began in the 1970s as a volunteer group dedicated to supporting people using street drugs (PATH, n.d.). As the program grew, so did the number of topics the group addressed. At the same time, 2-1-1 was being developed in Atlanta with a similar goal. 2-1-1 is a number that anyone can call (or look online) to connect to health and human services. As 2-1-1 was introduced to the nation in the 1990s, PATH stepped up to provide 2-1-1 services to the communities they were already serving in Illinois. Today, PATH is the largest provider of 2-1-1 services in Illinois. PATH also handles the suicide hotline calls made in McLean County and much of Illinois.

McLean County/City of Bloomington/Town of Normal

In 2007, McLean County recognized an alarming statistic[2]. Despite efforts to promote mental healthcare in the community, mainly through "capacity" grants to community mental health programs, the number of people treated for mental illnesses in jails increased (McLean County County Board Executive Committee, 2015). In 2008, McLean County made two major efforts to address this issue. Firstly, the McLean County Board worked with the Eleventh Judicial Circuit Court to obtain congressional support for a Department of Justice Drug Court Grant, which led to McLean County becoming one of the first counties in Illinois to have a Drug Court. Secondly, McLean County requested a complete report of the Adult Jail System within the county from the National Institute of Corrections. This resulted in a recommendation to form a Criminal Justice Coordinating Council. The Council began a year later "to examine the policies and procedures of the McLean County Criminal Justice System, identify model practices, identify deficiencies, and formulate policies, plans, and programs based on well-established research and statistical methodologies designed to promote change when opportunity presents itself" (McLean County County Board Executive Committee, 2015, pg. 1).

In 2015, the McLean County Board established the Behavioral Health Coordination Council in response to the Mental Health Action Plan "to assist the County Board with Policy Decisions" (McLean County County Board Executive Committee, 2015, pg. 5). The Mental Health Action Plan outlined precisely what the role of the organization would be, including "to discuss differences, facilitate communication, align strategic plans, and assist with the pursuit of external funding and technical assistance" (McLean County County Board Executive Committee, 2015, pg. 15). This group specifically included both publicly and privately funded

[2] The way Bloomington responds to mental health crises is largely driven by McLean County or county-wide organizations. That being said, much of this discussion will look at McLean County as a whole. Assume any discussion is for all of McLean County unless otherwise stated.

groups and non- and for-profit groups. This Council was further subdivided into a Best Practices group and a Needs Assessment group. This Council was a part of the National Association of Counties (NACCO) "Stepping-Up Initiative," which encouraged communities to collect more data on the issues related to the incarceration of those with behavioral health problems. This initiative focused on four critical questions that communities should be tracking:

1. How many people with mental illnesses are entering jail?
2. How long are they staying?
3. Are they connected to treatment once they are released?
4. How often do they come back to jail?

The Behavioral Health Coordination Council began meeting on June 16, 2016, and continued to meet quarterly. The Council consisted of representatives from local nonprofits, the McLean County Board, local businesses, local hospital and healthcare facilities, Circuit Court, McLean County Board of Health, the City of Bloomington, the local chapter of the National Alliance on Mental Illness, the Town of Normal, and the Regional Office of Education (McLean County Criminal Justice Coordinating Council, n.d.).

There are several ways to address behavioral health crises in McLean County and Bloomington. Born out of the Mental Health Action Plan, the County aims to have a "no wrong door" approach (McLean County County Board Executive Committee, 2015). The "no wrong door" approach means that no matter how an individual reaches out for help with a behavioral health issue, they are directed to the appropriate services. All participating organizations are knowledgeable about the purposes of the other organizations and are trained to know when each different organization would be most appropriate. This list of organizations ranges from school counselors to police officers to PATH and local hospitals. This approach is designed so that a

person in crisis will not be turned away by any organization, at least not without the organization providing the resources the individual needs to find the appropriate organization. The following section goes over the organizations in McLean County that are the primary resources for people experiencing a mental health crisis.

The Mobile Crisis Unit started in 2020 (McLean County Behavioral Health, 2021a). The Mobile Crisis Unit provides immediate counseling services wherever the individual in crisis may be. This allows the individual to stay where they feel comfortable and reduces transportation costs. Currently, the Mobile Crisis Unit will send a counselor to talk with the individual for as long as they need. The Unit is currently working towards creating a two-member team that will go on calls together. This team will consist of a counselor and a "peer" who have gone through similar experiences and can provide support from a place of shared experience. One caveat with this service is that if the person in crisis is under the age of 21 and/or has Medicaid insurance, they will receive support from the Center for Youth and Family Solutions (CYFS) instead of the Mobile Crisis Unit. CYFS provides the same services as the Mobile Crisis Unit currently does. They will also help these individuals get to the hospital if necessary and provide up to 90 days of follow-up services.

When a person calls 9-1-1 for a behavioral health crisis, the police are always the responding team. Almost all the police in McLean County have Crisis Intervention training. With this training, they can assess the situation and begin the crisis intervention process. They are also aware of the various resources for people going through a behavioral health crisis and can provide the individual with those resources.

If an individual wants or needs a place to stay while in crisis, they can go to the McLean County Triage Center. The McLean County Triage Center provides a safe place for individuals

to stay while they recover. In addition, the Center offers resources for the individual to begin addressing the issues that led to the crisis when they leave the facility. Notably, this is only a temporary service. They do not provide beds, and individuals are only allowed to stay up to 23 hours, when they must leave or go to a longer-term facility.

There is also the Chestnut Crisis Center (Chestnut Health Systems, n.d.). The Center provides 24-hour short-term supervised care for persons aged 18 years and older experiencing an acute psychiatric crisis that does not require hospitalization. The average length of stay is 14 days. The Center is primarily funded through Medicaid. Unfortunately, most private insurance plans don't recognize non-hospital placements, so not everyone with private insurance is covered. The Center has two programs - one for primary mental health diagnoses and one for detox admissions, though these programs are not exclusionary and often overlap.

As part of their patient registration, many facilities have standardized medical tests before they allow the patient to receive care. These medical tests evaluate whether the mental health crisis may be caused by a physical health condition, like low blood pressure, adverse medication reaction, or brain trauma. If detected, patients are taken to a hospital or other medical treatment facility to receive treatment.

Sometimes, people experiencing a mental health crisis may need hospitalization. Contrary to popular belief, this may not be the best option for everyone experiencing a mental health crisis. Firstly, as explained above, specialized care for several mental health emergencies exists. This specialized care will almost always be better than the general care offered at hospitals. Most of the hospitals in McLean County do not have separate emergency room spaces for those experiencing a mental health crisis. Strategically, those who reach out to PATH or 9-1-1 should be referred to specialized care first. Suppose a patient is in the emergency room for a

mental health emergency. In that case, it is due to the additional presence of a physical health condition or the patient arriving at the emergency room themselves. This is not the preferred care method because of the lack of specialization, the long waits, and the additional costs associated with emergency room visits.

Measuring the Success of Programs

Each organization has its own goals for meeting this issue's needs. However, this is a community issue, so community-wide measures may better understand the city's progress fully. In addition, these community-wide plans are critical because it is how community organizations and governments determine priorities and can be how grant funds, such as the John M. Scott Health Care Trust[3], determine what organizations get funding.

Bloomington's Comprehensive Plan (2015-2035), the drive behind this research project, does provide some goals and suggested measurements for tracking this objective. The Comprehensive Plan includes several goals that address improving mental health care generally, mental health awareness, and health care collaboration. The two goals that most directly relate are both found in the "Healthy Communities" section, under the broader goal of "Support[ing] coordination and integration of behavioral health services for all residents." Those two goals are "Provide 'Crisis Intervention Training' for those in law enforcement and public safety to help them better understand symptoms of mental illness" and "Investigate the possibility of screening the behavioral health-related calls and dispatching a crisis intervention team" (Bloomington Comprehensive Plan, 2015 pg. 163). Both goals have been met, though not all law enforcement have yet received the training. The Plan also includes metrics to measure the goals. The metrics for this goal include "decreased number of poor mental health days in the last 30 days based on

[3] The John M. Scott Health Care Trust is a trust controlled by the City of Bloomington that provides nearly one million dollars a year in grants to healthcare-related non-profit organizations within McLean County.

behavioral health surveillance information per Healthy People 2020", "decreased number of emergency room visits for a mental health issue," "decreased suicide rate," " increased number of police officers and firefighters with public safety certification," and "decreased number of police/Fire/EMS calls related to behavioral health issues" (Bloomington Comprehensive Plan, 2015 pg. 163). Bloomington is supposed to provide reports every five years to update the community on the progress toward these goals. However, they have missed their first five-year mark, so I can not say whether all of these goals were met. According to the most recent edition of the McLean County Community Health Needs Assessment (2022), the number of suicide deaths was 26 in 2020, an increase from 2015 (Illinois Department of Public Health, 2022, as cited in McLean County Community Health Council, 2022). Notably, the number was steady before 2020 and spiked in 2020, which the pandemic may have influenced. This number falls short of the Healthy People 2020 goal and is one of the highest rates as compared to other counties in Illinois.

Hospitals must complete Community Health Needs Assessments (CHNA) every three years to maintain their certifications (McLean County Community Health Council, 2021). County Health Departments are also required to complete CHNA but only have to complete them every five years. In 2016, the hospitals in McLean County and the McLean County Board of Health agreed to complete this assessment together to reduce costs and increase collaboration between the various health organizations in the community. Since then, Advocate BroMenn Medical Center, the McLean County Health Department, OSF St. Joseph Medical Center, and Chestnut Health Systems have published joint CHNA. Each assessment sets three health priorities for the community to address over the next three years, and these priorities can have a critical impact on the community. Local grants like the John M. Scott Health Care Trust and

local organizations like Invest Health[4] rely on these assessments to determine where funding and efforts should go. National grants and organizations also use these assessments to determine if their funded projects align with local needs. That said, the 2020-2022 CHNA for McLean County identified Behavioral Health, along with Access to Care and Healthy Eating/Active Living, as one of its top three priorities for the County, exemplifying the continued need for improvements in Behavioral Health Policy. In addition, the County recently published a new CHNA, which has maintained the same priority areas.

The Community Health Improvement Plan (CHIP) directly results from the CHNA and provides the County with specific goals to improve each identified priority. For the 2020-2022 cycle, the CHIP goals are to reduce the number of deaths due to suicide and reduce the death rate due to drug poisoning by 2023. Between the CHNA and CHIP, the county prioritizes addressing behavioral health issues and directly calls out behavioral health emergencies. Suicide rates were already discussed, but the death rate due to drug poisoning is not very promising either. For 2017-2019, McLean County averaged 18.6 deaths per 100,000, which is not significantly different from previous measures. It is lower than the state average but does not suggest much progress (Conduent Healthy Communities Institute, 2019, as cited in McLean County Community Health Council, 2022).

The Mental Health Action Plan dives deeper into crisis stabilization goals, with a whole chapter focused on addressing this topic in McLean County (McLean County County Board Executive Committee, 2015). The Behavioral Health Coordinating Council created this plan consisting of ten short-term and seven long-term goals. These goals address where the Council suggests expansion and improvement. These goals solely focus on outputs rather than the

[4] Invest Health is a coalition of local government and healthcare leaders that meet regularly to discuss public health goals and create partnerships to meet those goals.

outcomes they want to see in the community. Many of these goals have been met since the Plan was published, and the Council has recently published an update explaining where they've made progress and goals for the future (McLean County County Board Executive Committee, 2022).

Discussion

A Review of Bloomington's Mental Health Emergency Response System

Bloomington is quickly becoming a model city for mental health emergency response. The City has a CIT-trained police force, several specialized care options, a Mobile Crisis Intervention Team, and a clear plan for continued improvement, with a big update coming this year. Much of this improvement has come in just the past 5-10 years. Despite the late start, collaboration is apparent between organizations. Additionally, they have just updated their Mental Health Action Plan, showing a continuation of support for this issue.

However, there are some areas in which Bloomington and McLean County could improve. The first thing the City and the County should improve is integration with 9-1-1. Emergency dispatchers are not trained in CIT nor in diverting mental health crisis patients to the appropriate care. Instead, they are prepared to send police to help the person find reasonable care. However, this is inefficient and can be traumatizing. Emergency dispatchers are beginning to receive training in CIT, but they also need to be able to connect patients to appropriate care directly instead of having a patient wait for a cop to arrive. This may even consist of 9-1-1 operators being trained to connect all mental health calls to 2-1-1 or 9-8-8. Either way, 9-1-1, the first source many people will think of, should be well integrated into the continuum of care.

The second area is emergency mental health support for people under 21. While there are some options, they are not comprehensive. Depending on the type of insurance the child has and the kind of care the child needs, they may not be able to get care in McLean County and may

need to be driven over an hour away. This can be incredibly confusing and frustrating for someone seeking care.

On a broader note, Bloomington and McLean County could be doing more to spread awareness of their programs. The "no-wrong-door" approach naturally lends itself to needing less attention, since, in theory, as long as the public is aware of at least one service, they will be connected to the appropriate care. However, there are some holes in this approach. Firstly, people may be less likely to reach out if they don't understand the available programs. This is especially true for people experiencing mental health issues. Myths about emergency mental health care also make this an important area to address. The public may not understand why police are involved in a mental health emergency. They may not know what their options are if they are struggling with illegal drugs or if they are undocumented or don't have insurance. All these factors may make it unlikely that they seek out this information in the first place. Additionally, as stated before, if they first call 9-1-1, they may not get care as quickly as necessary. For all these reasons, the City and County must continue to spread awareness about what is available.

A significant gap discussed in the 2022 update to the Mental Health Action Plan is real-time communication between organizations (McLean County County Board Executive Committee, 2022). There are some collaborations and contracts between specific organizations to share information, but it is not comprehensive. This can be essential to ensure their vital information isn't missed when patients are transported between organizations. In addition, it doesn't force the person going through a crisis to repeat their trauma to multiple people and organizations. Additionally, this can help the organizations track essential long-term health information or identify people who frequently use services. Identifying these people, the types of

services they use, and their unique situation can help organizations create more specialized plans that find the gaps in their services.

Increased data-sharing between organizations would also help McLean County keep track of important measures to determine whether these programs are making a difference in the mental health of the public. Instead of only having point-in-time values of mental illness, drug use, and suicide rates, the County could use this information to better track the long-term health outcomes of those utilizing these services. For example, the Criminal Justice Coordinating Council has been working with Illinois State University, and the Behavioral Health Council has worked with the University of Chicago to research new programs and track progress. Continuing these partnerships to create long-term methods of tracking progress could improve these programs in the long run.

The last area that Bloomington should continue to work on is preventative measures. This is something the whole country needs to improve. There are many methods of preventing mental health crises from happening in the first place. They weren't fully discussed in this paper for brevity, but providing accessible and affordable mental health care, spreading awareness and reducing stigma, addressing substance use, addressing homelessness, providing social services, etc., can all help to promote good mental health in the general public. This is a broad goal, but not one the City should ignore.

What Other Cities Can Learn

Reviewing how Bloomington developed and continues to develop its mental health crisis emergency response system can teach a lot about how to address this issue in other cities. The first step for any city, town, municipality, or county to begin addressing its mental health crisis emergency response system is to review what is currently available. This can be done by a

collective of invested stakeholders in the community or by a Commission or Council created by the local government. Once it is known what is available, it should be determined where there are gaps. For example, what populations are not included? This could be rural populations, BIPOC, people of a certain income level, people with particular insurance or who lack insurance, or people of a specific age group. This list is not exhaustive. At the same time, it should be determined how easy it is for a member of the public to find the most appropriate services. This will likely involve making sure all relevant organizations are aware of everything available in the local area and what organizations can best address each type of issue and population. During this analysis, it is also possible that redundancies are discovered. For all these reasons, a formal group should be assembled at this point to ensure communication between organizations and continuing collaboration, if this group was not already formalized. With all this information, the group can create a plan to reduce unnecessary redundancies and address gaps. The most crucial step at this stage will be to find funding for any additional programs the group wants to implement. There are many federal, State, and local grants (depending on where you are). Universities and hospitals, the anchor health organizations in the community, will likely be a great additional resource for funding and research collaborations. The plan should have clear, measurable goals and a timeline. This will ensure continued efforts on these goals and may help inform organizations in the community on priorities.

Limitations & Future Research

Governments and organizations must do their best to address current problems, regardless of whether they have the information necessary to make the best decisions. As new programs to address mental health crises develop, research lags behind. This has been a significant shortfall in this field of police reform. Throughout this research, I have outlined the programs available.

To the best of my ability, I tried to judge the programs' effectiveness based on their statistics (when provided) and compared them to the available literature. As more research and statistics are made available, programs should continue to reevaluate and adjust. In the meantime, future research should compare analyses between cities, states, and countries to better understand the state of mental health emergency responses.

Additionally, I should add a disclaimer stating that the programs listed here are not exhaustive. For brevity, I generally summarized grant programs and organizations that do similar things. This is not intended as a comprehensive list of resources for organizations looking for funding or individuals looking for resources. Also, I excluded many programs that were only indirectly related to mental health emergencies. For example, programs that address police interactions with people with mental health issues and programs that prevent mental health crises are both crucial topics and would give a fuller picture of how cities and states address this issue.

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