Chicago Council for Mental Healthh Equity
Quarterly Meeting Minutes
July 31, 2023
Malcolm X College

I. Welcome, Attendance

a. Attendance Called

(*Attendees – per sign-in sheet*)

Joanne Farrell (CFD)	Andy Guevara (CPD)	Jim Poole (NAMI)	Eddie Markal	Annette Love (G4)
Lisa Hampton (DFSS)	Susan Doig (Trilogy)	Allisha Warren (CDPH)	Michelle Langois (VA)	Eric Cowgil (NAMI)
Harold Pollack (U Chicago)	Dawn Brumfield (Khesed Wellness)	Joseph Schuller (CPD)	Mary Sheridan (CFD)	Michael McGehee (CPD)
Amanda Antholt (Equip for Equity)	Patrick Bumbrowski (C4)	Katlynn Dallman (I am Able Center)	Dr. Donald Tyler (Chicago CRED)	Kendra Archer (CPD)
Stephen Brown (VI Hospital)	Esther Sciammarella (CHHC)	Eric Wilkins (Communities United)	Joel L. Rubin (NASW IL)	Mirna Ballestas
Sandra Rigsbee (Community Renewal Society)	Danielle Clayton (DOL)	Dan Fulwiler (Esperanza)	Kevin Barszcz (Mayor's Office)	Alexia James

***Quorum not met.*

b. Lisa Hampton, moved to approve the Meeting Minutes. No objections, Minutes approved.
c. Overview of CCMHE Member Survey participation:
    i. Discussed the subcommittee structures (Mental Health and Consent Decree). Identified survey participants' interest in subcommittees and Co-chairs.
    ii. Gathered folks' interest in participation in the forming subcommittees.
    iii. Co-Chair selection will be put to a vote. Quorum was not achieved; voting will take place during the next quarterly meeting.
    iv. New members: we have openings for slotted members that represent the agencies identified in the consent decree.
    v. Reviewed requirements for serving as a co-chairs within the bylaws.
    vi. Feeback on what the members would like to see moving forward.
    vii. Encouraged folks, who have not participated to complete the survey.

(Question): [Inaudible]

(Response - Daisha): Quarterly attendance of meetings is required. The last meeting was cancelled due to the transition [of the new administration], but meetings will be held quarterly moving forward. The business of the next meeting will be the selection of the co-chairs.

(Response - Matt) Regarding committee assignments, preferences were measured in the survey. Feedback from committee members was the reason for offering the choice because to gauge whether committee members wanted to be in one committee or another. As we do committee assignments please respond so you do not end up on a committee that you don't want to be on.

Working committees: sub-committees are the working committees and report out for feedback to the broader group.

II. Public Comment

No public comment(s) made.

III. Chicago Police Department

- **Introduce the Crisis Intervention Team Coordinator**

LT. Joseph Schuller, CIT coordinator last 21 months.

Role: Oversee the whole department's response to mental/behavioral health issues (policy, training).

CIT Training: CPD runs a basic refresher, helped developed 8 hour recruit training. Last year everyone in the department got an 8 hour training Lt. Schuller helped develop – training academy ran that program. Anyone in the group is welcome to attend basic / refresher training for feedback.

- Over 3,900 officers received CIT training. NAMI helps with the training, with lived experienced actors.

Orders and Directives are reviewed annually. CPD presents to the group for feedback and implement changes as appropriate.

District Operations Community Support (DOCS) Team:(Introduced SGT. Archer) Assigned to CIT unit, work citywide, follow-up work – connection to resources to stop them from utilizing the 911 System.

Care Program / Alternative response. Out for almost 2 years. Up for review on how it will be staffed. Lt. Schuller and staff response for Consent Decree compliance.

(**Question**) Inaudible

(**Response**) …New to the program is the refresher. Any officer who has not taken the training must attend a fresher. Update to the curriculum happens every 3 years.

(**Question**) not audible

(**Response**) for the most part we are ok, there is a limited number NAMI uses. Some classes for basic recruit training are taught by officers and some who teach have a certain background depending on the class. Always looking for people to teach.

(**Question**) [Inaudible]

Consent Decree has requirements. Ideally, we want everyone to volunteer for the program. Part is response ratio requirement for newly promoted FTOs, Sargeant /Lieutenant. CPD priorities volunteers, newly promoted officers and to help meeting response ratio we have people from patrol take the class.

(**Question**) [Inaudible] … '*How do you train to recognize the symptoms*.'

(**Response**) We don't have a model currently but are working with community-based partners.

(**Response - SGT. Archer**) A great part is working with outside agencies that have 590 Grants. CPD works with NAMI and Metropolitan Family Services. We have a service to help with handling language barrier. We have a CARE van that operates with a medic / social worker in the area. Police can be available to help with transport. Looking for agencies with 590 grants. We welcome suggestions.

(**Comment**) not audible

(**Response – Sgt. Archer**) That has been some of the challenges… not controlling each other…having a good team dynamic together. CDPH is doing training on teamwork building. Initially when the program started everyone went through training (use of force, behavior management, mental health) to recognize sign and symptoms. officers on the CARE van went through basic Mental Health training. We go to CIT conferences and get other trainings to stay current with trends in Mental Health across communities.

Hospitals are also on CIT SGT's agenda. CIT DOS Sgt started working with St. Bernard and trying to get Jackson Park on board.

We attend Beat meetings. If the community comes, they can begin to recognize officers.

(**Comment**) I think it is important to understand necessity and limitations of CIT. The public is focused on how well trained the police are. There are so many things that get neglected that are not the responsibility of the police: team-based care for people living in the community before there is a crisis, using Medicaid more effectively to provide services. Specific to intellectual disabilities, I wonder if CPD could work more intentionally with group homes in Chicago that serve people with intellectual and developmental disabilities to train the staff on when they need to call "us".

(**Comment**) Training and support is needed for CILAS, separate from mental illness, would love the CDPH to think about training and resources for people in CILA - Community Integrated Living Arrangement. Police are not the appropriate people to do the training.

(**Comment- Matt**) Important points made. With the CARE teams there is specialized training on developmental differences, and how they impact a person's presentation. It's a 4-hour training. What I hear you saying is more about locations where you have greater risk for crisis. It is more of a place-based approach, not just people, and you thoughtfully provide training and support. We are not doing that yet. Example: integrated behavioral health across shelter systems during covid. The transportation and shelter systems were 2 types of locations where we had the most BH crisis. If you integrate services across those systems, can you prevent a crisis before it arises. Same with Overdoes, we look at locations where we see high numbers, we put Narcan boxes.

IV. Mayor's Office for Community Safety

Introduce Deputy Mayor Garien Gatewood

(**Comment**) Excited about the work the group is doing. Excited to work together on a regular basis. Where this administration can be deep partners overall. Thanks, and excited to get to work.

V. Chicago Department for Public Health (CDPH)

Presentation: Review and Update on 2019 Recommendations
Matt Richards (Deputy Commissioner)
Background: 18 recommendations were made from the Crisis Intervention Advisory Committee generated in October, 2019. Approved by prior Mayoral Administration the following month.

There were 4 committees, (1.) Coordinated response (MH responses by 1st responders) (2.) Diversion / Deflections. (3.) Data Collections / Evaluation, and a set of recommendations (4.) Community Engagement, and a set of recommendations. Goal of presentation:

- ✓ Awareness of the 2019 recommendations.
- ✓ Call out exciting things that have happened.
- ✓ Exciting opportunities.

These recommendations were generated 4 years ago. Evaluate to determine recommendations that meet needs today.

1. **Coordinated response**: City to develop an alternate response model. In September 2021 – CARE started. 3 team types (Alternative response, community paramedic, multi-discipline response, and opioid response team). You can go to the dashboard (*crisis assistance response dashboard*) to see all the activity the teams are doing.

   Responded to over 1K calls with no arrest / use of force.
   Local coordination – Community providers, emergency dept, and 1st responders.
   There has been significant increase in CIT training for 1st Responders, including for 911.

   Diversion / Deflection: there are a number of recommendations that are summarizing research, the current state of diversion and deflection and best practices in other cities.

   There is an opportunity to do a lot of that work running parallel to the fact there is a lot more diversion programming happening.

   NAPD is the largest Law Enforcement led narcotics diversion program in the U.S.
   Not deferred prosecution.
   Over 1500 people diverted - 72% reduction in arrest rates.

   Sobering Center: diversion for alcohol use disorder.

   Stabilization Housing Pilot, just got approval for the City to buy a hotel to assist the unsheltered, with a history of psychiatric issues, who can have their own housing unit for 3-6 months plus on-sight primary care and addiction treatments to help a person achieve stability and then transition to the community.

There is a lot of work that has happened in the last 3 years in this space. We want to make sure as a City, the diversion portfolio is guided by a set of principles and grounded in a set of values.

Data evaluation: We now have epidemiologists that work in the public safety agency. That's new. One is in the Office of Emergency Management and Communications (OEMC) and the other at Chicago Fire Department.

-Smart911

Community Engagement: 'Unspoken' Campaign. Another version will launch this fall. There is a resource directory, all back-end data the Health Department indexes so the data is open source. You can call 211, data shared with 988.

Mental Health 1st Aide Training. More of the staff trained. As you look at the recommendations are there things that are missing, area where we need more of a focus. Good progress has been made and opportunities to expand.

(**Question**) Hospital systems with Behavioral Health systems, want support and, have baseline standards for how the person is treated. We work with departments who want to be involved with a crisis system of care that establishes safe standards of how to treat people with respect and dignity but also get the service they need, useful link to care where they can see someone as opposed to just getting a piece of paper.

(**Comment - Matt**) Looking at large City's systemwide resources other than ER that serve patience experiencing behavioral health crisis (i.e., Sobering centers, crisis stabilization units, low barrier shelters) we as a City have not made those investments at the level that we need to. Maybe we should think about it like stroke where certain settings specialized in and the staff are immersed. Knowledgeable about developmental differences, substance use. There is a baseline expectation but what does it look like when we thoughtfully direct patients to settings that are best equipped to help them in ways that are helpful.

(**Comment**) I think the sobering center is so needed. When we have to send people to the hospital, which is fairly frequent. We have people who have an emergency or a substance use disorder, are in danger for a short amount of time. Clients have a negative experience. I think it is a huge opportunity to take stress off of that system. 988 response has a peer on every shift. Good opportunity to close that loop and have better

care that's more targeted for a better result. Housing is another piece that we desperately need. We need more temporary housing.

(**Comment**) I was hoping you could give an update in the City's strategy of rehousing for people with behavioral health issues.

(**Response - Matt**) It was a recommendation, in the Diversion / Deflection – specialized housing connected to behavioral health.

The first part is this new stabilization housing pilot in the 40th Ward (Hotel Acquisition) City buying the building, which we don't usually buy residential property, so that's new. Second, this is a partnership with Health Department and the Housing Department.

We leverage the lessons learned from the pandemic.

Third, Power of non-congregant housing. Shielding / protective housing. Reduced Covid morbidity. Patients got access to medications. This a continuation of that program. 40 units. 1400 people in Chicago are a good candidate. We anticipate this pilot will run 2-3 years than we can evaluate. Mayor Johnson has voiced his support for it, and we are excited to get it going.

(**Question**) [Inaudible]

(**Response**) I defer to commissioner Knazze about thoughts. I know the team is aware and people have reached out on thoughts on coordinated entry. I can email you an update with more information.

(**Question**) [Not clearly audible]…. The stigma and if we are going to… we need to coordinate every single community. I think we need to take this model to the solvers in the community. We need to hear the community, what are their needs. I don't want to separate mental health and health. People desperately need the support.

(**Comment**) I think there is a lot of interest in this project. There are folks that have needs that exceed their abilities. Rapid interim housing options to feed into the. Learning to help how to do this best.

(**Comment**) Increased migrant community with chronic acute trauma with lost support and resources. Is there a plan, will we include a plan, to address this know it will soon show its face across mental illness and community safety.

(**Response**) From a health care component, we are integrating health care across the shelter systems. That's intended to provide Primary Care and Behavioral Health care. large system - 90 shelters. The Health Dept. is doing training for shelter staff and coordinate referrals to providers or assist folks who need a safety plan, we can assist with that.

(**Question**) I would encourage you to look at emotional CPR. What is the emotional experience the person is having to take time for the best next step. Those training would be helpful.

(**Response**) I think that's a great plan.

Questions / closing

(**Comment**) We are at the last 5 minutes, we will put OEMC's presentation on the agenda for the next meeting.

(**Comment**) One thing we can correct. We did an audit of the members list, review of the attendance in bylaws. As we are looking at new member recommendations and attendance to follow-up to see if there is continued participation as an active members. There is a difference between attendees and active members. Staying engaged, we are reconfiguring to make this an effective body as we gather professionals for the meeting.

(**Response**) not audible

OEMC presentation at the next meeting.

(**Question**) [Inaudible]… location of the meeting

(**Response**) We will continue to hold in-person meetings in the community.

Link to the live stream recording:

https://www.facebook.com/ChiPublicHealth/videos/155474164247769/