Chicago Council on Mental Health Equity (CCMHE) – Crisis Response Subcommittee

MEETING AGENDA

Date: June 28th, 2021
3:15 p.m. – 4:15 p.m.

Zoom link: https://zoom.us/j/3032424110?pwd=dWtiWER4WERWZ2hsekpuQWpicWlEZz09
Meeting ID: 303 242 4110
Passcode: CCMHE2021

I. Welcome and Introductions – attended members shaded gray

Co-Chair	Name	Agency
Co-chair	Dr. Eddie Markul	Region IX Medical Services
Co-chair	Deputy Chief Antoinette Ursitti	CPD
Co-chair	Alexa James	NAMI Chicago
	Rebecca Levin	Cook County Sheriff's Office
	Dr. Leticia Reyes-Nash	Cook County Health and Hospital System
	Michelle Langlois	Veterans Administration
	Peggy Flaherty	Thresholds
	Marc Buslik	Retired, CPD Commander
	Veronique Baker	IL Guardianship and Advocacy
	Chief Mary Sheridan	CFD
	Dr. Manoj Patel	LSSI
	Oswaldo Gomez	ONE Northside
	Zoe Russek	Uchicago Urban/Crime Lab
	Amy Spellman	Uchicago Urban/Crime Lab
	Dr. Shastri Swaminathan	Retired Advocate IL Masonic Hospital
	Eric Cowgill	NAMI Chicago
	Alderman James Cappleman	46th Ward Alderman
	Donald Tyler	Chicago CRED
	Dr. Ken Fox	CPS
	Hellen Antonopoulos	CPS

II. Public Comment – no public comments

III. CIM Presentation (power point presentation – Crisis Identification and Management training and Adult Mental Health Crisis Cycle – CCMHE June 28.2021)

Alexa James (AJ) to review the past recommendations
Slide 1 (integration of agency training), different policies
CIM developed (OEMC, CPD, CFD, ED department staff) 8hr role players, de-escalation tactics, first responder wellness
Dr. Edie Markul (EM): all agencies touch people in crisis but different policies, frequently have CPD and CFD on –scene. Training to help understanding of roles of different agencies for better outcome for patient

Slide 2 – AJ: CIM class small, on purpose, participants into hands-on scenarios, much discussion in classroom, asking questions, people started off segregated – end of class people intermingling
Participants wanted a full day of scenarios, more background info on roles and policies especially CPD CIT programs
Deputy Chief Ursitti (DC): CIM lab at CFD very unique, trainers can watch in real time (nice feature)

Slide 3- AJ: next steps for Interagency Refresher, working on refresher curriculum, incorporate policy changes, ensure facilitation in line with best practices and OEMC module

Slide 4 – Mental Health crisis continuum
AJ – working with antiquated system, challenge is that not everyone follows same protocol, inconsistency in care or what process looks like. Opportunities for reform

Slide 5 – skipped

Slide 6 – intercept 1 (crisis onset) many call into 911 that are identified as mental health related but often coming into 911 as domestic or property damage.
Everyone expresses crisis in different way

Slide 7 – helplines

Slide 8 – EM: explains process of emergency dept (ED), transports to approved facilities, and non-emergency departs (Roseland CTC). Calling 911 can get an ambulance, looking as a system to develop alternatives to ambulance
EM: Co-response pilot in development, to send out unit to respond to persons in crisis
CPD – can start involuntary petition, LE can fill out form, info from people on scene, transport person with this info

AJ: adult mobile crisis is available (through CARES line), if hospital transport necessary – have to use private ambulance or police transport

Slide 9: EM – walk in or transport to EDs, police and fire to deal with behavioral health crises and when get to ED there tends to be a lean to in patient admission. Other options – walk in to living room models, crisis stabilization units, transport to jail
DC: defer from CJ system, may be circumstance such as domestic that requires law enforcement mandatory arrest

Slide 10 – assessed for level of care (do you need to be inpatient?) not necessarily given treatment, upon discharge given referral,
AJ to explain
EM – critical point to find in-patient beds
Ald Cappleman (AC) – described example of one community member due to hygiene issues
EM: stable housing an issue – could really help people
AC: loses his cell phone so hard for Salvation Army to pick –up, he has fallen through every crack he can
AJ: 100,000 people falling through the cracks
DC: explained MH crisis report is required on all calls for service with MH, expect good data
AJ: not seeing the same numbers in Cook County Jail as in the past.

Slide 11 – AJ spoke to Next Steps, engage stakeholders in the mental health system, conduct site visits, develop and implement recommendations a tiered approach

QUESTIONS:
Dr. Swami – most critical real progress is communication
One thing is important is the co-chairs to connect and communicate as there is overlap between subcommittees. Concern of back-log is state systems. Many times we (ED at Masonic) would admit due to lack of housing. Different agencies sit down together and come up with coordinated plan.
EM: all players and agencies need to sit down and develop answers

Dr. Swami – has there any been any change from this new committee in the level of training in the CPD or people in the front line that can rapidly quickly assess a person in acute mental illness and not take to jail simply because there is a charge levied?

DC: training continues to offer basic CIT, recruit volunteers to attend training, enrolling members from districts to 40 hour training, recently implemented 2-day refresher training,
The biggest development in place is the expansion of the CIT District Operation and Community Support teams (area based – each are has a team), building relationships with officers and providers to identify trends

Elliot: 2 questions – how engaging persons with lived experience?

I understand 3 pilot programs are proposed, can you speak to mental health clinician training requirements, CESA (community emergency assessment services and support act) – requires non-police response program, are you developing training for that?
DC: are you asking about training on the CIM training class or CIT 40 hour training?
Elliot: you can speak to both,
DC: worked on CIM class development, work group process for CIT basic training (community engagement). CIT is through ILETSB – requirements through state.
(Described hours of training), CPD teaches 8 hours of CIT training – lived experience scenarios (role players give feedback)
Hosted curriculum work group with NAMI that incorporated feedback from comments

Elliott: community engagement question – glad to hear incorporate
Emmanuel: Community Outreach Coordinator – City liaison, making sure I am present in community meetings (Beat, CAPS) to see what communities need (resources)
Elliot: is there an interagency workgroup to coordinate between systems?

Alexa: foundation of CIT training is foundational, it is a programmatic
Not a training program, but more imbedding working together
Uniqueness of CIT is community engagement
Collaborative process, has been intentional alignment with NAMI
Lived experience members working on program

Emmanuel: the lived experience part if CIT training I share out in the community
I can put my info in the chat: Emmanuel.ares@chicagopolice.org
Elliot: thank you, one more question – is CESA taken into consideration?
Alexa: concerns with implementation of that, could connect you with person at NAMI with more knowledge on this subject

Next Meeting – July 26th, 2021 at 2:00 p.m.

Meeting adjourned.