Chicago Council on Mental Health Equity (CCMHE) – Deflection and Diversion Subcommittee

MEETING AGENDA

Date: May 26th, 2021
1:00 – 3:00 p.m.

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

I. Welcome and Attendance
Welcome remarks by Kate Sanchez, Mayor's Office
Declaration re: Zoom Videoconferencing

Name	Agency
Dr. Rashad Saafir	Bobby Wright Comprehensive Behavioral Health Center
Stephen Brown	U of I Health and Hospitals
Matt Davison	IL Guardianship & Advocacy
Dr. Wilnise Jasmin	CDPH
Fred Friedman	self
DC Antoinette Ursitti	CPD
Richard Rowe	Next Steps and CSH
Rebecca Levin	Cook County Sheriff's Office
Emily Cole	Cook County State's Attorney
Dr. Leticia Reyes - Nash	Cook County Health and Hospital System
Eric Lenzo	Sinai Health Systems
Joel Johnson	HRDI
Lori Roper	Cook County Public Defender
Zoe Russek	Uchicago Urban/Crime Lab
Amy Spellman	Uchicago Urban/Crime Lab
Esther Sciammarella	Chicago Hispanic Health Coalition
Nick Roti	HIDTA
Dr. Sharon Coleman	IDHS - DMH

Jac Charlier	TASC
Samantha Edwards	DFSS
Veronica Trimble	IDHS
Felix Rodriguez	IDMH

II. Public Comment
No requests for public comment.

III. Introductions
Co-chair Steve Brown introduction and welcome.
Attendance taken.
Welcome by Dr. Saafir
Welcome by M. Davison

IV. Background / History of the Committee
History of Committee
- 2016 advisory group formed to address crisis response.
- Evolution to: CIAC (crisis intervention advisory committee)
- Merged into bigger committee and formed into recommendations issued in late 2019.
- In 2020, after the merge, became CCMHE
- **Saafir**: been part of both previous groups before merge and deliberate efforts were made to ensure fair integration and nothing was lost for purposes of vision and recommendations.
- Transition into discussion earlier report and mission statement.
- S. Brown discussed roadmap for original efforts and the "why"
- Began cataloging local diversion and deflections efforts, not done yet.

V. 2019 Recommendations
- Outline of ensuring a well-resourced unified oversight body and framework.
- **COMMENT**: Howard Pollack about reiterating need for full picture and not just narrow CIT focus.
- Effort to consider this issue systemwide (everyone can touch parts of the elephant but not identify what they have unless in communication and in collaboration)
- What do stakeholders bring to the table, how can each particular org. interact with OTHER agencies and are there spots for collaboration or coordination?
- What does a behavioral health continuum look like?
- We were focused on CIT and consent decree but then realized we have a BH system that is not well-suited to divert people away from criminal justice system.
- S. Brown reviewed additional recommendations from earlier report.
- **COMMENT**: Esther S. one issue we encounter is the system is more focused on "justice" than mental health. There is a prejudice against mental health and the

general system does not properly view it. We encounter the police/justice system where there seems to be no consideration for the MH system.

    - **Response**: Thank you for the comment. No doubt. An additional issue is people bifurcating health care from mental health care. There is a need to be more integrated.

- What would be our ideal system for Chicago?
- Start small with pilots and build incrementally, help add insight into the problem and chip away at it. Always seek impact.
- Second Recommendation: prepare an assessment of CURRENT deflection and diversion practices.
    - This involved identifying current community services.
    - Not 100% complete yet. Open to review by all.
- Third Recommendation:
    - Analyze how other communities are already doing this and what formulas/methodologies they employ.
    - How to prepare a report to make recommendations for next steps.
- Fourth Recommendation: Based on the review and assessments from 2 & 3, identify a way to ensure ongoing care coordination and transition to community treatment.
    - Share data to confirm care coordination gaps and successes.

COMMENT, Esther S. – the situation is complex. How we connected with the community in the past. Language is a problem, too – barriers for care and treatment. Establish capacity for various agencies. Who will follow up with clients? Back to basics. General frustration by providers for how we collaborate and who measures it and who has capacity to accomplish this?

COMMENT, Wilnise J. – How do we coordinate and involve people with lived experience into this process? Important to consider the consumer point of view. How can we involve them in this effort? Emphasis on community engagement to help inform some of this work:

Follow up by Stephen B. and Dr. Saafir: We should make an effort to include people with lived exp as part of this very subcommittee. There are also other stakeholder groups in certain communities, there may be a way to link with them as well.

COMMENT, Owaldo – happy to hear about community engagement. We have an issue team that is made up of people with lived experiences. They are diverse. They often bring important voices to our organizing efforts. Be mindful of language and making sure it is accessible. Language should be intentional. There are already 2 pilots at the moment – do we get to address those or talk about those at any time? Will there be more info on these?

Kate Sanchez Response – Team from the mayor's office is attending and will address and highlight these very programs via a presentation.

COMMENT, Wilnise J. – consider paying these community members for their time and participation.

Comment Felix Rodriguez – Has anyone addressed or considered the triage centers that we do have? Does Roseland have a role in this? Given their location and population that they serve? Will it be addressed?

Dr. Saafir response: as part of our draft report from before, we were already mapping out which providers were already doing this type of work, including the work highlighted by this very question. My hope is that we will revisit that and also get a more "live description" of the work being done there.

Felix -- the presence/participation of these triage centers could have a big impact.

- We also want to acknowledge that homelessness drives a lot of this. So we need to tap into better housing options and supportive housing.
- **Question, Kelsey Burgess:** Will we focus at all on re-entry? I mention b/c it's great we try to divert/deflect but because of the cyclical nature of the system, how do we catch folks who are being released and incorporate them into these systems?
- **Becky Levin** – This is why the Sheriff's office is participating.
- **Richard –** work directly with IDOC? How about jail and prison?
- **Emily Cole, State's Attorney** – deferred prosecutions are growing, programs for drug offenders, programs for felonies and misdemeanors, fitness diversion in the branch courts and Maywood in partnership with dr. Saafir.

<u>Alex Heaton Presentation:</u>

Some plans for introduction alternate crisis response
Over past 8 months, office has worked with community, CPD, Fire, DPH, hospitals
Three prongs for crisis response:

(1) Pre Response

Staff in 911 center. Clinicians to resolve calls without need for dispatch.

(2) Alternate response

MH Staff dispatched alongside police or fire. Responding to substance abuse or MH calls. Help stabilize on location. Transport individuals to alternate destinations.

<u>Three models for this</u>:

(i) police/fire/med + behavioral health tech (any calls)
(ii) paramedic + MH professional (lower risk calls for homeless), goal is stabilization
(iii) community paramedic and peer recovery specialist, focus on substance use.

(3) Post Response: what exists in the community already and is it possible for us to connect people with this care at alternate sites? Focus on plugging people into larger systems of care.

Oswaldo: for the 3rd pilot (substance), clarification on team. Timeline for pilots?
Response: model (i) will launch in the summer and (ii) and (iii) launch in the fall.

Dr. Swaminathan: re model (iii) the peer specialist, who certifies that level of training?
Dr. Jasmine – the mental health clinicians will be CDPH staff. We will hire the clinicians.
Matt Richards: the peer recovery team is certified by DHS.
Elliot: Would these pilot programs, are they based in dept of public health? **Answer**: there will be staff from different departments on the team and delegate agencies as well. Physically will be based in south loop and address all of city. Follow up: Was this framework established by consent decree? **Answer**: No, not an entirely new team. **Elliot**: how would an organization join this team or effort? How are the groups selected? **Answer**: Some of the different parts of this strategy, we will have delegate agencies coordinated with grants issued by the city. If a local agency is interested in this, they would apply generally to competitive requests for proposals.

Dr Coleman: Curious about these models. Is the police model intiated by a call to 911? Who is on the end of the call that assesses it as a MH call and who designates which team goes out on the call? Is it done with an embedded expert? Answer: calls are received by 911 OEMC, and then they are dispatched similar to current dispatches, they will have question tree to go through to clarify the call and what would be needed.

Harold Pollack: It's also important to give attention to who is checking on this person weeks/months later after the incident. Very often the failure is we forget about the people between the incidents and we should focus on longitudinal care.

Richard: time frame of pilots? Opportunities to give input? Response: officer model starts this summer. The other 2 models start in the fall. We want input about these. City plans on providing data and learning what questions/data would be helpful or inform better coordination.
Is there a way to get a description of the three models/pilots? City is working on a 2-page and will circulate.

Oswaldo: concerned about policy for officers who are involved with these calls. Do we have a timeline for when CPD will release information about the policy related to these calls re: use of force, CIT --- will this be released in advance?

Dep. Cheif Ursitti – the members who participate in this pilot are expected to adhere to exiting policies and CIT policies. These officers have existing policy and procedures and are available at our existing database. There will be a Dept. Directive establishing the pilot program and its scope (location, hours, the entities) – when this is finalized, it will be presented to this group.

The pilot will not alter existing directives to how CPD responds to particular crises or emergencies.

Name of pilot group that Alex is working with or on? There is no formal name.

Presentation by Matt Richards

Dep. Commissioner for B.H.
2019 recommendations, one was around doing an inventory of national best practices for div/def.
Would it be helpful for us to highlight existing D/D efforts across the spectrum and what is about to happen?
Interested in doing more D/D for individuals with substance use disorders.
Expect to embed MH professionals in 911 calls. This can work as an intercept in and of itself.
Triage centers and CSUs as alternatives to Eds.
We've embedded MH services in the homeless shelters as well.

Link circulated for SAMHSA guidelines for BH crisis care.

Stephen B. – question for Matt R., any thoughts on utilizing MH Code and Mental Health Courts? Response: Health Dpt has been doing some engagement on this nexus to better understand this. Housing presents a barrier here, b/c if can't offer patients an appropriate level of housing, it is difficult to work with that person to get a handle on what's going on.

Stephen and Matt R. discussion of housing and sufficient resources to offer before considering
Richard: there was mention of chronically homeless, this is an opportunity to just say homeless and not use that other definition. Be careful of pigeonholing this term and approach.

Dr. Swaminathan: Agree with City's approach. My point is diversion and deflection only works when we have adequate resources! Do we have a list of resources of what's available out there? Where are these helpful places?
Response: What we are trying to do for this initiative is to create our very own resource director and circulate it. We are working on resource director citywide and piloted on city's microsite for mental health. Refinement will be needed around ability to query to give the user options for the exact type of service required/needed. We know we need to make it easier for these connections. Over time, it will get more sophisticated.

VI. Next Steps
   a. Where do we go from here?
   b. How do we measure success?
   c. Messaging

d. Key Performance Indicators

Stephen Brown Concluding Remarks:

Next meeting is June 30th, same time.
We will distribute the draft of our older report.
We would like input on the D/D definitions so we can incorporate into report.
Comment: Interested in knowing what the plan is for this particular group about community engagement and getting members with lived experience involved? How do we create a pipeline for participation?