Chicago Council on Mental Health Equity (CCMHE) – Mental Health Safety Net Subcommittee

MEETING MINUTES

Date: September 15th, 2021
11:00 a.m. – 1:00 p.m.

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

I. Welcome and Attendance – members present at the meeting are shaded gray

Co-Chair	Name	Agency
Co-chair	Matt Richards	CDPH
Co-chair	Mirna Ballestas	Private practice
Co-chair	Dr. Inger Burnett-Zeigler	Northwestern Hospital
	Mark Ishaug	Thresholds
	Susan Doig	Trilogy
	Pastor Chris Harris	Bright Star
	Dan Fulwiler	Esperanza
	Denise Fuentes	HHC
	Joel Rubin	NASW
	Alderman Roderick Sawyer	6th Ward Alderman
	Belinda Stiles	Christian Community Health Center
	Dr. Donell Barnett	City Colleges of Chicago
	Darci Flynn	Mayor's Office (Recovery Task Force)
	Patrick Dombrowski	C4
	Marco Jacome	HAS

II. Public Comment – no public comment

III. CPD CIT Policy Review

a. S04-20 “Recognizing and Responding to Individuals in Crisis”

Mark: How are MH intake facilities defined

(response): as level 1 trauma centers, PEDS trauma comprehensive care hospitals, detoxification facilities and MH facilities

Mark: Does it include living rooms as MH facilities

(Sgt. Reyes): (let’s flag this for a f/u) the order for approved facilities state the living room

(Matt R.): (regarding living room stabilization settings) there is approval for living rooms as an alternate destination for the CARE pilot program

(Kate): please note that CPD’s department directives/policies are available to the public online

Mark: How many certified CIT officers are there currently? How did this compare to the past few years? Does the consent decree recommend a specific target # or percentage of the overall force to be trained?

(Sgt. Reyes): I’d have to refer to our dashboard, our numbers are increasing every year. We’re trying to have at least 75% compliance trained in CIT and then we’re looking to determine if we’re going to prioritize them for dispatch so we’ll have officers that are part of the Crisis Intervention team that are CIT certified and they’ll be prioritized for dispatch

(Zoe): We’re currently working on sufficient data to determine enough CIT officers that are needed to timely respond to 75% of calls involving individuals in crisis. This will determine how many officers are needed to meet that timely response that’s needed per district. The superintendent’s goal is to train every officer with the basic 40-hr CIT training to ensure that each officer has the basic tools to respond to these types of calls. We currently do not have a specific number, but a ballpark number is about 3k officers CIT trained

Kate: (comment) the importance of the “Z-code” is for data tracking

Question (unknown person): How does the ISP 2-649 form differ from the petition involuntary admission

(Sgt. Reyes): Read section L-4 on CIT document/policy form goes to ISP (it’s part of FOID). CPD directive “Person determined to pose a clear and present danger” is a policy and the ISP 2-649 is a form

(Susan): Is there a place for the involuntary admission in this

(Kate/Sgt. Reyes): it's included in the narrative

(Zoe): asked Susan to restate her recommendation

James: Sgt. Reyes mentioned there were 3k trained CIT officers, what percentage of this is the department

(Sgt. Reyes): to give an accurate number, I'd have to run a report

(Kate): once this is done, I'll ensure this gets out to the group

James: What percentage of CIT trained officers does the consent decree call for

(Zoe): estimated 12k, but it needs to be confirmed

(Zoe): it doesn't call for an expressed number, it calls for enough officers to respond timely to 75% of calls for service in individuals in crisis in each district. We need to collect more data on this

James: Are CIT officers prioritized to districts most in need

(Zoe): the calculation will be district by district

(Sgt. Reyes): We're currently working on the CIT officer implementation plan/dashboard

Kate (to James): CPD/CIT officer implantation plan per the consent decree, CPD is required to do that as well as the city – to complete a crisis intervention plan, because it's somewhat new, we're still working on this data collection piece

(Sgt. Reyes): There will be roll call trainings

James: Is there any information on where the CIT officers are – like a roll call/list of officers for them? Are there more CIT officers in the areas where there are more CIT related calls?

(Kate): District assignments overall non CIT/CIT are dependent on the amount of calls total (where there's a need more for officers overall)

(Sgt. Reyes:) the implementation plan and the dashboard does help us identify where the greatest needs are as it pertains to these calls. The CIT officers are identified on a roster by the "Z-code" for OEMC and identifies them as CIT certified and prioritized for CIT calls

S04-20-02 "Persons subject to Involuntary and Voluntary Admission, Non-Arrestees"

Kate: asked Sgt. Reyes to touch on page 3-b

Department members can provide transport to a person who needs a MH treatment – supervisor's approval when there's a relative or 3rd party who is willing to sign a petition and the person consents to being transported

Susan: Do we need both the petition and the certificate if someone is involuntary – it doesn't sound like a petition by itself would trigger a transport if it's someone determined to be at imminent risk

(Kate): if the petition is filled out by a 3rd party with the officer, the officer can do the transport. If the recommendation is a specific hospital, youth/patient program are not hospitals will have transport

(Sgt. Reyes): there's a protocol for CFD/EMS recruits – I'll need to review a bit further and include this in feedback

Dr. Mirna Ballestas (expanding on a previous question): Discussed basing her referrals on the client's specific need/specialty (i.e. LGBTQ, Bilingual provider, etc.), but the response has been that the client has to be taken to the nearest ER which will increase the amount of time it takes to get the client the services they need – is this my place to make that call?

S04-20-03 "Persons on Unauthorized Absence (UA) from a State-operated Mental Health Center"

Question: Will this policy explain when/how the crisis response pilot programs will be dispatched and how to prioritize dispatch among those pilot units

(Matt): there's a separate policy related to the Crisis Assistance Response and Engagement (CARE) which is the MH pilot that includes dispatch instructions. Each agency (CPD, OEMC, CFD, CDPH) has department specific policies in place, but we have an integrated protocol that spells out the policy

Question: Do the CDPH MH clinics qualify as approved medical MH facilities for crisis stabilization intakes and services

(Matt): CDPH MH clinics are outpatient MH centers and are available (and we've requested approval for them to be alternate destinations or where we can transport a patient. They are not crisis stabilization centers.

Marco: Matt, neither are facilities that offer social agency services that provide mental health services

(Matt): There are different levels of care when it comes to crisis stabilization

Esther: FQHC's might be a good option as well for these types of services

Matt: Interesting approach to consider

Kate: All directives are available to the public online

i. any ideas for presentations for this group especially in 2022
    a. how is CPD doing the petitions
    b. how are they being trained
    c. what are they looking for

IV. Trauma-Informed Centers of Care Program Overview and Data Update - Presentation by Kathy Calderon

Focus on supporting providers in City of Chicago
Mental Health Equity Framework has 4 pillars

1. Expansion of publicly funded outpatient mental health services in communities of high need – CDPH mental health budget has tripled in past 2 years to support providers and clinics.
   10 CMCHS, 15 FQHCs, 11 CBOs
   TICC projects: adult/youth services expansion, increased capacity at existing or new locations, increased capacity of service types,
2. Coordination of Trauma-informed victims services for persons impacted by violence
   Measuring trauma informed care
   Measuring integrated care – 14,511 people served (mid year 2021), / CBOs 30%, CMCHs 25% , and HQHCs 45% / over 28k units of service
3. Expansion of community based treatment teams for persons living with serious mental illness and co-occuring disorders
4. Systems coordination

Marco: can we get the presentation?
Kate: Yes, this will be presented again at the Oct 25th full committee meeting, would you mind waiting?
Elliot: What percent of 36 million is spent on services provided directly by CDPH as opposed to third party?
Matt: I think it's close to 50/50, I don't remember exact. The City's approach in the past has been to focus on the 5 clinics, this is a serious problem, when you have 200 public funded clinics. Gratifying to see the results, finally engaging the broader system in intelligent manner and best practice in our field. On track for 500% increase on number of people served. Thanks to Kathy and her team and all of you.
Kathy: specific percent is 58 (CDPH clinics) to 42

V. Next Meeting

Kate: thanks for commitment. Any questions please email and I will send to Kathy. Next full committee meeting is Oct. 25th. Next subcommittee meetings are the 27th and the 29th.