Chicago Council on Mental Health Equity (CCMHE) – Systems and Data Coordination Subcommittee

MEETING MINUTES

Date: August 19th, 2021
3:00 – 4:30 p.m.

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

I. Welcome and Attendance – subcommittee members attended shaded in gray

Co-Chair	Name	Agency
Co-chair	Joanne Farrell	CFD
Co-chair	Jac Charlier	TASC
Co-chair	Dr. Colleen Cicchetti	Lurie Children's Hospital
	Alisha Warren	CDPH
	Deputy Chief Antoinette Ursitti	CPD
	Cheryl Potts / James Burns	The Kennedy Forum
	Harold Pollack	Uchicago Urban/Crime Lab
	Zoe Russek	Uchicago Urban/Crime Lab
	Amy Spellman	Uchicago Urban/Crime Lab
	Carolyn Vessel	I AM ABLE
	Esther Corpuz	Alivio
	Brian Bragg	Frye Foundation
	Emily Neal	Mercy Home
	Dr. Ken Fox	CPS
	Veronica Trimble	IDHS
	Dr. Diane Washington	Cook County Health and Hospital System

	Gabriela Zapata-Alma	National Center on Domestic Violence, Trauma, and Mental Health
	Darci Flynn	Mayor's Office
	Lisa Hampton	DFSS
	Sue Golab	OEMC

II. Public Comment – no public comment

III. Continue mapping of process flow

Joanne: review of process map from previous subcommittee meeting, describing when someone in crisis has police respond

Kate: I will follow up on the Mental Health Incident Notice and CIT report

Joanne: used stable condition – what terminology should be used to describe next step of mental health issue? How will OEMC differentiate escalating situation? Is ti ok to send a mental health Crisis team to a non-threatening call

Colleen: when I think of threatening I think of harm to self and others, what police think of may be different. Need to distinguish.

Harold: so many situations to describe

Joanne: what are situations? Not a threat to themselves or others, what other descriptions? Is there a step in between?

HP: escalating symptoms? Keep in mind developmental disabilities or intoxicated

CC: does this mean long term issues? Sudden on-set versus long-term? Stable seems odd to use when calling 911

JF: encounter on street where everyone offered a resource and person did not except it

CC: maybe just a concern?

Joanne: is there a step in between concern and escalating? What would escalating look like?

HP: behavioral dysregulation? I'm not quite sure the best way to describe?

CC: behavior and affect concern with danger, include risk? Ex: girl at camp who ran in front of golf cart

JF: that is probably next step, “risk to injury” would a call to 911 be best choice?

HP: missing is when someone creates public nuisance but not threat to injury. Not doing anything illegal. Worth distinguishing between situations

CC: who are the right people to call? Is that a NAMI call?

JF: two different branches (escalation behavior – not injurious), (escalating behavior-risk of injury)

WJ: I would think the call takers at 911 would ask questions about behavior

CC: difference between call to have someone removed and in crisis?

Question from committee member: as a citizen who do I call in this situation? 911?

JC: confused about 311 versus 911 and when to call. People get flustered and then don’t call either. I want a system in place to respond to fast, in a panic situation

HP: need a one stop place for all crisis calls

WJ: by January will have a mental health clinician at 911?

CC: what are the set of questions for 911?

Kate: good point about the questions and what will they be for the mental health clinician to be embedded in 911
Question from committee member: will 988 be an alternative and if so when?

WJ: the state dept. of MH divided into regions to set up the 988 system, probably won’t go live for another 2 years

JB: the 988 is not a catch-all either, still a lot of questions with that system as well. Who is going to respond and the funding attached to the 988? Lots of questions to be answered.

CC: lot of talk with training of 911 operators? How to quickly connect people to alternatives? Text line?

WJ: Able to recognize if mental health issue. Plan to release request for proposal by Oct to start in Jan (rough estimate)

Kate: is there a point that you may be able to speak to the committee on the two different directions for the MH clinician in the 911 center
Could this committee help develop the questions and if already in place could they give input?

WJ: at 911 already have protocol in place but could refine that when MH clinician is on board. There is room for committee input.

JF: what is going on now? Realize that the police are called and were working to process map when police are called

Kate there is a system in place for questions at 911 for call taker to determine if a CIT officer should be dispatched

WJ: caller can ask for CIT officer directly

JF: possible to let people in the community know who CIT officers are assigned in each community?

WJ: not sure that is possible. 911 will dispatch nearest CIT officer

JF: what does CIT officer offer that a beat officer cannot?

Kate: explanation of CIT officer and dispatch protocol, switch topics for a second.
Subcommittees do cross-over in their functions

JF: CIT is available (or not) and police respond. Is there any delay for CIT?

Kate: not going to be a delay in dispatching an officer, but if possible officers on scene may wait for CIT officer

JB: CIT officers go through 40 hours of training, recognizing signs and symptoms, de-escalating skills, role-playing,

Kate: reminder of CIT training observation opportunity for CCMHE member

Sarah Yousef: how many officers per region?

Kate: better question for DC Ursitti, as they are in all districts and watches

Sarah: are there more officers in areas where there are more calls for service? Is there a way to balance it out? Would Lincoln Park have the same amount as North Lawndale? I am curious in division

JB: heat maps provide data of incidents, would be advantageous to have more officers in the busier districts

Sarah: efforts to make that happen?

CC: efforts to expand the whole program?

JB: DC Ursitti can answer this in much greater detail. Is the current number 35% that department should get to?

Kate: I think the department is at 26% and DC presented earlier in the year. I will reach out to her and verify. She is pushing the direction of increasing recruitment. Every member of dept. has had mental health awareness as part of 2-day training to identify. I'd like to ask her to speak to training plan for 2022.

CC: Until other systems in place, people are going to call 911 so more officers trained would be better. Can this committee recommend more officers be trained and not just optional? Would it benefit if new officers get this training prior to

Kate: some training in Academy. Previous studies show officer retain training after having time on street. Learning to read people. It is a different training as it is nuanced.

CC: notion of this as optional is concern, always people will volunteer and step up. How do we get more training to more people?

Kate: two points you are making – first is more training to more officers. This is a top priority for DC Ursitti. Second is how do you inform community? The Kennedy Forum has done quite a bite of outreach to inform communities about CIT officers.

CC: Is there a public awareness campaign out there? CPD has invested a lot into the CIT program, how to increase officers attending.

Kate: bring questions to DC Ursitti

HP: need to look at where calls are coming from? Shelters, service providers? Educate employees how to call and what to ask for when someone is in crisis

CC: trying to remember what to ask for when calling 911, a lot of onus on community members

JF: what if person self-presents to a community resource? Anyone online that can speak to that?

WJ: not in place now, but once alternate destinations sites will be optimal

JF: what happens when a threat to self in terms of a CIT officer response? Could this go directly to a State facility/

WJ: I will check but I believe has to go through Emergency room. I can check on any agreement

JF: problems with ED - long waits, found in alternate community, re-start medical history, unknown community home

WJ: team in ED will try to locate a bed and that take time

CC: shortage of beds (youth and adults), long wait. This system here is a huge area of need. Big issue.

JF: if someone in ED long enough waiting for bed, they may be stabilized enough for discharge

JC: example of local community member – all agencies worked together and sought petition to bring to hospital but once in ED he was released soon after

JF: is SASS able to get beds for children any quicker than adults?

HP: policy issues with Medicaid, competing with kids that have better insurance and less acute problems

JF: scenario with person is threat to others? Direct admission to Cermak Hospital?

HP: go through Cook County jail first, have P-flag first, Becky Levin would be good person to fill committee in on process

JF: how is it different if person is arrested? I feel like we have gotten as far as we can today with our resources. Does anyone have anything else to add?

Kate: will bring CPD CIT question to DC Ursitti and get forms to group before next subcommittee meeting

LH: cross-conversation on Youth deflection and diversion and youth mental health. Way more closely tied together than most people think. How can we help officers make the best decision for youth? Glad to hear it.

Kate: recognize youth is missing from this committee.

IV. Next Steps

Another subcommittee meeting in Sep (Thu Sep 16th), next full committee meeting in Oct. Please keep an eye out for CIT policies to look at beginning in Sep. Co-chair meeting in Sep. CIT training observation for CCMHE members, please get back to me with dates and times.