


Breakout B1C Community Emergency Services and Supports Act (CESSA) Implementation

Presentation to the Illinois Association
of Problem-Solving Courts

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October 18, 2023




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Session Abstract

Illinois' Community Emergency Services and Supports Act (CESSA) requires the creation and maintenance of an alternative response to community mental health crises. This complex work represents a significant shift from traditional first responses rooted primarily in law enforcement, and is raising important issues related to politics, justice, race and technology. Dr. Lorrie Jones and Peter Eckart are supporting the implementation of CESSA on behalf of the state's Division of Mental Health, Department of Human Services. **They will describe work happening statewide in Illinois, and how the Illinois experience builds on similar state and local initiatives around the country.**

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Presentation Goals





- CESSA Legislation and Implementation Overview
- Overview of Alternative Response Models
- CESSA Accomplishments and Challenges
- What's Next
- Questions

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Crisis Hub

**Illinois DMH Academic Partner:
Behavioral Health Crisis Hub
Jane Addams Center for Social Policy & Research
Jane Addams College of Social Work
University of Illinois Chicago**

The Illinois Department of Human Services / Division of Mental Health develops and implements policy related to all facets of the crisis continuum including program development, funding, and operational oversight. The UIC Behavioral Health Crisis Hub supports this work through an academic partnership.

UIC Hub staff provide program management and support for crisis care continuum

- Community Linkages in support of CESSA and Mobile Crisis Response Teams
- Training coordination, standards and evaluation for 988 LCCs and MCRT providers
- Community Engagement for communications and collaboration

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<h3>Mental Health Services</h3> <p>Provided when a person is in need of mental health support but is not experiencing immediate or intense distress, suicidal intent, or psychotic features. Coping mechanisms are intact and functioning.</p> <ul style="list-style-type: none"> • Counseling • Partial Programs • Case Management • Psychiatric Care • Assertive Community Treatment • Recreational & Complementary Therapies 	<h3>Crisis Services</h3> <p>Provided when a person considers themselves to be in a crisis state. Examples can include distress, intense overwhelm, confusion, anxiety, feelings of hopelessness, etc. Coping mechanisms break down.</p> <p>Historically limited:</p> <ul style="list-style-type: none"> • Hotlines • Crisis services when/where available (e.g. Walk-in Clinics) • Emergency rooms • Jails <p>Working towards:</p> <ul style="list-style-type: none"> • No wrong door • Mobile crisis response • Crisis receiving & stabilization
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The Illinois Department of Human Services / Division of Mental Health is charged with operationalizing plans to coordinate the state's continuum of crisis services in alignment with SAMHSA guidelines.

- **Someone to Call** (988 Crisis Call Hub Services)
Currently six call centers, seven anticipated in early 2024
- **Someone to Respond** (Mobile Crisis Team Services)
Over 60 providers expanding capacity of crisis services within the community
- **Somewhere to Go** (Crisis Receiving & Stabilization Units)
Over 20 Living Rooms and 11 Crisis Residential Programs (not yet available 24/7 nor statewide)

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OVERVIEW

The Continuum of Law Enforcement / Behavioral Health Crisis Responses

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Key Data Points



- 29% of persons with serious mental illnesses in the U.S. had police involved in a pathway to care (Livingston, 2016)
- At least 1 in 4 individuals fatally shot by police had a serious mental illness (Fuller et al., 2015; Lowrey et al., 2015)
- People with mental illnesses overrepresented among those arrested for misdemeanor charges
- Once they enter the criminal legal system, people with serious mental illnesses stay longer
- A disproportionate share of the burden of this problem is shouldered by persons of color

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"We have to challenge the belief that mental health crisis services must come in a police car."

"It fell to us, but we aren't the best solution or help to a person in an escalated state."

"Every time a police officer goes out to a crisis situation, it's going to escalate the person's emotional state. Yes, we can and will train officers to de-escalate situations, but often, their mere presence is stressful, and the person in crisis can become fearful and enter flight or fight. That's when we see major problems."

~ Ron Bruno, retired Utah police officer & CEO of Crisis Response Programs & Training (talk.crisisnow.com)



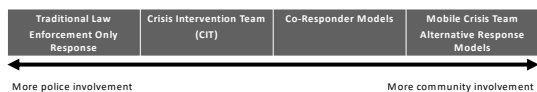
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A continuum of police and community response

The state envisions a continuum of responses based on the conditions and potential lethality of each crisis call.

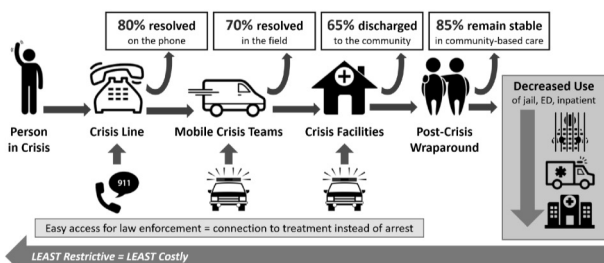
CESSA does not prohibit Law Enforcement from participating in resolving certain situations and co-responder models and CIT training remain valuable assets in the continuum.

A diverse set of innovative law enforcement and behavioral health collaborative models are being tested and implemented across Illinois and nationwide.



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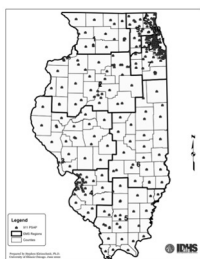
Crisis System: Alignment of services toward a common goal




Balfour ME, Hahn Stephenson A, Winsky J, & Goldman M. (2020). Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies. Alexandria, VA: National Association of State Mental Health Program Directors. <https://www.nasmhpd.org/2020/08/13/20200813.pdf>

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176 separate 911 Public Safety Answering Points in Illinois




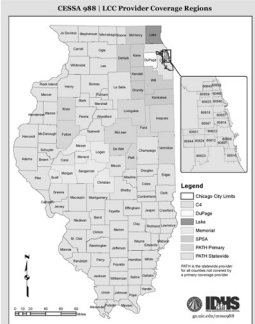
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988 Overview 

- The three-digit dialing code for the line previously known as the National Suicide Prevention Lifeline, which began in 2005
- Operated by Vibrant Emotional Health who has the contract from SAMHSA
- Vibrant controls the routing of 988 and the infrastructure of the call system
- July 16, 2022 – FCC required that all phone systems/providers in the US and territories have capacity to connect 988 with the ten-digit NSPL number
- Vibrant was further required to integrate text and chat functions into their 988 routing which requires a separate technological platform

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CESSA 988 | LCC Provider Coverage Regions 



988 Workflow – Structure of Program

- Call centers are selected by Vibrant and have contracts and onboarding provided and determined by Vibrant
- Six exist currently – 2 county based, 2 call-center only, and 2 community mental health centers
- NAMI Chicago is in the process of developing a center that will be primary for the Chicago zip codes not covered by C4. Expect to be onboarded with Vibrant in early 2024.

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988 Data 

Outcomes

- Answer rate: 18% in June 2022, average 82% since launch
- Average speed to answer rate:
 - 30 minutes
 - 17 minutes
 - 14 minutes
- SPARS indicators:
 - 2.3% of callers require emergent follow-up
 - 1.1% of callers require crisis intervention
 - 1.0% of callers require hospitalization
 - 1.0% of callers require admission to an emergency

Notable Trends

- 57% increase in demand June 2022 to June 2023
- Text/chat are younger, in more distress, more likely to require emergent referrals
- Increase in Veteran Crisis Line calls since Governor's Challenge promotions began (1792 to 2346/month)

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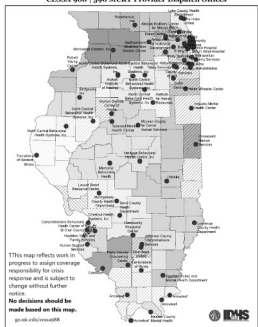
Mobile Crisis Response Teams

- Teams of clinicians that can be accessed or deployed without any law enforcement involvement
- Offer triage, screening, assessment, de-escalation, crisis resolution, peer support, coordination with behavioral health services, crisis planning and follow up
- May respond at the request of crisis line or law enforcement
- May request law enforcement assistance when safety issues are identified
- Typically not dispatched directly via 911 system
- Over 60 MCRT providers in Illinois (funded by DMH Program 590), most with 501c3 designations

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CESSA 988 | 290 MCRT Provider Dispatch Offices



590 MCRT Coverage

- 100% of Illinois counties currently covered
- 68% of MCRTs operate 24/7
- Average response times vary by region

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The Community Emergency Services and Support Act (50 ILCS 754)



- **Stephen Edward Watts Act**
- **Public Act 102-0580**
 - Effective Jan. 1st, 2022
- **Public Act 102-1109**
 - Effective Dec. 21, 2022
 - Extended to July 1, 2023
- **Public Act 103-0105**
 - Effective June 27th, 2023
 - Amended CESSA
 - Extended to July 1, 2024
 - 9-8-8 Suicide & Crisis Lifeline Task Force Act

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CESSA STATUTE

Section 5. Findings

- It is necessary to provide an emergency response for persons requiring mental or behavioral health services in a manner that is substantially equivalent to the response provided to individuals requiring emergency physical health care

Section 10. Applicability

- Applies to every unit of local government that provides or coordinates ambulance or similar emergency medical response or transportation services

Section 60. Scope

- Applies to individuals of all ages

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CESSA Statute

Section 25. State Goals

- Coordinate services so that State goals are achieved. MCR to be available regardless of initial contact. (a)
- Prioritize requests for emergency assistance. (b)
- Provide appropriate response times. (c)
- Require appropriate mobile mental health relief provider training. (d)


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CESSA Statute


Section 25. State Goals

- Require minimum team staffing. (e)
- Require training from individuals with lived experience. (f)
- Adopt guidelines directing referral to restrictive care settings. (g)
- Specify regional best practices. (h)

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CESSA Statute




Section 25. State Goals

- Adopt system for directing care in advance of an emergency. (i)
- Train dispatching staff. (j)
- Establish protocol for emergency responder coordination. (k)
- Integrate law enforcement. (l)
 - DMH shall provide for law enforcement to request responder assistance at parity with physical health emergencies and assistance from EMS

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CESSA Statute




Section 25. State Goals

MCR must:

1. Ensure persons are diverted from hospitalization or incarceration when possible and linked to services
2. Include the option of on-site care if appropriate
3. Make referrals as appropriate
4. Provide transportation to the most integrated and least restrictive setting

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CESSA Statute



Section 30. State Prohibitions

- Regardless of threat assessment, law enforcement may station personnel so rapid response for assistance to responders may occur
- Mobile mental health relief providers shall not assist in involuntary commitment beyond notifying dispatch or law enforcement that they believe the situation requires assistance. (On hold until July 1, 2024)
- Law enforcement shall not be used for transportation except where no alternative is available


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Section 30. State Prohibitions

- Law enforcement shall not be dispatched unless:
 - Individual is involved in the criminal activity
 - Individual presents a threat of physical injury to self or others
 - MCR is not available for dispatch cannot meet the maximum response time appropriate
 - Requested by responders


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Section 35. Non-violent Misdemeanors

- Shall provide guidance for responding to persons who appear to be in a mental or behavioral health emergency while engaged in conduct alleged to constitute a non-violent misdemeanor.
- Shall promote:
 - Prioritization of health care access
 - Diversion from criminal justice involvement

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Section 40. Statewide Advisory Committee


Section 45. Regional Advisory Committees

Section 50. Regional Advisory Committee Responsibilities

Section 55. Immunity

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CESSA Statute




Section 65.

- Each 911 PSAP and emergency service dispatched through a 911 PSAP must begin coordinating its activities with MCR once all 3 of the following conditions are met, but not later than July 1, 2024.
 - The SAC has negotiated useful protocol and 911 operator script adjustments
 - RAC has completed design of the specific 911 PSAP's process for coordinating activities with MCR
 - MCR is available in their jurisdiction

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CESSA Statute



Section 70. Report.

- On a quarterly basis beginning July 1, 2023, DMH shall submit a report to the General Assembly on its progress in implementing this Act.
- Two reports have been submitted thus far and are available on the General Assembly's website.

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State Partners




Department of Human Services Division of Mental Health

- Responsible for implementation
- Oversees grants, providers, & vendors
- UIC Crisis Hub – Academic Partner
 - Under contract with DMH
 - Oversees assigned projects
 - Provides analysis, consultation, facilitation, etc.

Department of Public Health

- Oversees Medical Directors and EMS

Statewide 911 Administrator for Illinois State Police


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CESSA

The DHS Secretary has established 12 Advisory Committees:

- 1 Statewide Advisory Committee
- 11 Regional Advisory Committees to assist with the execution of this legislation.

Regional best practices are being developed by the Regional Advisory Committees consistent with the physical realities of various locations.



Map Created July 19, 2011

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CESSA

Local systems are diverse

Regional Advisory Committees are made up of representatives of

- 176 911/ PSAPs and dispatched emergency service providers
- Over 60** Mobile Crisis Team program grantees
- 875 Law Enforcement Entities
- 1300+** Local Fire Departments, county/fire-dept based and privately operated ambulances
- Six 988 Call Centers
- Advocates and People with Lived Expertise of Crisis

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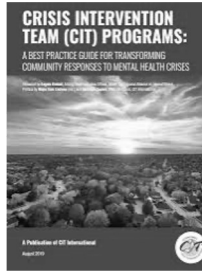
Alternative response models vary within a community response
Important variations within and across models

How dispatched/accessed	Who Responds	Transport options	Where is service housed?
<ul style="list-style-type: none"> • 911 • 988 • other crisis line, non-emergency line, 311 	<ul style="list-style-type: none"> • Police • EMS/Fire • Clinicians, Crisis Worker, Medic, Peers 	<ul style="list-style-type: none"> • Police car • Ambulance • Van 	<ul style="list-style-type: none"> • Police agency • Fire/EMS • Mental Health Agency

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Crisis Intervention Team Model

- **Partnerships** with other first responder agencies, community providers, advocates, family members and persons with lived experience of SMI
- Single point of entry to emergency psychiatric care
- 40-hour CIT Training for specialist officers



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What the evidence says about CIT

There is **strong evidence** that CIT training improves officer knowledge, attitudes, self efficacy, use of force preferences. There is **good evidence** that CIT training/program implementation increases linkages to care. Evidence related to use of force and arrest is unclear. Availability of Mental Health resources matters. There is indication that training of call takers/dispatchers and call coding is an important component of CIT.

- (Watson, Compton & Draine, 2017, Watson, Owens, Wood, Compton, 2021)



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Co-Responder Teams



Pairing of clinicians and officers to provide response

Goals of Co-Responder Teams

- Reduce arrests & increase safety
- Reduce ED transports & hospitalization
- Increase linkage to community care

Significant variation exists within the model

- Ride together, arrive together, or telephone support
- Hot calls vs. secondary response or follow-up
- Often not 24/7

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What does the evidence say about co-responder teams?

Two systematic reviews and quasi-experimental and descriptive research suggest versions of the model:

- Are generally acceptable to stakeholders
- Improve collaboration between police and mental health
- In some communities, may reduce officer time on scene
- **May reduce ED transports** but increase admission rate for those transported
- May reduce repeat calls for service
- May reduce immediate risk of arrest
- Are preferred over police-alone approach by service users and family members



(Puntis et al 2018; Shapiro et al 2015)

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Alternative Response model, which leverages Mental Health Response Teams

- This is the model that is reflected in the CESSA Legislation
- A key component of the federal SAMSHA Crisis Services Continuum: someone to call, someone to respond, somewhere to go



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Limited research on Mobile Crisis Response Teams



- First descriptions in the literature in the 1970s
- The limited research suggests
 - MCT intervention may increase connections to services in the community
 - MCT intervention may reduce pressure on the health care system via reductions in ED visits and hospitalizations
 - MCT intervention may provide cost savings
 - Findings are similar for youth mobile crisis teams
- Common finding related to MCT programs is lack of 24/7 availability, long wait times



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Early conclusions regarding the community response models

Re-examining mental health crisis intervention: A rapid review comparing outcomes across police, co-responder and non-police models

Effectiveness of current policing-related mental health interventions: A systematic review

Variation across police response models for handling encounters with people with mental illnesses: A systematic review and meta-analysis

Conclusions Overall, rather than indicating that one approach is more effective than another, the review points to the need for a multi-faceted approach within a structured and integrated model, such as the CIT model. This is generally not the current pattern of interventions, and policy makers, service commissioners and providers may wish to review future options. Copyright © 2017 John Wiley & Sons, Ltd.

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Virginia Department of Behavioral Health & Developmental Services

Crisis Services

DBHDS Vision: A life of possibilities for all Virginians

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Division of Crisis Services

The DCS is tasked with organizing the formerly disconnected crisis efforts of multiple offices to enhance the buildout and deployment of crisis services.

-REACH -Emergency Services -CSU/CTH -CITAC
-Crisis Call Centers -Crisis Receiving Centers
-Marcus Alert

Division of Crisis Services Efforts

- Connecting Crisis Data Points across service modalities
- Data driven decision making related to system buildout
- Completion of Data Platform Core components
- Program Standards across crisis services that lack appropriate definition
- Enhancement of CRC buildout
- Review of CSU funding needs
- TDD Reduction
- Increased Community Resource Utilization during/post crisis

Someone to talk to, someone to respond, a place to go.

Project Bravo

988 Implementation

Crisis System Transformation

STEP-VA

Marcus Alert


Hospital Census

Department of Justice Settlement Agreement

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Vision for the Crisis System Transformation

Objective: The development of a community-based, trauma-informed, recovery-oriented crisis system that responds to crises **where they occur** and **prevent out-of-home placements**




HIGH-TECH CRISIS CALL CENTERS

These programs use technology for real-time coordination across a system of care and leverage big data for performance improvement and accountability across systems. At the same time, they provide high touch support to individuals and families in crisis.




24/7 MOBILE CRISIS

Mobile crisis offers outreach and support where people in crisis are. Programs should include contractually required response times and medical backup.



CRISIS STABILIZATION PROGRAMS

These programs offer short-term "hold, assist" care for individuals who need support and observation, but not ED holds or medical inpatient stays, at lower costs and without the overhead of hospital-based acute care.



ESSENTIAL PRINCIPLES & PRACTICES


These must include a recovery orientation, trauma-informed care, significant use of peer staff, a commitment to Zero Suicide/Suicide Safety Care, strong commitments to safety for consumers and staff, and collaboration with law enforcement.

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Three Required Protocols

Crisis System: Alignment of services toward a common goal



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Call Center Risk Assessment

Recipient: Laura Clark TEST E-Link | Home & Close | Clear All | Mobile Support

Participant: Assessment: Case Planning: Chat History:

Screen for Risk

EMERGENCY	HARM TO SELF	HARM TO OTHERS	OTHER MENTAL HEALTH	SUBSTANCE USE
<input type="checkbox"/> Medical Emergency <input type="checkbox"/> Home to Self Emergency <input type="checkbox"/> Home to Other Emergency <input type="checkbox"/> Substance Use Emergency <input type="checkbox"/> No Emergency	Current suicidal <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unstable to Suicide Recent ARISS <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unstable to Suicide	Current suicidal <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unstable to Suicide Recent ARISS <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unstable to Suicide	<input type="checkbox"/> Compensating Thoughts <input type="checkbox"/> Compensating Behavior / Mind <input type="checkbox"/> Compensating Behaviors <input type="checkbox"/> Suicidal Comments	<input type="checkbox"/> Substance Use <input type="checkbox"/> Alcohol <input type="checkbox"/> Medication

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Call Center Risk Assessment

Virginia Sanyal
sanyal@virginia.gov

Checked in

10/17/2023 10:00 AM

Dashboard

Call Center Hub

Case Management

Case

Follow Up

Follow Up Progress

Request Search

Community Referrals


Case History

Assess Risk			
HARM TO SELF	HARM TO OTHERS	OTHER MENTAL HEALTH	SUBSTANCE USE
<p>Desire</p> <ul style="list-style-type: none"> <input type="checkbox"/> Current Ideation <input type="checkbox"/> Hopelessness <input type="checkbox"/> Perceived Burden <input type="checkbox"/> Impairment <input type="checkbox"/> Self-Harm <input type="checkbox"/> Psychological Pain <input type="checkbox"/> Feeling Irrelevant/Alone 	<p>Intent</p> <ul style="list-style-type: none"> <input type="checkbox"/> Attempts in Progress <input type="checkbox"/> Plan with Method/Means <input type="checkbox"/> Preparatory Behaviors <input type="checkbox"/> Expressed Intent 	<p>Capability</p> <ul style="list-style-type: none"> <input type="checkbox"/> History of Attempt <input type="checkbox"/> Available Means <input type="checkbox"/> History Self-Harm (Non-Suicidal Self-Harm) <input type="checkbox"/> Dysregulation <input type="checkbox"/> Currently Intoxicated <input type="checkbox"/> Accessibility <input type="checkbox"/> Exposure to Suicide <input type="checkbox"/> Strong Determination <input type="checkbox"/> Impaired Anxiety <input type="checkbox"/> Access Mental Health Services <input type="checkbox"/> History of Violence 	<p>Buffers</p> <ul style="list-style-type: none"> <input type="checkbox"/> Immediate Supports <input type="checkbox"/> Resources for Living <input type="checkbox"/> Attachment <input type="checkbox"/> Sense of Purpose <input type="checkbox"/> Planning for the Future <input type="checkbox"/> High-Care Engagement <input type="checkbox"/> Social Support <input type="checkbox"/> Case Status

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Mobile Crisis Response

- Rapid response, assessment and early intervention to individuals experiencing crisis
- Provided 24/7
- Purpose:**
 - Prevention of acute exacerbation of symptoms,
 - prevention of harm to the individual or others,
 - provision of quality intervention in the least restrictive setting,
 - development of immediate plan of safety to help avoid higher level of care



Alexei Morozov/Stock

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Mobile Dispatch

Virginia Sanyal
sanyal@virginia.gov

Checked in

10/17/2023 10:00 AM

Dashboard

Call Center Hub

Case Management

Case

Follow Up

Follow Up Progress


Request Search

Community Referrals

Case History

Team Details			
Team	Status	Location	Action
Team 1	Available	Richmond	<input type="button" value="Assign"/> <input type="button" value="Release"/>
Team 2	Unavailable	Richmond	<input type="button" value="Assign"/> <input type="button" value="Release"/>
Team 3	Unavailable	Richmond	<input type="button" value="Assign"/> <input type="button" value="Release"/>
Team 4	Unavailable	Richmond	<input type="button" value="Assign"/> <input type="button" value="Release"/>
Team 5	Unavailable	Richmond	<input type="button" value="Assign"/> <input type="button" value="Release"/>
Team 6	Unavailable	Richmond	<input type="button" value="Assign"/> <input type="button" value="Release"/>
Team 7	Unavailable	Richmond	<input type="button" value="Assign"/> <input type="button" value="Release"/>
Team 8	Unavailable	Richmond	<input type="button" value="Assign"/> <input type="button" value="Release"/>
Team 9	Unavailable	Richmond	<input type="button" value="Assign"/> <input type="button" value="Release"/>
Team 10	Unavailable	Richmond	<input type="button" value="Assign"/> <input type="button" value="Release"/>

Map: Satellite

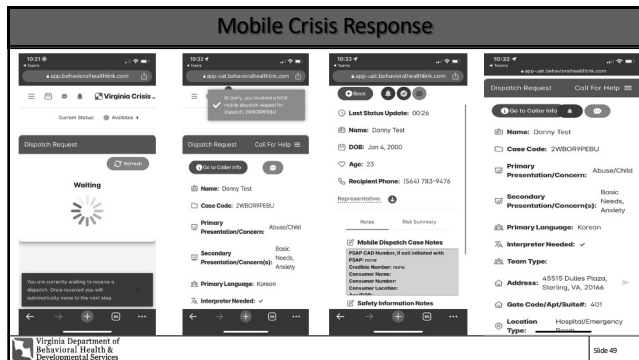


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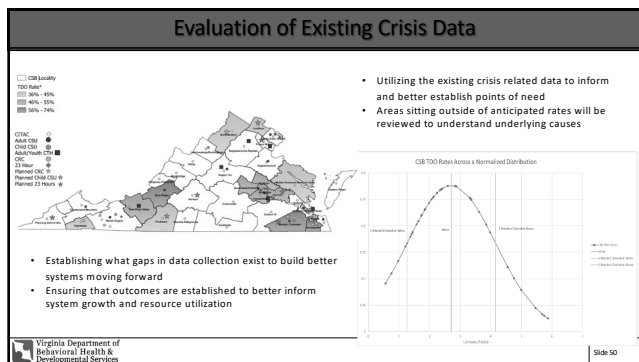
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CBI Integrated Care, Inc.
A PROGRAM OF CHANDLER-BROSCHER, INC.

About Us

Community Bridges, Inc. (CBI) is the premier non-profit fully integrated healthcare provider of substance use and behavioral health programs in Arizona, including prevention, education, and treatment using cutting-edge, nationally recognized, evidence-based models.



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CBI Integrated Care, Inc.
A PROGRAM OF CHANDLER-BROSCHER, INC.


Community Bridges, Inc. Call 988

- CBI has 20- 24/7 mobile crisis teams in 10 different counties in Arizona.
 - > 8 Rural Counties
 - > 1 Metro (Tucson)
 - > 1 City First Responder Program (Mesa AZ)
 - > 1 Tribal Team (San Carlos Apache)
- CBI Integrated Care Inc. has 5- 24/7 mobile crisis teams providing statewide coverage in Oklahoma.
 - > 2 Metro (Oklahoma City, Tulsa)
 - > 3 Rural




Understanding your Options 53

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CBI Integrated Care, Inc.
A PROGRAM OF CHANDLER-BROSCHER, INC.

How Does it Work?



- Services Include**
- Mobile Team Crisis Intervention
- Crisis Assessment
- Psychiatric inpatient/Urgent Recovery Center care coordination
- Information and referrals to community-based mental health services.
- Law Enforcement community and jail access to teams- as a priority.
- Connection to community resources
- 24 and 72 hour Follow Up

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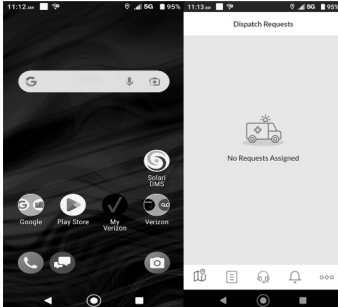
Dispatch Operations

- Consumer activates via calling 988, or established hot line numbers
- Call center triages to determine if crisis mobile team activation is needed.
- Crisis Mobile Team activated via smart phone app. All teams have a telephonic backup system in the phone.
- In rural/frontier areas teams also carry satellite phones.
- Crisis Mobile Team receive location, name, reason for activation and additional data (weapons on scene, Law Enforcement on scene, etc.)
- Call outcome disposition data entered back through the phone app once call is completed.
- Once team has cleared scene and back in rotation for activations, the team select the "available" option on the phone app.
- Phone has built in security features. Teams can select a single help tab on app that will alert the call center and the call center will dispatch Law Enforcement to the location of the team. The GPS in the phone is used to pinpoint location. Call center dispatchers will do routine one hour check in with team to ensure the team is safe as well.

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Technology


- Activations received through the app
- Consumer information and reason for activation displayed.
- GPS tracking
- One touch on/off scene
- Ability to enter disposition data
- Staff emergency one touch option



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**2023 CBI (Tucson) Pima County Teams (Population 1.052 Million)
06.2022-06.2023**

- Total Calls -> 597
- Per Month Average -> 496
- Per Day Average -> 17
- Adult -> 5076 (83%)
- Adolescent -> 881 (17%)
- Community Stabilized -> 4110 (69%)
- Voluntary Higher Level of Care Placement -> 1668 (28%)
- Involuntary Higher Level of Care Placement -> 179 (3%)
- Calls Resulting in Law Enforcement Assistance -> 239 (40%)
- Average Response Time -> 41 Minutes
- 24hour and 72hour Follow-Up -> 100% of patient's received a 24 and 72 hour follow-up call.

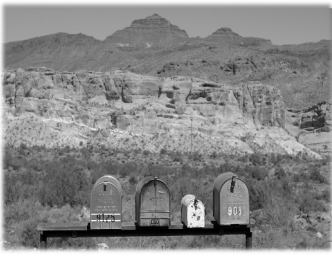


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CBI Integrated Care, Inc.
A DIVISION OF COMMUNITY HEALTH, INC.

2023 CBI Gila County Team (Population 59,589)
06.2022-06.2023

- ☐ Total Calls: 1233
- ☐ Per Month Average: 103
- ☐ Per Day Average: 3
- ☐ Adult: 1077 (86%)
- ☐ Adolescent: 156 (13%)
- ☐ Community Stabilized: 926 (75%)
- ☐ Voluntary Higher Level of Care Placement: 271 (22%)
- ☐ Involuntary Higher Level of Care Placement: 36 (3%)
- ☐ Calls Resulting in Law Enforcement Assistance: 78 (6%)
- ☐ Average Response Time: 38 Minutes
- ☐ 24hour and 72hour Follow-Up: 100% of patient's received a 24 and 72 hour follow-up call.



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The Interim Risk Level Matrix is a Tool

- A tool to structure conversations about matching the right dispatch/response to specific types of mental health crises
- Describes different types of crisis and matches them to different levels of crisis response, based on the nature and lethality of the crisis
- Developed based on national best practices, with expert consultant input from Illinois, developed and approved by S&P and reviewed by the SAC
- An interim document, subject to revision by the CESSA Statewide Advisory Committee
- Designed to be used by RAC membership as part of the discussions leading to protocols and standards recommendations
- **Please note that the Risk Matrices described here and in the Toolkit are for working purposes only and are not for public distribution.**

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The Interim Risk Assessment Matrix describes four levels of risk to health or safety

Emergent Risk – Level 4	Urgent Risk – Level 3	Moderate Risk – Level 2	Low Risk – Level 1
<ul style="list-style-type: none"> • Immediate threats to life • Active situation with weapons involved, lethal weapons present 	<ul style="list-style-type: none"> • No immediate threats to life with active assault on others • No weapons actively involved; non-lethal weapons present with plans to access them 	<ul style="list-style-type: none"> • No immediate threats to life/ minor self-injurious behavior • No weapons actively involved 	<ul style="list-style-type: none"> • No immediate threats to life • No lethal weapons present and no plans to access non-lethal weapons
Dispatch Response Type: Law Enforcement and/or EMS Response once scene is secured Dispatching Entity: 911 Response time: Immediate	Dispatch Response Type(s): • Law Enforcement/ Co-Response team • Law Enforcement and/or EMS Response with MCRT • Law Enforcement Dispatching Entity: 911 & 988 (for MCRT dispatch) Response Time: Immediate	Dispatch Response Type(s): • Law Enforcement / Co-Response team • Law Enforcement with MCRT (30 min) • Law Enforcement and/or EMS Response with MCRT • Law Enforcement Dispatching Entity: 911 & 988 (for MCRT dispatch) Response Time: LE/EMS—Immediate; MCRT: up to 30 min	Dispatch Response Type: Mental Health Crisis Counselor and/or MCRT Dispatching Entity: 988 or MCRT MCRT Response Time: Up to 60 min

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Current Status of Implementation

- SAC has been meeting since June 2022
- RACs have been meeting since December 2022
- Technical Subcommittees have been meeting since September 2022
- Interim Risk Level Matrix (IRLM)
- Landscape Surveys
- Customization of response types and times for Levels 2 and 3 of the IRLM
- MCRT Surveys
- Training interests surveys and courses
- Credential recommendations
- Data collection recommendations
- Communication strategy, messaging, and informational materials



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Initial CESSA Quarterly Report

- Required by statute in the CESSA revision
- Due July 1, 2023 and quarterly thereafter
- Delivered on time to the General Assembly, and to the SAC members on July 6, 2023
- Prepared by Illinois Department of Human Services/Division of Mental Health, in consultation with University of Illinois Chicago, Jane Addams College of Social Work, Center for Social Policy and Research Behavioral Health Crisis Hub
- Table of Contents
 - I. Executive Summary
 - II. Introduction and Context
 - III. Current Strategy and Status of Implementation
 - IV. Benchmarking Progress
 - V. CESSA Implementation Opportunities and Challenges
- Future quarterly reports will update progress on plans without repeating base description and context

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First Quarter Implementation Opportunities and Challenges

- **Growing levels of knowledge and trust** between different participants, and the opportunity to increase understanding of the different organizational cultures that make up the system.
- A system change strategy such as the one required for this implementation requires **all parties to consider new possibilities** that require operational changes.
- **Illinois is a diverse state** including dense metropolitan areas and dispersed rural communities that complicate ensuring consistent statewide MCRT coverage.
- **Lack of interconnected technological solutions** allowing for rapid routing of calls between diverse 911, 988 and MCRT provider systems.
- Initial misunderstandings about a unified system envisioned by CESSA create **an opportunity for all participants to learn about the crisis response continuum.**
- **Difficulties hiring/retaining staff for new operations**, including the new statewide 988 vendor and MCRTs, especially the hiring/training and retention of individuals with lived expertise.
- **Coordinating this work with pre-existing committees within state structures** including 988 Key Stakeholder Group (IDMR), EMS Medical Directors Committees (DPH), 911 Advisory Board (ISP).
- Building a consensus around a vision for robust behavioral health crisis systems across the state and requires **time to implement the systems changes.**

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Second Quarter Implementation Opportunities and Challenges

Medical Director Role

- EMS Medical Directors are designated in the CESSA statute as Chairs of the Regional Advisory Committees and are responsible for implementing CESSA at the regional levels. While acknowledging the importance of this work, some medical directors have voiced concerns about the time commitment required to complete this work, stating that their competing demands in their hospital-based duties makes it difficult to fulfill this additional responsibility. SAC members have acknowledged this challenge and suggested a possible statutory change, broadening the category of RAC members beyond the Regional EMS Medical Director who should be eligible to serve in the role of Chair.

PSAP Fiscal Requirements for Systems Change

- The PSAPs have diverse, complex, and idiosyncratic processes and technologies supporting the work of their telecommunicators who must make rapid dispatch decisions to Law Enforcement, Fire and/or EMS 24/7. Over 85% of the PSAPs use one of three private vendors to develop their protocols for assessing the nature of the 911 calls, leading to proper incident coding and dispatch. Each of these private companies has proprietary protocols and scripts along with specific requirements, including fiscal requirements, for making protocol changes required to implement CESSA. The Statewide 911 Administrator, with support from the UIC Crisis Hub, is in the process of quantifying the financial impact of such requirements with the intention of creating a budgetary estimate for the change.

Geographic Distance Limitations of MCR Teams to Meet Crisis Response Expectations

- Despite the establishment of MCRT teams across the state, with 64 providers covering 102 counties, the average response times for many MCRTs falls short of the demands for an immediate response as assessed by a 911 telecommunicator. Members of the September SAC asserted that the statute should support the development of new, innovative alternative response models in addition to strengthening and improving the DMH funded MCR teams. They each can play a role in the behavioral health crisis ecosystem and lead to more satisfactory responses to a wider range of incident types.

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Developing a shared vision: the SAC, the RACs and state partners

Purposes to drive the visioning exercises

- To co-develop a roadmap to ensure every community across the state has a system/capacity to deliver an appropriate on-scene response to Tier 4 crisis calls is available in a timely, effective way
- To identify a cross-section of localities where there exists a commitment to work together to pilot innovative approaches to Tier 2/3 calls and use those experiences to inform approaches across the state
- To co-develop and champion this vision in a way that meets legislative requirements and reassures principals that this approach is consistent with CESSA

Phased visioning and relationship building at the SAC and 11 RACs

- DMH and state agency leaders develop approach with Crisis Hub and consultant
- Consultant leads SAC membership to be convened in person at a single location
- Parallel process designed to be implemented by Crisis Hub staff with RACs

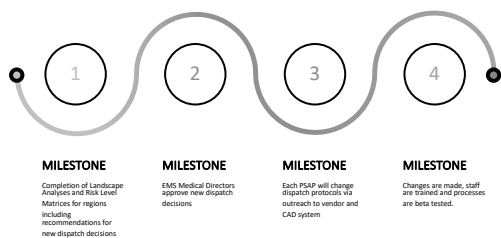
Outcomes of the visioning exercises

- Revised plans to deliver the current and amended legislative deliverables
- Broadened plans to recognize/integrate the community crisis response continuum
- Consideration of additional legislative work will be needed to extend the life of CESSA beyond 7/24 – feedback, monitoring, further improvements in the system

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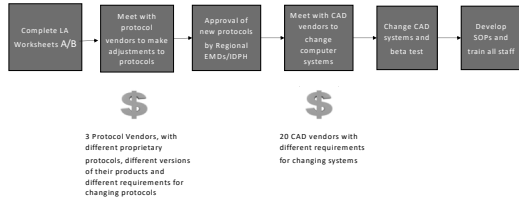
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CESSA Crisis Response Dispatch Change Roadmap



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Steps to Changing Protocols and Dispatch Decisions



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CESSA SAC MEETING DATES:

- OCTOBER 16, 2023
 - In-person convening
- NOVEMBER 13, 2023
- DECEMBER 11, 2023
- JANUARY 8, 2024
- FEBRUARY 13, 2024
- MARCH 11, 2024
- APRIL 8, 2024
- MAY 13, 2024
- JUNE 10, 2024

ALL DATES ARE THE SECOND MONDAY OF THE MONTH WITH THE EXCEPTION OF THE DATES IN BLUE.
 ALL MEETINGS WILL BE HELD FROM 1-3PM.

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Coordination of Efforts

- Pre-existing Committees
 - 988 Key Stakeholder Group (DMH)
 - Emergency Medical Directors Committee (DPH)
 - Statewide 911 Advisory Board (ISP)
- New Legislation / Initiatives
 - 9-8-8 Suicide and Crisis Lifeline Workgroup (P.A. 103-0105)
 - Strengthening and Transforming Behavioral Health Crisis Care in Illinois Act (P.A. 103-0337)

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