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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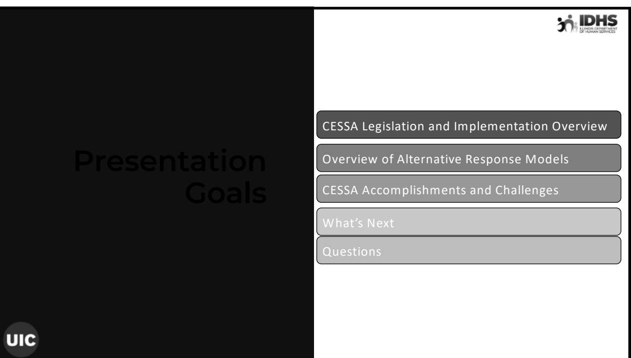

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Crisis Hub

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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Mental Health System

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Mental Health Services

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.

- Counseling
- Partial Programs
- Case Management
- Psychiatric Care
- Assertive Community Treatment
- Recreational & Complementary Therapies

Crisis Services

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.

Historically limited:
- Hotlines
- Crisis services when/where available (e.g. Walk-in Clinics)
- Emergency rooms
- Jails

Working towards:
- 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.

Traditional Law Enforcement Only Response	Crisis Intervention Team (CIT)	Co-Responder Models	Mobile Crisis Team Alternative Response Models

More police involvement ⟷ More community involvement

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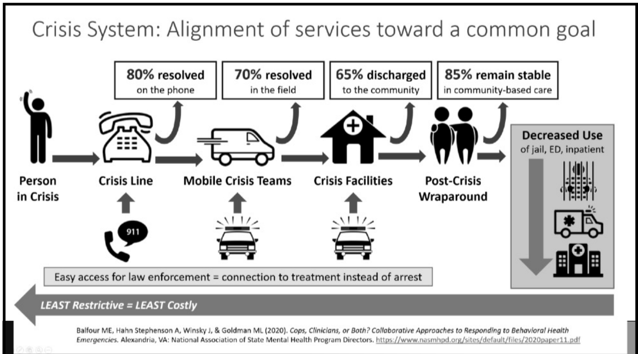

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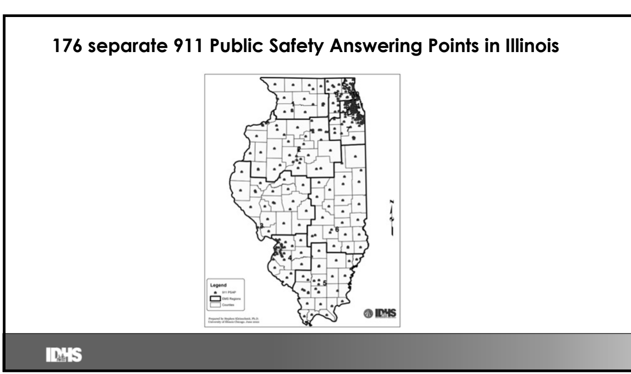

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988 Overview

- 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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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 seconds calls
  - 17 seconds texts
  - 5.8 seconds chat
- SPARS Indicators:
  - 2.3% of callers require emergent follow up care (911 or Mobile Crisis Response)
  - 30% of callers are provided with referrals for some additional supports (non-emergent)

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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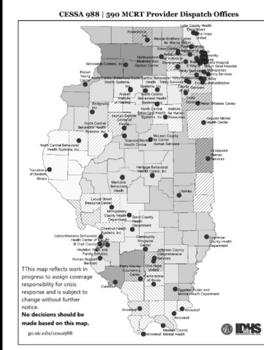

590 MCRT Coverage

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

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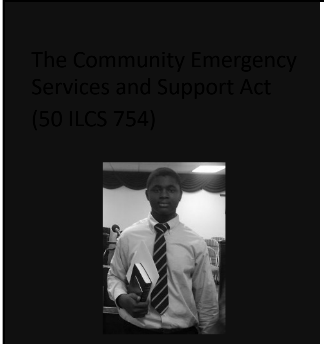
The Community Emergency Services and Support Act (50 ILCS 754)



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- **Stephon 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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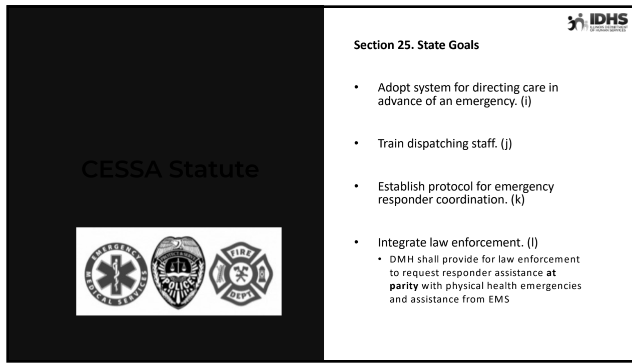

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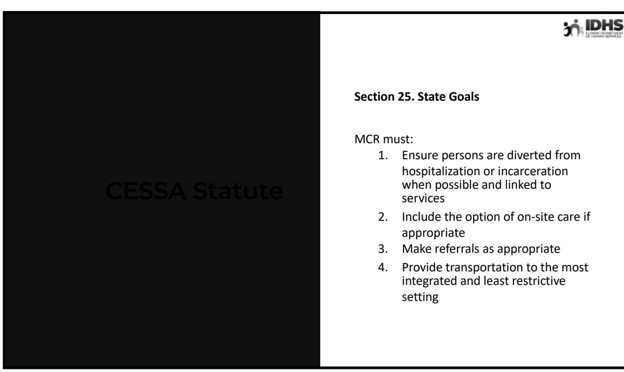

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CESSA Statute

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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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CESSA Statute

Section 30. State Prohibitions

- Law enforcement shall not be dispatched unless:
  - Individual is involved in the criminal activity
  - Individual presents a threat pf 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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CESSA Statute

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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CESSA Statute

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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CESSA strategy and implementation led by state partners

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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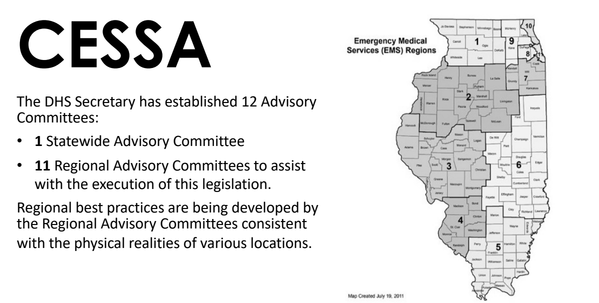
CESSA

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.



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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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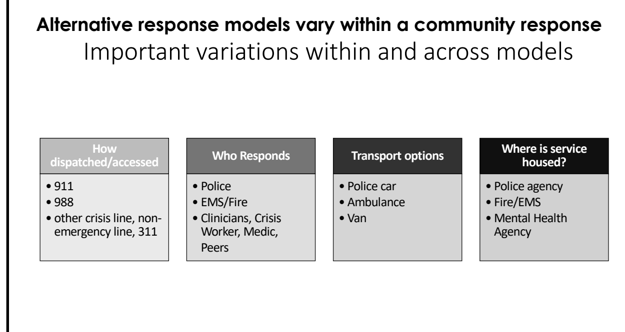
Alternative response models vary within a community response

Important variations within and across models



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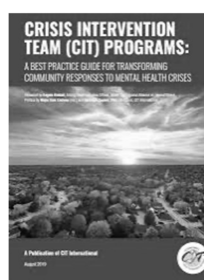
Crisis Intervention Team Model

- **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

EVIDENCE

(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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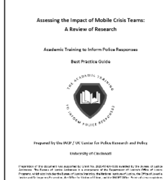
Limited research on Mobile Crisis Response Teams



Assessing the Impact of Mobile Crisis Teams: A Review of Research

Academic Training to Inform Police Responses

Best Practice Guide

Prepared by the IACP / UC Center for Police Research and Policy

University of Cincinnati

- 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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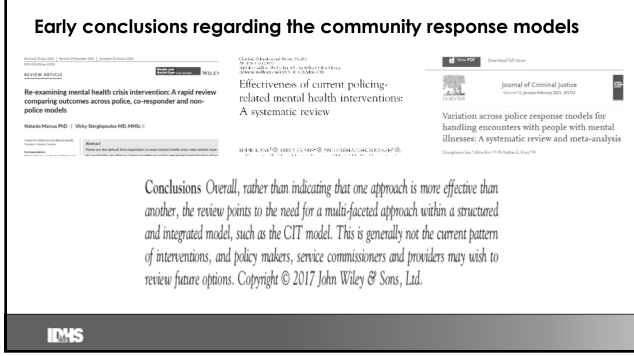

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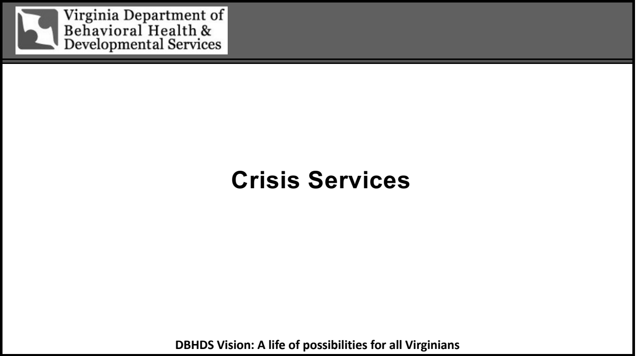

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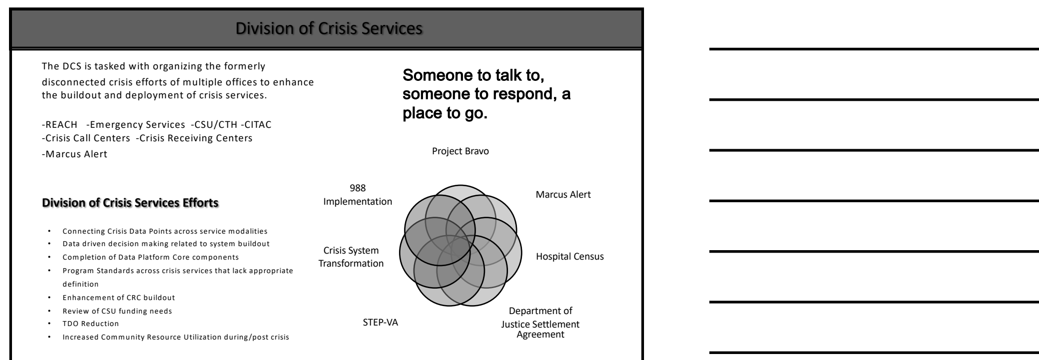

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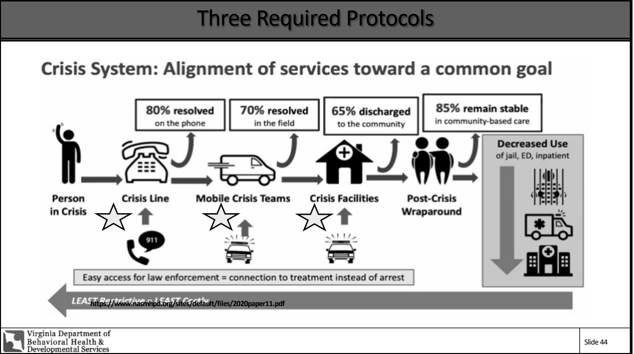

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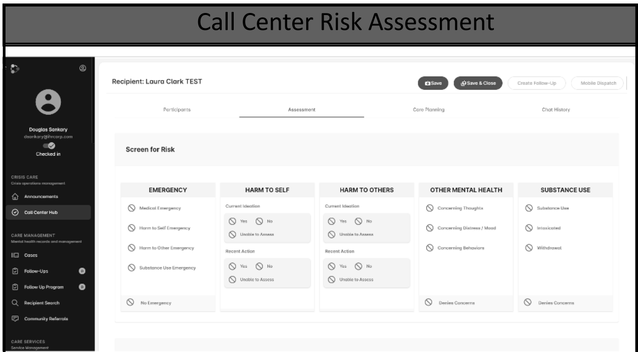

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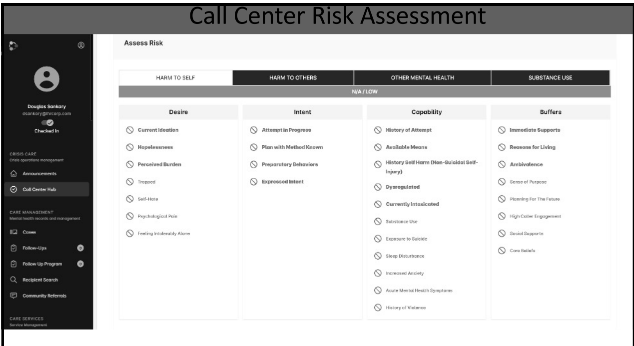

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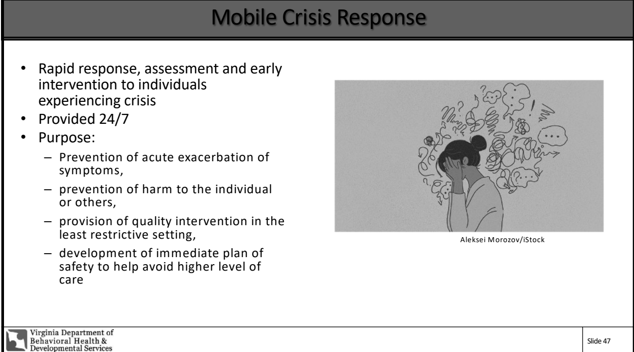

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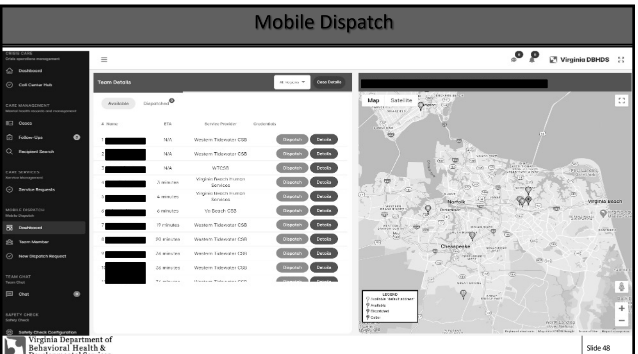

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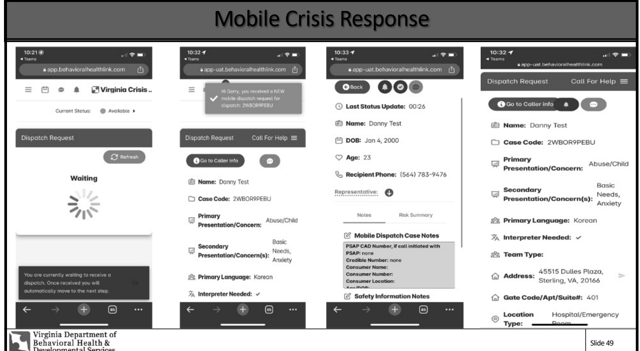

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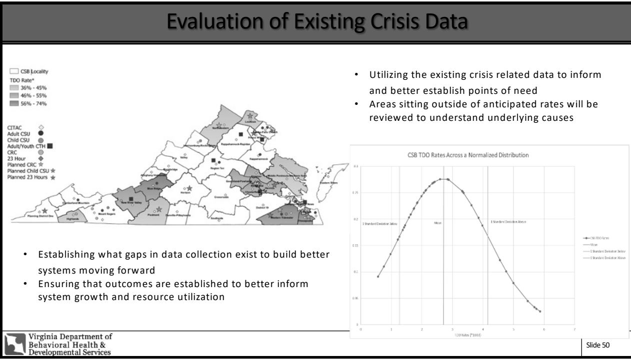

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About Us

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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Community Bridges, Inc. Call 988

- CBI has 20- 24/7 mobile crisis teams in 10 different counites 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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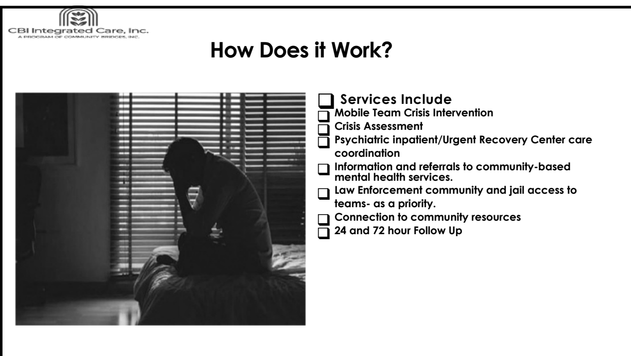
How Does it Work?



- 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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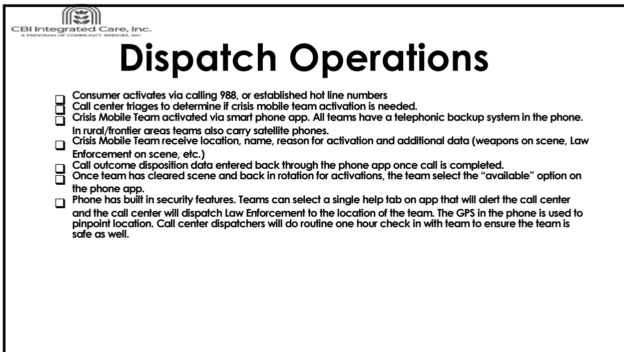

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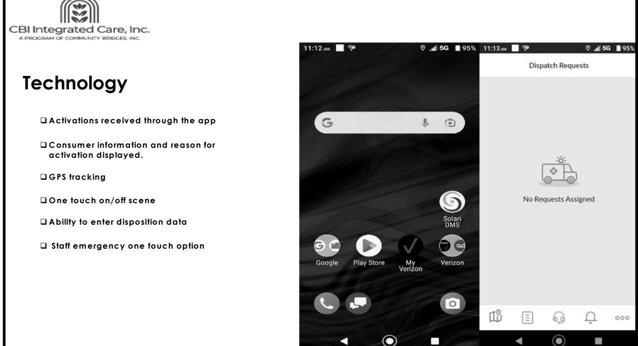

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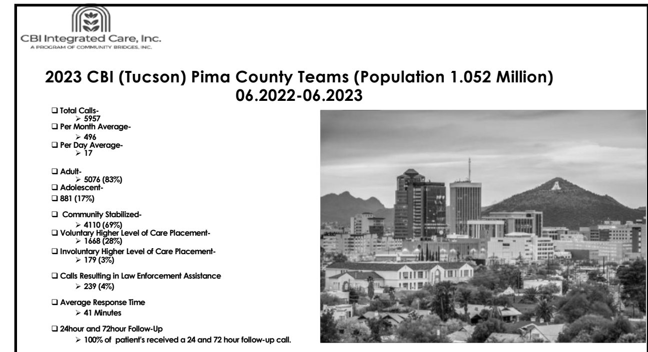

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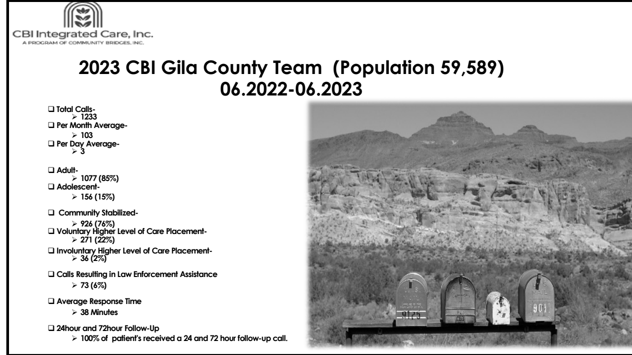

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The Interim Risk Level Matrix is a Tool

- 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
• Immediate threats to life • Active situation with weapons involved, lethal weapons present	• No immediate threats to life with active assault on others • No weapons actively involved; non-lethal weapons present with plans to access them	• No immediate threats to life/ minor self-injurious behavior • No weapons actively involved	• 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 statue 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 (IDMH), 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.

IDHS THIS MEETING IS BEING RECORDED.

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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

IDHS THIS MEETING IS BEING RECORDED.

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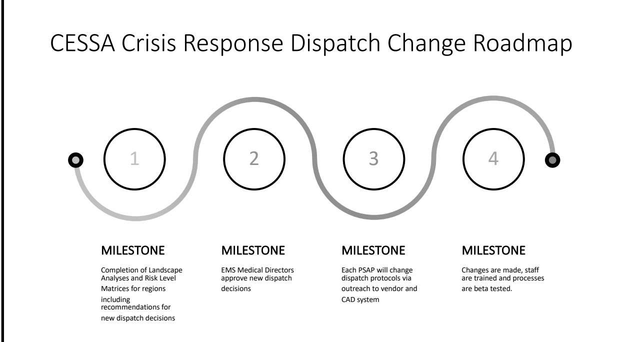
CESSA Crisis Response Dispatch Change Roadmap



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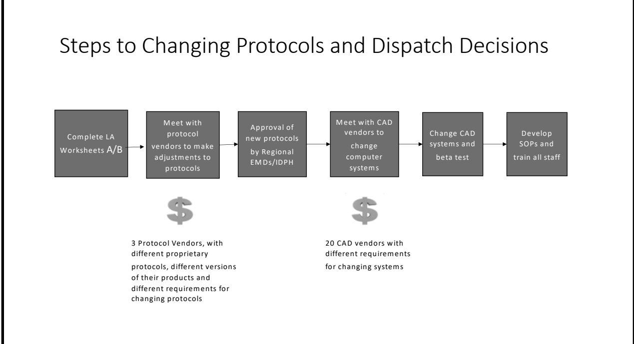
Steps to Changing Protocols and Dispatch Decisions



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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.

IDHS THIS MEETING IS BEING RECORDED.

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IDHS

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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