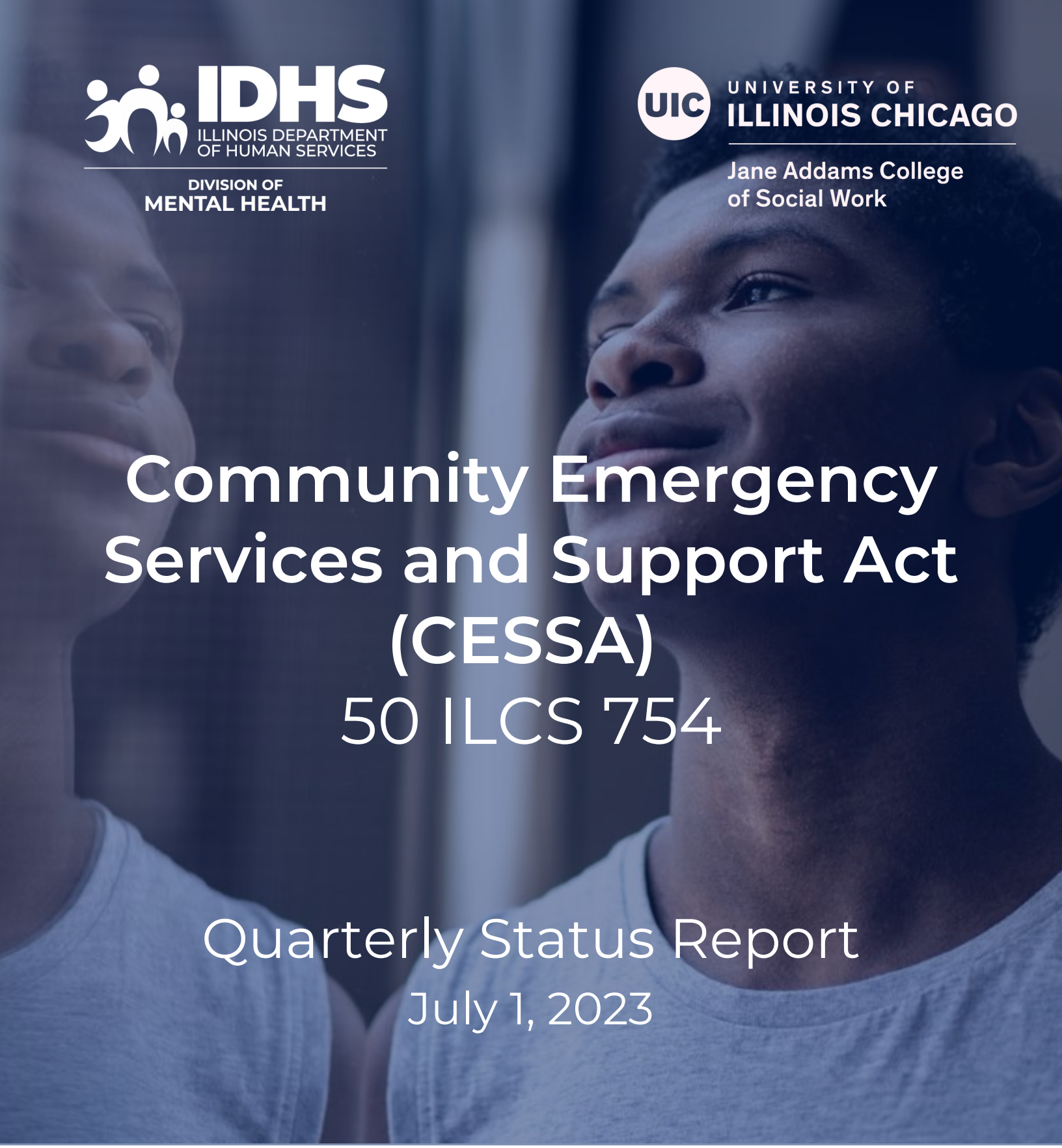


IDHS
ILLINOIS DEPARTMENT OF HUMAN SERVICES
DIVISION OF MENTAL HEALTH

UIC UNIVERSITY OF ILLINOIS CHICAGO
Jane Addams College of Social Work

Community Emergency Services and Support Act (CESSA)

50 ILCS 754

Quarterly Status Report

July 1, 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

EXECUTIVE SUMMARY

The Community Emergency Services and Supports Act (CESSA) called for sweeping changes to how emergency response systems address calls seeking mental and behavioral health support in Illinois. Since the law was enacted in August 2021, the Division of Mental Health (DMH) and its partners across the State have been working to design and implement the transformation. DMH is issuing this first quarterly report to the General Assembly pursuant to the requirements of HB1364, which was signed by the Governor on June 27th, 2023, and to provide the legislative sponsors and the public an up-to-date understanding of where implementation of CESSA stands. DMH also wishes to acknowledge the extension of deadlines afforded by the Illinois General Assembly through HB1364, which have provided additional time that is necessary to the success of this initiative.

CESSA requires emergency response operators to refer calls seeking mental and behavioral health support to services that can dispatch a team of mental health professionals instead of law enforcement. In addition to the changes required by CESSA, DMH has been implementing statewide expansion and improvement of the entire continuum of behavioral health crisis services, including statewide availability of Mobile Crisis Response Teams and of the three-digit 988 Suicide and Crisis Lifeline. These major developments in the crisis service continuum must be integrated into and coordinated with the changes made under CESSA.

Some of the key achievements of the CESSA implementation process include:

- DMH launched the Statewide Advisory Committee (SAC) and 11 Regional Advisory Committees (RACs) authorized by CESSA, as well as four Technical Subcommittees.
    - These groups are developing the protocols and procedures for CESSA's alternative response model; these dispatch protocols provide clear guidance to 911 dispatchers and emergency medical service providers on the types of services that are available in the caller's region and when referrals to such services are appropriate.
    - The Protocols and Standards Technical Subcommittee has developed an Interim Risk Level Matrix that was shared with the RACs to be customized for each region's specific needs.
    - The Training and Education Technical Subcommittee has completed a training needs analysis to determine the needs of 911 dispatchers, 988 call centers, and mobile crisis response team members, and has offered several online training sessions to these groups.
    - The Technology, Systems Integration, and Data Management Technical Subcommittee is developing recommendations to collect and report out on the performance indicators required by CESSA.
- While communications and public messaging are not explicitly addressed by CESSA, the SAC has been working to ensure that consistent and accurate messages regarding CESSA, 988, and the crisis continuum are delivered statewide.

DMH has developed an expert consulting team to lead and guide this work. DMH, along with its partners at the University of Illinois Chicago Behavioral Health Crisis Hub, are developing key performance measures, particularly those that align with the requirements of CESSA and national standards. These key benchmarks reflect 911 systems' handling of behavioral health crisis calls, 988 response standards, and mobile crisis response team performance. As data collection and reporting becomes more robust, these benchmarks will be included in future reports. While implementing the transformation required by CESSA is technologically, logistically and organizationally challenging, DMH and its State partners have been diligently working to build the capacity of all system partners to meet this singular opportunity.

Please note: This is the first quarterly status report required by statute, and as such, includes base descriptive and contextual information that will not be necessary to be repeated in subsequent reports.

INTRODUCTION AND CONTEXT

On August 25, 2021, Illinois Governor J.B. Pritzker signed the Community Emergency Services and Supports Act (CESSA) into law, that would require emergency response operators to refer calls seeking mental and behavioral health support to a new service that can dispatch a team of mental health professionals instead of police, marking a significant change in policy. The law was passed as a result of strong activism by concerned advocacy organizations following the tragic police shooting of Stephon Edward Watts, a 15-year-old boy diagnosed with autism, in his home. Over the past several years, there has been an elevated level of awareness of shootings of persons with mental illnesses by law enforcement. The National Alliance on Mental Illness (NAMI) reports that between 2015 and 2020, 25% of all fatal police shootings involved someone with serious mental illness (NAMI 2023). Further, persons with serious mental illness are 10 times more likely to experience use of force in interactions with law enforcement than those without serious mental illness.

The Illinois Law Enforcement Training and Standards Board (ILETSB) has been providing Crisis Intervention Team (CIT) training to law enforcement officers across the state who volunteer to participate. This specialized training consists of one week (40 hours) of training and has reached over 8,125 officers statewide from more than 560 distinct agencies. Law enforcement officers who are not trained as mental health professionals often do not recognize signs and symptoms of mental illness and lack the skills to resolve incidents involving persons experiencing a behavioral health crisis. Further, it is widely acknowledged that law enforcement officers should not be expected to be experts in the management of serious behavioral health crises. Officials at the National Police Accountability Project have proclaimed that police are not qualified mental health professionals and their unwarranted presence during such crises may increase risk of adverse incidents (National Police Accountability Project 2022).

In general, there is little opposition to the position that law enforcement officers are not the appropriate professionals to respond to most behavioral health crises. For the advocates who fought for this legislation, the legislators who sponsored and passed the law, and the state officials who are committed to implementing the requirements of the law, it is the goal that that no persons with mental illness shall suffer any fatalities or harm at the hands of law enforcement officers not trained to manage behavioral health crises. To reach this goal, the CESSA statute specifically endorses the “alternative response model” as the default model for responding to behavioral health crises, in lieu of law enforcement, with some limited exceptions. There are multiple jurisdictions, cities, and counties nationally, where this model has been implemented for use in responding to specific types of incidents. In these models, response teams have been created with some combination of behavioral health clinicians, community workers, and people with lived experience of recovery (peers). They often respond to low-risk incidents involving persons with mental illnesses, issues relating to the needs of persons who are homeless and, in some situations, appear alongside law enforcement who have called them to the scene to assist with de-escalation and referrals to care.

The systemic changes that must be implemented pursuant to the CESSA statute are occurring in the context of major reforms in the behavioral health crisis continuum both within Illinois as well as at the national level. The reforms of CESSA will inform and be informed by the policy and operational advances planned for the entire behavioral health crisis continuum. In 2021, the Illinois Department of Human Services Division of Mental Health (IDHS/DMH) issued a Notice of Funding Opportunity to Illinois community providers to increase the number of Mobile Crisis Response teams to expand the geographical coverage offered by these teams statewide. These teams are considered by SAMSHA as one of the three pillars of a crisis continuum that include crisis call centers at the front end (988/911), mobile crisis response, as necessary, and crisis stabilization centers as drop off sites. Funding for Mobile Crisis Response Teams (MCRT), also referred to as 590 programs, resulted in the development of teams across the state staffed by mental health clinicians and individuals with lived expertise. These teams are specifically cited in the CESSA statute as the "alternative response" teams to be dispatched in lieu of law enforcement when confronted by a behavioral health emergency. The coverage areas for these teams are currently too expansive and response times need to be improved related to situations requiring an immediate response.

The 2022 launch of the three-digit dialing code for the 988 Suicide and Crisis Lifeline as a result of the National Suicide Hotline Designation Act, passed by Congress in 2020, was designed to help ensure states have the flexibility to strengthen local crisis call centers and save lives. Illinois currently has statewide coverage for 988 with six Lifeline Call Centers (LCCs) across the state, including one center that has primary coverage responsibility for 85 counties and serves as a "back-up center" for the remaining five centers.

These three major policy initiatives, CESSA, 988 and Mobile Crisis Response Teams, are clearly interdependent and provide the impetus, the foundation, and the guideposts for the considerable work underway reforming the behavioral crisis system in Illinois. Much of the work of CESSA depends on the successful implementation of these and other reforms anticipated for the behavioral health crisis system.

The IDHS Secretary, in partnership with the 911 Administrator at the Illinois State Police, and the EMS administrators under the purview of the Illinois Department of Public Health, is responsible for leading the implementation details for this law. Concurrently, implementation for other reforms in the behavioral health crisis system have been tasked to the Division of Mental Health in IDHS, the Department of Healthcare and Family Services, and the Illinois Department of Insurance. The complexity of these changes will serve to be transformative and need to be approached thoughtfully and with significant collaboration between all governmental parties and relevant constituencies.

It is also noteworthy that Illinois is one of only two states that is undertaking this level of systems change statewide, pursuant to similar legislative mandates. A similar law passed in the Commonwealth of Virginia following the police shooting of a 24-year-old

high school teacher, Marcus David-Peters, who was experiencing a mental health crisis. The first year following the passage of the Virginia bill was dedicated to system planning and incremental benchmarks for the system's change were identified over the course of five years.

The implementation of the Illinois CESSA statute serves as a component and foundation for broader transformation to achieve a truly robust behavioral health crisis response system, operating with the values of parity with Illinois' health care emergency response and with a fully trained workforce that is trauma informed and stigma free. These goals, while aspirational, are achievable. CESSA provides a "north star" for the work that remains, which, by definition, creates more opportunities for law enforcement to refocus on criminal offenses. While the system is constrained by current resources, through local and statewide planning, Illinois can build upon CESSA to create new models of crisis response, maximize the use of technology in operations, and continue to build alliances between all crisis responders across Illinois.

This report offers a description of the current strategy and accomplishments to date, future targets for implementation and benchmarks for tracking and monitoring implementation in the future. It will also highlight challenges in implementation and immediate next steps that will continue to move the process forward.

CURRENT STRATEGY AND STATUS OF IMPLEMENTION

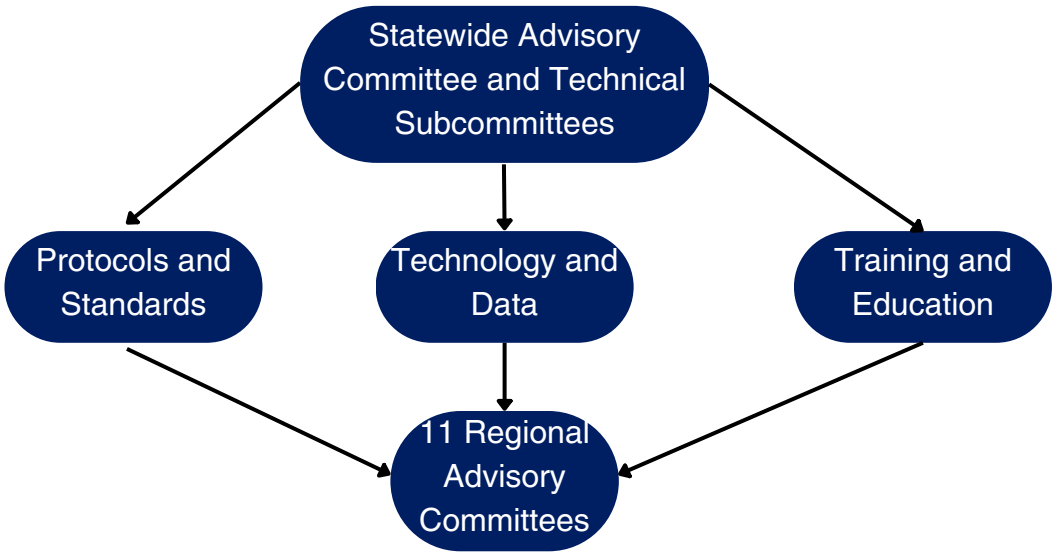
Immediately following the passage of the CESSA Bill, IDHS/DMH commenced a planning process for implementation that included weekly meetings with the Illinois Department of Public Health (DPH) and the 911 State Administrator. These "state planning partners" agreed on an implementation strategy and created an operational structure informed by statutory requirements and best strategies to organize the work for task completion. In addition to the Statewide Advisory Committee (SAC) and 11 Regional Advisory Committees (RACs), authorized in statute, the state created four Technical Subcommittees and an expert consulting group to focus on specific technical elements of the implementation. The Technical Subcommittees comprised of Statewide Committee members and supported by members of the expert consulting group include:

- Technical Subcommittee on Protocols and Standards (PSTSC)
- Technical Subcommittee on Training and Education (TETSC)
- Technical Subcommittee on Technology, Systems Integration, and Data Management (TSIDM)

A fourth Technical Subcommittee on Communication, Information Sharing, and Public Messaging (CIPTSC) was sunset in May 2023, with the subject of Communications and Messaging becoming a standard agenda item of the SAC.

Statewide, Regional, and Technical Subcommittees all operate with a charter and are subject to the Illinois Open Meetings Act (5 ILCS 120). The diagram below depicts this operational structure and the flow of information between the structures. Information and guidance flows from the SAC and the Technical Subcommittees to facilitate the work and changes that must occur and be approved by the EMS Medical Directors at the local Regional Advisory Committee level.

CESSA Organizational Structure and Flow of Information of Support to Regions



Achievements, Accomplishments and Current Status

Table 1 below provides an overview of the major milestones achieved by the state planning team, CESSA SAC, Technical Subcommittees and RACs to date, as well as summary level steps yet to complete. The narrative that follows provides an overview of the focus of each Technical Subcommittee which had the bulk of the responsibilities for meeting the milestones, their accomplishments, and current status of progress toward meeting the milestones. A latter section of this report describes work performed by the RACs whose work also focused on milestones following the guidance from the SAC and Technical Subcommittees. Although the infrastructure has been put in place to complete the work of CESSA, several barriers to implementation have been identified and are described in detail in Section IV. Operational complexities with changing dispatch decisions, including costs from protocol vendors to amend protocols in accordance with directives from Illinois as well as costs from Computerized Assisted Dispatch (CAD) technology vendors to update computer systems, are areas outside of the control of this process. While this could delay planned implementation timelines, areas under the direct control of this stakeholder process are progressing at an appropriate pace.

Table 1: Developmental Milestones of the State Planners, Statewide and Regional Advisory Committees

Commence planning process of key state agencies (IDHS, IDPH, Statewide 911 Administrator)
Appointment of all members of the Statewide Advisory Committee consistent with statutory requirements
Convening of the Statewide Advisory Committee and orientation of all members
Development of charter and subcommittee structure with identification of subcommittee participants
Appointment of all members of the eleven Regional Advisory Committees
Schedule all RAC and Technical Subcommittee meetings
Adopt SAC prototype of risk matrix and incident coding approach
Collect data on MCRT response times per locality
Cadence/modality of communications with updated list of key local stakeholders
Document current partner data systems, performance metrics, reports
Agree to approach to script approval and mapping incident codes to dispatch decisions
Agree on credentials of staff answering calls (911, 988) and BH staff responding to crises (MCRT)
Public communication strategy with local media outlets, etc.
Complete basic assignment of codes to dispatch decisions and script approval
Complete dispatch recommendations based on MCRT response times
Approve training requirements for MCRT staff, 988 crisis counselors and 911 telecommunicators
Deliver training for MCRT staff
Research emerging best practices regarding technology, systems, and data. Develop draft performance metrics and sample reports
Draft recommendations for data system and call transfer information sharing practices
Approve performance metrics and sample reports
Approve data collection and reporting procedures, and reporting phased data system and call transfer information sharing recommendations
Document current call transfer tech options and information sharing practices
Review best practices for diversion of non-violent misdemeanors
Complete dispatch modifiers for non-violent misdemeanors
Complete local SOPs for new dispatch protocols
Approve regional training calendar
Conduct beta test of new protocols/CAD system changes;
Deliver training for 988 crisis counselors
Deliver training for 911 telecommunicators
Implement public communication strategy

Key	Completed	In Progress	To Be Completed

CESSA Requirements for Protocols, Standards, and Dispatch

Illinois CESSA legislation required each RAC to develop plans to coordinate emergency responses between 911 Public Safety Answering Points (PSAPs), EMS Providers dispatched by 911 PSAPs, law enforcement, 988 entities, and IDMH funded MCRTs. The intent is to provide an alternative response option, as appropriate, to individuals experiencing mental health or behavioral health crises.

This approach requires that 911 PSAPs and other dispatchers in the crisis system across the state:

1. incorporate and use a standard set of risk factors as a basis for making dispatch decisions for mental health/behavioral health crisis calls; and
2. are knowledgeable with regard to the range and kind of crisis service alternatives that exist, where within the region they operate, and when they are available.

The CESSA Protocols and Standards Technical Subcommittee (PSTSC) of the SAC has the responsibility and authority for providing "…guidelines for all dispatch protocols statewide to include any best practices on risk stratification methodologies and matrices that guide decisions about entities dispatched given specific types of call incidents."

Accomplishments

The PSTSC has developed an Interim Risk Level Matrix (IRLM) to address this issue and the guidelines described above.

The process of developing the matrix included:

1. a review of current national best practices on the development and use of risk stratification tools developed to guide dispatch decisions for individuals experiencing behavioral health crises;
2. presentations to the subcommittee by program managers from state, county and city jurisdictions from across the country that have developed and implemented risk stratification methods for mental/behavioral health crises including discussion regarding preliminary outcomes associated with their use; and
3. consultation and technical assistance provided by Illinois subject matter experts regarding dispatch decision protocols currently used by 911 PSAPs and who made recommendations regarding development of the Illinois specific matrix. The four-level IRLM, which ranges from minimal (Level 1) to emergent risk (Level 4) and includes recommended response type and time for behaviors within each level, is subject to update as the Illinois crisis system continuum changes over time and becomes more mature.

The goal is for the IRLM descriptors and recommended response types and times to be incorporated into PSAP dispatch protocols statewide and used as a guide for making dispatch decisions for individuals experiencing mental and behavioral health crises. However, response type and time may vary by region, and possibly within region, for individuals at moderate (Level 2) and urgent (Level 3) risk levels because resources vary across the state. Some localities/jurisdictions may need to provide different crisis response types and times based on what is currently available. For example, some areas may have access to MCRTs and some may not. Therefore, a task assigned to

each RAC was to customize response type and time only for Levels 2 (moderate) and 3 (urgent) of the IRLM. Utilization of the IRLM by PSAPs requires the establishment of an understanding of the range, type and response times of crisis services within the respective jurisdiction.

The UIC Behavioral Health Crisis Hub created two toolkits to provide guidance to CESSA RACs who were assigned to collect the information: a Landscape Survey Toolkit and an Interim Risk Level Matrix Toolkit. Average and median response times of MCRTs were obtained to inform decision making regarding response type.

Some RACs have compiled their survey data and completed their landscape analysis and are actively working with PSAPs in their region to customize the interim risk assessment matrix. Others are working on compiling and analyzing the data collected from the landscape analysis. Several RAC co-chairs noted that working with crisis providers with whom they have previously had minimal or little contact has been a valuable learning experience providing insight into how each type of provider contributes to service delivery for individuals experiencing a mental health/behavioral health crisis.

CESSA Requirements for Training and Education

The SAC, the body that is charged with implementing the CESSA legislation, created a Technical Subcommittee to focus on Training and Education (TETSC). The duties and scope of TETSC, as expressed in its charter include:

- Recommend training/education plan for behavioral health crisis responder staff inclusive of training cadence, modality, and potential training resources
- Recommend training for 988 Suicide and Crisis Lifeline staff, inclusive of training cadence, modality, and potential training resources
- Recommend training for 911 Dispatch staff, inclusive of training cadence, modality, and potential training resources
- Development and execution of a statewide training plan
- Development and execution of a regional training plan
- Specification of credentials for staff serving as crisis responders

Accomplishments

The Training/Education Training Plans for PSAP (911), Lifelines and Crisis Center (988), and MCRT (590) staff aim to develop and enhance the skills of suicide crisis counselors, mobile crisis response counselors, and telecommunicators.

The accomplishments include training/education plans incorporating four phases: analysis, development, delivery, and evaluation. Based on feedback received from the needs assessment surveys as described below, specific training topics and curricula are being developed for 911, 988, and MCRT staff.

Training Needs Analysis

911 PSAP Telecommunicators: A 911 Training Interests Survey was conducted from March through April 2023 to identify training areas for the Training Plan based on the National Emergency Number Association Standards (NENA). Several training courses unique to NENA will be conducted and managed by the Illinois State Police (ISP)

Division of the 911 Statewide Administrator in conjunction with the NENA Training Workgroup. The topics listed below specifically related to the 988 Suicide and Crisis Lifeline will be conducted and coordinated with the ISP Division of 911 Statewide 911 Administrator. The 911 Training Plan focuses on 4 four specific areas: Administrative, Mental Health, Crisis Intervention Team Training (CIT), and Special Needs.

988 Crisis and Lifeline Centers: Using the findings from February 2023 Suicide and Crisis Lifeline Call Center Training Survey, the following training categories/topics were identified in the Training Plan: Clinical, Crisis, Mental Health, and Insight.

Mobile Crisis Response Teams: The following topics were identified based on findings from the February 2023 Mobile Crisis Response Teams/Behavioral Health Crisis Responder Survey: Clinical, Crisis, Mental Health, and Insight.

Status of Training Delivery and Development of Credentials for Staff Serving as Crisis Responders

The Crisis Hub is currently reviewing different Learning Management Systems (LMS) to create, manage, and report on the training provided and will select and utilize a system to managing registration, evaluation surveys, continuing education exams and certificates. The results of the 911, 988 & MCRT Training Surveys created a pathway for selecting the topics for Spring 2023 Training Calendar. The Crisis Hub's first training was launched on March 30th in response to the increasing demand and concerns regarding safety and self-care. As of May 2023, the Crisis Hub has convened four online training sessions, which 696 individuals attended.

Credentials for Staff Serving as Crisis Responders

The UIC Behavioral Health Director of Training presented and recommended credentials for 911, 988, and MCRT personnel to the TETSC meeting on Tuesday, May 23, 2023. The credential recommendations will be reviewed with the SAC for approval.

CESSA Requirements for Technology, Systems Integration, and Data Management

CESSA legislation requires the SAC to recommend a system for gathering data related to the coordination of the 911 and 988 systems for purposes of allowing the parties to make ongoing improvements in that system. The Technical Subcommittee on Technology, Systems Integration and Data Management (TSIDM) was created and charged with providing guidance and recommendations to the SAC in the areas of data collection, system performance monitoring, and investigation into call transfer methodology and technology between emergency response operators (e.g., 911 and 988).

The following data reporting requirements are outlined in the legislation.
As practical, the system shall attempt to determine issues including but not limited to:

- The volume of calls coordinated between 911 and 988
- The volume of referrals from other first responders to 988
- The volume and type of calls deemed appropriate for referral to 988 but could not be served by 988 because of capacity restrictions or other reasons

- The appropriate information to improve coordination between 911 and 988
- The appropriate information to improve the 988 system, if the information is most appropriately gathered at the 911 PSAPs

The TSIDM has proposed an expansion of the original elements included in the legislation to collect data that will be inclusive of the entire crisis continuum, including MCRT. These additional data elements will enhance the effectiveness of data collection, system performance monitoring, and call transfer methodology and technology between emergency response operators. The proposed revisions will contribute to more robust and informed decision-making processes in the mental and behavioral health crisis system. These additional data elements will allow for future reporting on the benchmarks identified later in this report.

To implement the recommendations of the PSTSC, the TSIDM recognizes that a system will be needed that ensures 1) data collection plan for aggregate statewide data and regional data; 2) call transfer technology; and 3) phased implementation of new processes and systems.

CESSA Communication Approach

The CESSA legislation does not specifically require a communications approach. However, recognizing the importance of public messaging, and the need to provide explicit information regarding the roles of 911 PSAPs, law enforcement, EMS responders dispatched through 911, 988, and MCRTs to minimize misunderstandings with the introduction of 988, the state planning partners created the Communications, Information Sharing & Public Messaging Technical Subcommittee (CIPTSC). This Subcommittee, which was sunset as of May 2023, provided recommendations to the State and Regions to ensure that consistent and accurate messages regarding CESSA, 988 and the crisis care continuum are delivered state-wide and at local and regional levels, regardless of who is initiating the communication. This work will continue as a standard agenda item of the SAC.

Accomplishments

Staff of the UIC Crisis Hub worked closely with DMH and the IDHS Office of Communications in developing a communication approach and to create public information designed to correct misinformation concerning CESSA and its implementation. A UIC Behavioral Health Crisis Hub website is under development and the infrastructure has been completed. It will host all important communications concerning the CESSA implementation including updates, FAQs, technical support materials, reports, research, and recordings of all training. It is anticipated that the website will be launched in July 2023.

Informational materials have been created specific to CESSA, such as the CESSA Myth Busters: Communications Regarding CESSA Misinformation. This answers questions such as: What is the Community Emergency Services and Support Act (CESSA)? When will CESSA be implemented? What types of responders are included in the CESSA law?

Regional Progress

Committee membership in the RACs is prescribed in the CESSA statute, and the 11 regions operate in a similar manner to the SAC. They are all subject to the Illinois Open Meetings Act, adopted a charter, hold monthly meetings, and create Technical Subcommittees or workgroups to conduct the technical work of CESSA. It is important to note that the regions all have different resources, operate at a different pace, and despite ongoing structured support from DMH and the Behavioral Health Crisis Hub, vary in their capacities and engagement with the process. Table 2 on the next three pages depicts completion of targets by each of the regions. Information will be tracked and reported in this format throughout FY24.

Table 2: Status of Requirements Completed by Regional Advisory Committees by EMS Region

	CESSA EMS Regions										
	1	2	3	4	5	6	7	8	9	10	11
Protocols and Standards											
Convening of Monthly Regional Meetings	√	√	√	√	√	√	√	√	√	√	√
PSAPs conduct Landscape Survey with PSAPs, Law Enforcement and Emergency Medical Services to determine crisis response services currently available by EMS region							√	√		√	
Regions conduct analysis of Landscape Survey Data and summarize findings for each PSAP jurisdictional area							√	√		√	
RACs complete work on customization of response type and time of Levels 2 and 3 of Interim Risk Level Matrix for each PSAP jurisdictional coverage area using results of Landscape Survey and Mobile Crisis Response Team Response Time Survey											
Review and approval of Interim Risk Level Customization for Levels 2 (Moderate) and 3 (Urgent) by EMS Regional Emergency Medical Directors											
Key	Completed (√)				In Progress				To Be Completed		

	CESSA EMS Regions										
	1	2	3	4	5	6	7	8	9	10	11
Review EMD protocols to assess fit with recommendations for Levels 2 and 3 of Interim Risk Level Matrix											
Complete process for updating EMD protocols with vendors											
Complete process, working with vendors, to update CAD systems											
Determine process for standardizing reporting of PSAPs computer aided dispatch (CAD) determinate codes											
Review best practices for diversion of non-violent misdemeanants											
Complete local SOPs for non-violent misdemeanants											
Update all local SOPs											
Training and Education											
Approve/adopt credentials for crisis staff											
Approve/adopt training requirements for 911 staff											
Approve/adopt training requirements for MCRT staff											
Approve/adopt training requirements for 988 staff											
Approve regional Training Calendars											
Key	Completed (√)			In Progress				To Be Completed			

	CESSA EMS Regions										
	1	2	3	4	5	6	7	8	9	10	11
Training and Education											
Deliver and complete training for 911 staff											
Deliver and complete training for MCRT staff											
Deliver and complete training for 988 staff											
Technology and Data											
Approve performance metrics and sample reports											
Approve recommendations for data system and call transfer information sharing practices											
Approve data collection and reporting procedures											
General											
Beta test new protocols and CAD systems											
Launch new reporting requirements											
Develop local communication strategy											
Launch communication plan											

Key	Completed (√)	In Progress	To Be Completed

BENCHMARKING PROGRESS

As planning for the implementation of CESSA continues, it will be necessary to develop and adopt key performance indicators and measures to evaluate the CESSA implementation process, quality of services and outcomes once CESSA is fully implemented. Process measures and indicators will be used to determine if CESSA is being implemented as planned, as a means of keeping the implementation on track and making changes and course corrections as warranted. Outcome measures will be used to determine the impact of CESSA on the individuals receiving crisis services, quality of services, system related outcomes and to determine if CESSA goals as outlined in the legislation have been met. Targets will be established as appropriate. When possible, system outcomes will be evaluated by benchmarking values of Illinois performance measures against national performance standards that have been developed by the Substance Abuse and Mental Health Services Administration as part of the National Guidelines for Behavioral Health Crisis Best Practice Toolkit, the National Association of State Mental Health Directors 988 Playbooks, and the CrisisNow model. Various aspects of these models and toolkits are being utilized in the majority of states implementing or expanding crisis care systems. The indicators and measures that are described will be implemented incrementally as data systems evolve and are modified as data is available to populate the indicators/measures.

Many of the performance indicators and measures listed below were proposed by the TSIDM to monitor the evaluation process and system and consumer level outcomes, which were listed in a prior section of this report. An asterisk (*) displayed next to the measure indicates that national or other standards may exist and be used when appropriate as benchmarks for Illinois CESSA performance indicators and measures.

Table 3: Key Performance Measures and Possible Benchmarks

Consumer Level Outcomes
Reduction in Emergency Room Visits by Individuals Experiencing behavioral/mental health crises
Reduction in psychiatric hospitalizations by Individuals Experiencing behavioral/mental health crises
Consumer Outcomes/Perception of Care Received (911, 988, MCRT)
Consumers following through on referrals for mental/behavioral healthcare
System Level Outcomes
Percentage of 911, 988 and MCRT staff completing training curricula
Reduction in LE response to mental/behavioral health crisis situations*
Reduction in hospitalization of individuals experiencing mental/behavioral health crises*
Reduction in emergency room visits by individuals experiencing mental/behavioral health crises*

Identification and implementation of a system that allows individuals who voluntarily chose to do so to provide confidential advanced care directions to individuals providing services under this Act.
Mental/behavioral health crisis calls to 911 are transferred to 988 using incident codes aligned with the CESSA IRLM
Dissemination of marketing material to providers, first responders and the public using a range of dissemination methods (e.g., social media, tv spots, radio, pamphlets, town hall meetings, conferences etc.
Linkage of individuals experiencing mental/behavioral health crisis to MHAs for follow-up/on-going treatment as needed after MCRT response
911 PSAPs
Number and percentage of MH/BH crisis calls received by 911 meeting criteria for transfer to 988 transferred to 988
Mental/behavioral health crisis calls received and referred to LE and/or EMS*
Type of crisis call received (determinate/incident code)
988 Lifeline and Crisis Centers
Receipt and handling of behavioral health/mental health crisis calls from 911 (e.g., call answer time, abandonment rate, call delay time, average call length), chats received and responded to, texts received and responded to, and call duration)*
Source of calls referred to MCRT (e.g., 911, LE, EMS, Individuals experiencing mental/behavioral health crises, other 988 lifeline centers (instate/out-of-state)*
Crisis situations resolved by 988 (percentage) Crisis Counselors*
Calls referred back to 911 from 988*
Number of MH/BH crisis calls received by 988 meeting criteria for transfer to MCRTs that are transferred to MCRTs
Number of MH/BH crisis calls received by 988 meeting criteria for transfer to MCRTs that are not transferred to MCRTs due to factors such as non-availability of MCRT or other factors

CESSA IMPLEMENTATION OPPORTUNITIES AND CHALLENGES

CESSA envisions an integrated community-based mental health crisis response system that requires relationships and resources not currently available in Illinois. The progress detailed in this report is a testament to the high degrees of commitment exhibited across the current system to broadening the kinds of responses and deepening the interconnections between providers – from the 911 centers to 988 operators, from law enforcement and EMS to community based mental health providers, and especially with the persons with lived experience of crisis, present throughout the crisis response ecosystem. As noted earlier, there is a broad consensus for this change across the statewide and regional participants in the CESSA convening processes, and significant assets on which to build and expand Illinois' mental health crisis continuum.

Listed below are assets and challenges that have been noted in the first year of implementation. Some have been fully addressed with ongoing interventions and others reflect issues associated with changes needed in resources or relationships. All will remain a focus of the implementation team until fully resolved.

- *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 components, including 911/law enforcement, EMS/public health, and MCRT/mental health.*
  This system change requires the collaboration of several disparate systems manifesting sometimes vastly different work cultures, values, protocols, and lexicon. Throughout this process, DMH and its state partners have been intentional in educating respective systems about these nuances. This remains an ongoing opportunity for collaboration towards an overall commitment to support and engage those with mental illnesses and to co-develop with them a system that best serves them. The UIC Crisis Hub will continue to offer training in this area, and we will create more exposure and discussion of these issues in the local and statewide committees.
- *A system change strategy such as the one required for this implementation requires all parties to consider new possibilities that require operational changes.*
  The implementation team must understand and work through issues to ensure a successful implementation. For example, some stakeholders are more comfortable with specific models of emergency response and may be unfamiliar with other models that could achieve the same goal. New possibilities must be examined. These and other operational issues will require ongoing education and negotiation.

- *Illinois is a diverse state including dense metropolitan areas and dispersed rural communities that complicate ensuring consistent statewide MCRT coverage.* Although the state has procured MCRT services from 68 providers across the state and provides coverage in nearly every Illinois county at present, response in a timely manner to all emergent situations is not always available, given the significant distances between providers and all possible locations where emergencies may occur. Exploration of alternative approaches and models is being considered to address this issue. In addition, the state will continue to attempt to identify providers willing to serve "uncovered" service areas/communities and explore emerging technology that may help fill this gap.
- *Lack of interconnected technological solutions allowing for rapid routing of calls between diverse 911, 988 and MCRT provider systems.* There is no current system in Illinois that enables rapid routing of calls to the appropriate service provider, which is essential to ensure that individuals experiencing a behavioral health emergency have immediate access to care. 911 PSAPs differ significantly in their technology capacity for these system changes, and not all 988 call centers have the requisite resources to receive the calls and possibly transfer the calls for MCRT dispatch if necessary. Emerging best practices include centralized dispatch systems that should be explored. However, financing these technological enhancements remains a challenge.
- *Initial misunderstandings about a unified system envisioned by CESSA create an opportunity for all participants to learn about the crisis response continuum.* Communications concerning the systems changes remains an ongoing challenge and an actionable opportunity. FAQs posted on IDHS websites have provided ongoing updates to stakeholders and the public. However, because there is not widespread experience with or knowledge of some elements of CESSA, such as 988 and mobile crisis response teams, it is particularly important to build awareness of these changes across Illinois communities. One key change is the introduction of 988 as the first number for the public to call when dealing with a behavioral health emergency. Increased awareness of this resource will limit the number of calls that go to 911 and reduce the chance of an unnecessary law enforcement response.
- *Difficulties hiring/retaining staff for new operations, including the new statewide 988 vendor and MCRTs. For MCRTs, there is a particular concern regarding the hiring/training and retention of Engagement Specialists who are individuals with lived expertise.* Workforce challenges in the behavioral healthcare field, in general, are affecting the state's implementation of CESSA, as are providers of crisis and mental health services across the country. Providers across the entire system in Illinois report hiring and retention challenges. IDMH continues to lead discussions with providers on strategies to deal with this issue including using technology "extenders" and remote work schedules.

- *Coordinating this work with pre-existing committees within state structures including the 988 Key Stakeholder Group (IDMH), the EMS Medical Directors Committees (DPH), Statewide 911 Advisory Board (ISP).*
  CESSA implementation has benefited greatly from strong collaboration between IDHS/DMH leadership and its partners at IDPH, the state 911 Administrator, the Division of Substance Use Prevention and Recovery, and others. While the number of pre-existing and new committees and task forces and new workgroups enabled by statute create a management challenge to assure cross communication between groups, it also further strengthens these agencies by creating greater levels of understanding and experience across the agencies and providers.
- *Building a consensus around a vision for robust behavioral health crisis systems across the state and requires time to implement the systems changes.*
  The CESSA statute exposed an important policy and organizational culture opportunity in Illinois' emergency response systems and required immediate action in the form of systems change. The legislation anticipated that stakeholders and system users across the state would determine the approaches that are best for their communities. While there is consensus on the importance and value of reducing law enforcement involvement in the responses to behavioral emergencies whenever possible, systems change of this magnitude takes multiple years and will benefit from a robust planning process that includes a view of the entire crisis continuum

Next Steps

Table 4 represents a project timeline for task completion. Activities noted in green will be the focus of FY24 Quarter 1.

Table 4: Project Timeline for Completion of CESSA Activities

Tasks to Meet CESSA Requirements	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
Protocols and Standards												
Convening of Monthly Regional Meetings	√											
PSAPs conduct Landscape Survey with PSAPs, Law Enforcement and Emergency Medical Services to determine crisis response services currently available by EMS region	√											
Regions conduct analysis of Landscape Survey Data and summarize findings for each PSAP jurisdictional area	√											
Key	**Due Date=X; Green shading connotes FY24 Q1 due date**						**Completed by SAC and forwarded to regions = √**					

Tasks to Meet CESSA Requirements	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
Protocols and Standards												
RACs complete work on customization of response type and time of Levels 2 and 3 of Interim Risk Level Matrix for each PSAP jurisdictional coverage area using results of Landscape Survey and Mobile Crisis Response Team Response Time Survey	X											
Review and approval of Interim Risk Level Customization for Levels 2 (Moderate) and 3 (Urgent) by EMS Regional Emergency Medical Directors			X									
Review EMD protocols to assess fit with recommendations for Levels 2 and 3 of Interim Risk Level Matrix			X									
Complete process for updating EMD protocols with vendors			X									
Complete process, working with vendors, to update CAD systems						X						
Determine process for standardizing reporting of PSAPs computer aided dispatch (CAD) determinate codes						X						
Review best practices for diversion of non-violent misdemeanants			X									
Complete local SOPs for non-violent misdemeanants												
Update all local SOPs												
Training and Education												
Approve/adopt credentials for crisis staff			X									
Approve/adopt training requirements for 911 staff				X								
Approve/adopt training requirements for MCRT staff					X							
Approve/adopt training requirements for 988 staff						X						
Approve regional Training Calendars							X					
Key	**Due Date=X; Green shading connotes FY24 Q1 due date**						**Completed by SAC and forwarded to regions = √**					

	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
Training and Education												
Deliver and complete training for 911 staff									X			
Deliver and complete training for MCRT staff										X		
Deliver and complete training for 988 staff										X		
Technology and Data												
Approve performance metrics and sample reports							X					
Approve performance metrics and sample reports						X						
Approve data collection and reporting procedures						X						
General												
Beta test new protocols and CAD systems									X			
Launch new reporting requirements											X	
Develop local communication strategy								X				
Launch communication plans											X	
LAUNCH NEW SYSTEM												X
Key	**Due Date=X; Green shading connotes FY24 Q1 due date**						**Completed by SAC and forwarded to regions = √**					

Respectfully submitted by

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