**Meeting: IMHPAC Justice Committee, June 24, 2019** **Conference Number: (605) 472-5362, ACCESS Code: 242-409#**

**Attendees:** Keri Barker, Dar Bryant, AJ French, Fred Friedman, Tracey Hopkins, Paul Jones, DMH Director Diana Knaebe, Sue Schroeder

**Absent:** IDOC Dr. Melvin Hinton (without notice), Julius Mercer (excused), Matt Perry (excused)

| Topic | Context | Discussion/Decisions | Action Steps (include who does what) |
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| **Justice Committee Composition** | CURRENT COMPOSITION: IMHPAC's Justice Committee includes: AJ French, Fred Friedman, Melvin Hinton, Tracy Hopkins, Diana Knaebe, Julius Mercer, Judy Rushton and Sue Schroder. Keri Barker's committee membership is pending approval from IMHPAC.<br><br>GUEST SPEAKER: Paul Jones from the Lt. Governor's office joined us to share about the Justice, Equity & Opportunity (JEO) initiative and to listen to our concerns.<br><br>PUBLIC PARTICIPATION: Dar Bryant joined the call. | None. | The following items in **red font** are reminders from the 04/17 meeting which we did not discuss during the 06/24 meeting.<br><br>**Matt Perry** will reach out to Eleshar Nightingale.<br><br>**Jeff Sims (IDOC)** will speak with legal department to find out if he can provide most recent monitoring report and reply back with his findings.<br><br>**Diana Knaebe (DMH)** will email Town Hall schedule for Justice, Equity & Opportunity once it becomes available.<br><br>**AJ French** will review previous meeting minutes and forward to Council co-Chair Matt Perry.<br><br>**AJ French** will follow up with IDOC Assistant Director Gladys Taylor. |
| **Welcome & Introductions** | AJ French called the meeting to order at 2:01pm and welcomed everyone.<br><br>French reminded everyone of the importance of using person first language and identifying people as individuals instead of their life circumstance. For example, we want to avoid | **AJ** is with Gift of Voice, a mental health and trauma recovery training center operated primarily by people in recovery. She has trained Crisis Intervention Team (CIT) police officers, Judges, probation officers, parole officers, correction officers and has presented a few wellness presentations inside state prisons. Her personal mental health recovery experiences have catapulted her professional work. **Fred** described himself as a person with chronic and persistent mental illness. He said he first attempted suicide at age 13 and was in/out of the mental health system for over fifty years. He talked about spending time in a homeless shelter and nursing home. Before he got out of homeless shelter, he started Next Steps which is an | Continue. |

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| | saying “the mentally ill” and instead say “person with a mental health condition. Similarly, we want to avoid describing someone as an “offender” or a “felon” and instead say a person who is incarcerated or a person with a felony conviction.<br><br>This is important because one’s life circumstances do not constitute one’s identity.<br><br>French asked people to please begin speaking by identifying themselves and conclude remarks by saying “thank you.”<br><br>French gave instructions for people to share their name and talk about their personal and/or professional experience at the intersection of criminal justice and mental health. | organization that has a “lived experience” voice in creating policy around homelessness, mental health, substance abuse and justice systems. He was the lead organizer for 17 years, teaching CIT officers and correctional officers. He resigned last year, though he continued to represent Next Steps as a they pursued a lawsuit against the City of Chicago and he testified at numerous hearings.<br>**Sue** serves as CEO of Stepping Stones in Rockford. She is a Licensed Clinical Social Worker (LCSW), working in the field since 1981. Stepping Stones has contracts with the state, providing services for persons who have been found not guilty by reason of insanity (NGRI) and fitness restoration in the community for people who have been found unfit to stand trial. Stepping Stones also works closely with Winnebago Mental Health Courts.<br>**Keri** has a background in law enforcement as a police officer. She has personal experience with both mental health challenges and the justice system. She currently has a loved one that is currently incarcerated and works as a Peer Wellness Coach for an Assertive Community Treatment (ACT) team at a community mental health agency. She is a Wellness Recovery Action Plan (WRAP) facilitator and recently completed requirements for the Certified Recovery Support Specialist (CRSS) credential. Previously, she worked as Coordinator of the Dream Center of Alton. She described herself as a mental health advocate and a mental health advocate for first responders. She is looking forward to co-presenting with AJ at the InterNational Prisoners Family Conference in Dallas this October.<br>**Tracey** works for Robert A. Young Center as a CRSS and is a WRAP facilitator. Her youngest son is incarcerated, with eight more years to serve. She has experience as a Certified Peer Recovery Specialist (CPRS) and has lived experience recovering from substance abuse, as well as mental health issues.<br>**Paul** is a legal extern in Lt. Governor’s office, currently in law school pursuing criminal justice issues and working with the JEO.<br>**Dar** has served as Center Director of the Dream Center of Alton since January 2016 with a re-entry program for individuals coming out of prison or jail. Prior to that, he served in ministry for about ten years. Before that, he described his life as “quite the opposite” and “on the other side of the law”, being in prison multiple times over a thirty-five year period. He now serves as a Prison Ministry Pastor. | |
| **SAMHSA’s Competency Restoration Learning Collaborative** | **AJ** said that we would briefly discuss the “Competency Restoration Learning Collaborative” which is shortened from a much longer title. | **Diana –** The State applied to SAMHSA’s GAINS Center’s for the GAINS Center’s Outpatient Restoration Competency Learning Collaborative. The Learning Collaborative was two days with individuals from Champaign, McLean & Winnebago Counties who responded to a request for information. The RFI was previously sent to six counties with a large number of individuals who end up in jail, primarily for misdemeanor arrests and some unfit to stand trial. In addition to Illinois, six other states were selected to participate. | Continue. |

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| | | **Sue** – During the Learning Collaborative, my feedback to Dr. Coleman was "How are we going to pay for this?" There were fantastic ideas put on paper. Winnebago County has not followed through with anything since the Collaborative, despite reaching out a couple times. It was a great two days to hear from national experts and learn about opportunities because individuals needing competency restoration don't always need an inpatient setting.<br>**AJ** – The only comments I have are<br>1) There was nobody in the room that actually has been through the competency restoration process. I was the only person in the room who even disclosed living with a mental health condition. The group composition needs to include people with that specific life experience because when voting occurs, decisions are made on majority interests…though my feedback was well received by the group. 2) Senate Bill 1188 would potentially divert people who had misdemeanor offenses from an expensive competency process. | |
| **Wellness Recovery Action Plan (WRAP®)** | WRAP® is an evidenced based mental health education curriculum that DMH has effectively implemented in community mental health agencies and state hospitals. | **AJ** – Regarding WRAP Orientation for the IMHPAC Council, I have followed up with IMHPAC Council Chair Matt Perry and I will continue to follow up with him prior to the July IMHPAC Council meeting. Regarding WRAP in IDOC, I'm sorry to report that IDOC has declined having WRAP in the prisons despite grant funds existing to support the program. | Continue. |
| **JEO** | AJ asked Paul to provide a brief overview of JEO work. She then asked individuals to identify solutions that would improve outcomes for persons with mental health conditions whose lives intersect with the criminal justice system. | **Paul** – The JEO initiative allows the Lt. Governor to convene any state agency related to criminal justice to identify problems and come up with solutions. Lt. Governor is particularly focused about trauma-informed solutions. Right now, we're going on a listening tour meeting with community groups who are working on ground level so we can put a plan together.<br>**AJ** – I spoke with Paul and shared two specific recommendations from Gift of Voice 1) Utilize recovery support services within IDOC by structuring recovery support services similar to the current DMH structure, specifically by hiring CRSS professionals in the prisons. 2)Utilize the WRAP curriculum in diversion, prison and re-entry programs.<br>**Tracey** – I agree that having a CRSS professional prior to being released and throughout the process is the biggest thing. That's what I want for my son. I want my son to be supported in the community. I'm certain that another individual who has been through that process would be helpful to my son.<br>**Keri** – #1) I agree that having peer support available for prisoners as they're incarcerated and as they come out. People should be given the option to have peer support available when they come out. It's on a different level than the parole officer. #2) There are a lot of things presented on paper that IDOC is providing these services, but there's no follow up or consistency about how people who are incarcerated | Continue. |

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| | | physically get to the groups. Keri gave the example of a loved one being identified as someone with serious mental illness (SMI) and twice being directed to the wrong group therapy, but was not allowed to attend the correct therapy without a hall pass. #3) Being treated poorly by medical staff and being unable to advocate for themselves in that environment about their medications and side effects. Even if they're communicating respectfully, they're running the risk of angering the providers who can label them as hostile and put them in segregations. Sometimes people who are incarcerated become more prone to anxiety and stress due to the "hoops" a person has to jump through to stay on medication. I think there's also a problem with inmates who are heavily medicated and may not know what drugs they're actually taking. #4) The blanket practice of denying spousal visits if spouse was involved in the arrest of the person who is incarcerated. It's common for family members of persons with mental health challenges and co-occurring substance abuse to become arrested in that situation. The person who is incarcerated is denied a family visit from their loved one because the loved one is a co-defendant. #5) Treatment of individuals who are incarcerated regarding illness and end of life care for those incarcerated.<br>**Fred** – First, the mental health system is complex and the justice system is maybe more complex. There is no "one size fits all" solutions. "I am uniquely unique." There is no one else with my combination of symptoms, experiences and motivation. What works for some, might not work for others. It is impossible to talk about mental health and justice systems without talking about economic and racial justice. I testified before Judge Dow in the Illinois vrs. Chicago consent decree about my interaction with the Chicago Police Department. It was incredibly moving. Judge Dow listened to over 90 people in two days. I'm not afraid of Chicago police officers hurting me because I'm white and old. I have privileges that others don't and I don't want to give up those privileges because I don't want to get shot. The consent decree, filed by a state agency, is "a floor, not a ceiling." The most important issue is that people need to be diverted from the justice system. For many people, once you fall into the system it is very difficult to get out and the results can be catastrophic.<br>**Sue** – Making sure that medications and proper treatment is being provided at the county jail. My comments are in the framework of the county jail and forensic unit at DMH. There needs to be more beds in the community. Our state contract is for individuals found NGRI. We have 15-20 referrals for people who are sitting in state operated facilities because there's not a community conditional release option the courts are comfortable with. We need more money, more beds, more homes for people to be able to move into.<br>**Diana** – Following the sequential intercept mapping, to reach people who need mental health and substance use treatment at the initial | |

point of contact verses them ending up in the criminal justice system. It's where I'd like to see the state move. How quickly we get there is another matter. The things that have already been brought up assist people in functioning at a higher level at a quicker point.
**Dar** – Everything's that's been talked about so far is spot-on. A) The Peer Coaching that Keri talked about is what we want to do. Upon release, an individual would be assigned a Peer/Life Coach who would come alongside them. This person would be a positive influence who would build a repour, encourage them, take them to meetings, etc. Having a weekly contact with someone like that, not just a weekly check in with their parole office, would go a long way. I think it would be life changing. I was talking to Judge Hylla and he loves this idea so hopefully we can get something rolling. B) Another thing that would be so simple and have a huge impact is to have a program in place to allow people to turn in prison ID for state ID. This way, there is no lag time when applying for a job and it's not like the state doesn't know who they are. This would enable someone to immediately apply for employment without having to obtain a birth certificate, etc. It would be so simple and probably more cost effective. C) Another thing, that goes along with what Fred was saying is empathy training for corrections officers. Correction officers tend to have a narrow view. Most corrections officers – not all – view inmates as animals and they're treated as such. They need to understand more about what it was like and what the family goes through. There needs to be a collective effort across the board. 98% of people incarcerated are getting out. Empathy training would be good for correction officers, counselors, parole officers and community organizations. D) Lastly, I cannot believe IDOC said no to WRAP in the prison system. WRAP class should be in the prisons. Why wouldn't it be? It increases outcomes and, with no cost to the state, it's a tremendous benefit.
**AJ** – Paul, we want to give you opportunity to respond. We didn't collectively prepare a statement. This is diverse individual perspectives. Please feel free to ask any questions you may have.
**Paul** – Thank you everyone for sharing your recommendations and input. A lot of things that you've said are things we are already working on so it's good we're in the right direction. The one thing that stood out is the talk about medications and making sure that people aren't facing backlash from those who provide medication. Poor treatment is something I will make sure to make a note of, especially when talking about quality of life. Can you talk a little bit more about being treated poorly by Doctors and staff?
**Keri** – It's kind of across the board. My loved one was taken off of medication that was helping. He went for years suffering and, when he was out on bond, began taking medication and started to feel like he was recovering. Upon entry, the state took him off of those medications and put him on medications they wanted him to take. The

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| | | state said “we don’t give that here” and they weren’t expensive medications. They are the same medications covered by Medicaid. Just staying on those medications, the poor treatment is across the board. The words he used was “treated poorly, useless to society.” To stay on medication, he has healthcare requirements and those interactions are often adversarial. He’s now in the process – with support from the prison Psychiatrist – of going off medication because he doesn’t want the extra anxiety. Also, regarding terminally ill treatment, my loved one is a care provider for other inmates and has had four people in his house pass away since he’s been in. Two died very grueling deaths without access to pain medication. One gentleman was in and out of consciousness, released and transported to a hospital, was admitted to ICU and died a week later.<br>**Sue** – It seems the jail formulary is much narrower than what is available on most Medicaid plans. Unless we take medications that have been prescribed in the community, the jail will have completely change or discontinued in jail which sets people back. If we could get something where the formulary is broader to continue medication. Also, when someone is not stable it would be helpful if Doctors in jail would not be afraid to make some changes.<br>**AJ** – I also want to emphasize that a “lived experience professional” can sometimes be just as important as medication. In Illinois there are lived experience credentials for mental health recovery, addiction recovery and a trauma recovery for Service Members and Veterans. The role of the Recovery Support Specialist is to listen to people and support their self-determined choices. It’s not to direct people toward formal treatment, though this may occur naturally. The goal is to walk with that person and support them in their process – diversion, incarceration or re-entry. | |
| **Evaluation** | What worked well in today’s meeting? | -It worked well having Paul with us today. I got a lot of insight talking about medication and hearing the battles people have on the inside trying to stay on medication. The meeting flowed very well.<br>-Dar’s idea of the ID exchange was excellent and I’m excited to hear about the peer support role you’re working toward. I appreciate having Paul here to listen and take information.<br>-As a guest speaker/listener, it went well hearing everyone’s feedback and especially hearing the personal stories. It helps shows how critical these issues are.<br>-As a guest, I thought it was great. I got a lot of insight, learned a lot about the concerns across the board, would like to participate again.<br>-It was great having new folks on the call. Dar, I hope you come back. It was nice having our guest speaker.<br>-I thought it went very well. It was a nice structure.<br>-As facilitator, it was helpful to have so many people call in and participate. | *“They can get the best rehabilitation programs in the world, but it won’t work if the people administering them don’t care if they’re successful.”*<br>*-Man who is currently incarcerated* |

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| **Evaluation** | How can we improve the next meeting? | -No suggestions.<br>-No suggestions.<br>-If this is the norm for guest speakers, I think this is amazing.<br>-No suggestions.<br>-More time. Maybe see if a 1.5 hour call will work for folks so we can work on some action items.<br>-I agree with the Director. We need more time to talk about these very difficult issues more in-depth. More time would be helpful so we can deliberate on making changes and recommendations.<br>-As facilitator, I agree that maybe a 1.5 hour meeting would work better for folks. | Meeting adjourned at 3:03pm. |

Attachments: Sequential Intercept Model