City of Worcester Human Rights Commission Minutes
VIRTUAL MEETING – Monday, August 1, 2022, 6:00pm

Members Present: Elizabeth O'Callahan, Edward G. Robinson, Charles Hopkins, Ellen Shemitz, Jorge Lopez-Alvarez, Jacqueline Yang

Members Absent: LaToya Lewis, Guillermo Creamer Jr, Jamaine Ortiz

Staff: Jayna Turchek

Guests:
Dr. Mattie Castiel, City of Worcester Commissioner of Health and Human Services
Charles Goodwin, Worcester Director of Emergency Communications and Emergency Management
Tamara Lundi, President of UMass Memorial – Community Healthlink

1. Call to order and Introductions

A quorum was established, and Vice-Chairperson O'Callahan called to order. The Chairperson welcomes members of the commission and those present and introductions of those in attendance as well as roll call were taken.

Chairperson began with an acknowledgement of the traditional, ancestral, territory of the Nipmuc, the first people of Massachusetts and those whose land we are convening on tonight. While the Nipmuc history predates written history, records from the 1600s inform us that the original inhabitants of Worcester dwelled principally in three locations: Pakachoag, Tatesset (Tatnuck), and Wigwam Hill (N. Lake Ave). It is important to make this acknowledgment and to honor the ancestors that have come before us. It is all too easy to live in a land without ever hearing the traditional names and the history of the people who first resided and prospered in these lands and continue to reside and prosper.

The Human Rights Commission was established to promote the city's human rights policies. It is the policy of the City to assure equal access, for every individual, to and benefit from all public services, to protect every individual in the enjoyment and exercise of civil rights and to encourage and bring about mutual understanding and respect among all individuals in the city. Our work requires us to address institutional racism so that as a community we can achieve racial equity. Our work also requires us to make visible the unheard, unearned, and unquestioned privilege enjoyed by some members of our community to the detriment of others. We take time to make this acknowledgement, to educate, so a path can be cleared for healing.

The term **"institutional racism"** refers specifically to the ways in which institutional policies create difference outcomes for different racial groups. The institutional polices may never mention any racial group, but their effect is to create advantages for whites and the oppression and disadvantage for people from groups classified as people of color.

The term **"racial equity"** is the active state in which race does not determine one's livelihood or success. It is achieved through proactive work to address root causes of inequalities to improve outcomes for all individuals. That is, through the elimination or shifting of policies, practices, attitudes, and cultural messages that reinforce differential outcomes by race or fail to eliminate them.

The term **"privilege"** describes the unearned social power and informal institutions of society to all members of a dominant group. For example: "white privilege" and "male privilege." Privilege is usually invisible to those who have it because we are trained to not see it but nevertheless it puts them at an advantage against those who do not have it.

2. Approval of the meeting minutes from June 13, 2022 and July 11, 2022.

Commissioner Shemitz motioned to approve the minutes as distributed. Commissioner Yang seconded. On a roll call vote the meetings minutes were approved.

3. Updates to mental health crisis dispatch (988 and Worcester 311 Call Center)
Background:
https://www.nimh.nih.gov/health/topics/suicide-prevention
www.worcesterma.gov/emergency-communications
https://www.communityhealthlink.org/chl/adult-outpatient-services/emergency-services.html

Dr. Castiel: We have known for a long time of equities that exist, as we saw through COVID, that exist in healthcare. In particular, during COVID, we saw that the most vulnerable neighborhoods are the ones that have the lowest vaccination rates and the highest COVID rates. Those are the neighborhoods that are communities of color. We know, overall, that there is a shortage of clinicians to really be able to respond to our entire population. We could have a system in place to address issues within the communities such as addiction issues, homelessness, child welfare, elderly welfare, overdoses, any response really where we could respond, in the community by a clinician, mental health worker, recovery coaches, etc. Ideally, it would bring clinicians to that area and ultimately, not only have those clinicians meet with individuals but also, continue to follow them so that there will continue to be someone who will intervene during whatever is happening to them. Community Healthlink was given an award to be able to produce this response and part has also been done with our Emergency Management. Charles Goodwin will show you data of where this response will take place, where our vulnerable communities are, where we will be responding to calls and ultimately our goal is to be able to provide services for the community in this manner.

Charles Goodwin: As Dr. Castiel said, we are working on that program, throughout the city, trying to make sure that we identify some of those areas and get clinicians to where they need to be. That is a program being worked on right now. Ultimately the goal is to work that into our 911 center which also falls within Emergency Management so that, instead of the way we used to do it where we would throw a police officer or an ambulance at a mental health, or drug overdose,

call, we can identify and respond accordingly by utilizing those clinicians and mental health workers who we believe to be the best opportunity working with our 991 center to identify those calls. Also, it would help our 911 call center and dispatchers with some training, education, and support on how to properly deal with calls like that. I have been doing this for just over 11 years now. Ten years ago, this is not something we would have ever talked about in 911 because it was not something we really had to deal with initially. Now, it is becoming a more prevalent-type call for us, meaning a mental health call or drug overdose call. We are in an area that we have never been prepared for before and we are doing our best to educate telecommunicators, dispatchers and call takers on the best way of dealing with them and the right way of talking to people as well as the right way to ask questions in those cases. It has never been something we needed to be prepared for or something that 911 thought was ever going to go in that direction.

The next bullet point on the list is 988 in the state. 988 is essentially taking over the suicide hotline. It is something that 911 is working closely with so far as how that is being rolled out. It is live now. It started in July and if someone called 988 it goes to the same place that the suicide hotline would have gone to before. The suicide hotline is still live and still available. They did not get rid of it. They are just making it more easily accessible. The ultimate long-term plan, I believe, is to create a larger set of call centers. Right now, there are five locations in Massachusetts that answer the suicide hotline, primarily the Samaritans organizations and there are two other call taking centers that take those calls who will now be taking the 988 calls. Long term they want to expend that and be3 able to utilize the technology that we have at 911 so that, when there are serious emergencies which would require a public safety response, they would have more information and be able to identify and interconnect with 911 to make that happen. That is a long-term thing, I think that the state is taking it one step at a time and, although it sounds like it is going to take time to get off the ground, it is the right way of doing it. I think they are learning from all the mistakes we had at 911 when we took 911 and started developing a system. There is a lot that goes into it and a lot that goes into the background to make the system work the right way across the state and to make sure that people get the calls they are supposed to get and people are taken care of the way they are supposed to be. They are taking those lessons learned from deploying the 911 system in 2000 and trying to do it the right way the first time. It is a slow go. Those 5 call centers continue to take 988 but ultimately that is the right direction for the time being and then long-term they want to identify centers to take those and then potentially some day I could see it being more of a combined agency call taking center with 911 and 988 if the state rolls it out the right way and they really want to put the money into making it operate where they could interconnect and communities could respond to those emergencies but elsewhere they could take on a roll, such as we have here, where we have clinicians in a 911 center that could take those 988 calls in those free times. With that being said, onto our next three-digit number, 311.

With our 311 center, that is another thing that although people are excited to see it roll out, it is something we are taking the right steps with. It has been announced. We are utilizing the current DPW customer service center and we have transitioned those customer service representatives up to my building where we have created a call center utilizing them. If you were to call the 929 number that we currently have, it still rings there, to our call center with the customer service reps. But also, if you call 311 it will also bring up to us now. Long term, we will be rolling out a cell phone app for people to report different things throughout the city,

whether it be traffic, trash issues, potholes, sidewalk issues, pulls down, lights out, anything you can kind of think of will be able to be reported through there. Following that, we are working to roll out a more automated system to help people. We will have these "phone bots" that will be able to answer questions for you. This way, if call center reps are not available, and you have a simple question, for example wanting to know where to get a copy of your birth certificate, those answers will be built into the automated system allowing for you to call the 311 system after hours and that automated system will help to answer a lot of those questions. Additionally, we are building out an online system, a chat bot, where you would be able to go to the Worcester website and chat with the computer system, perhaps asking it to enter a work order for a pothole, which will also be available if you ask it to speak to a customer service representative during our operating hours. In the future you will be able to speak to a live Rep through the chat services as well as the bot.

The goal is for it to be easy and comfortable for everybody to use. i am a huge proponent of doing it the right way first time so we do not have to pay to fix it later. It might take a little longer to get it out, but we are building all of that now. there's a lot of infrastructure in the background that are building. I jumped on the idea of this being created back in January or February when the acting city manager brought the idea out and said he foresaw is something that would be great for the city. I jumped on trying to help him with it, but I also warned him, like I warn everybody else, that it takes time. We want to do it the right way. I do not want this to be quickly thrown together. Otherwise, people will struggle to use it later. We want it to be done the right way. The phone system is up, if you dial 311, well in the city of Worcester, it will ring to one of our service representatives, during operating hours. If you call outside of operating hours, you will receive a message that the office is closed and we have set up a full recording voicemail system so you can always leave a message. They check those messages every morning when they come in.

As we start building more of the infrastructure out we will have the app. They just finished designing colors and logos. Before we know it that will be rolled out. then comma in the background comma we are building out a contact center, our chat bot, and our phone bots, to be able to help answer some of those as well. This is to help the city of Worcester citizens who may want or need help outside of the emergency system with an easy way of making requests and submitting them.

Tamara Lundi: For those who do not know much about the Community HealthLink I will give a bit of background and where we are with planning, grant process, that we are speaking about tonight in terms of response. CHL is the largest behavioral health services provider in Worcester County. We serve over 22,000 clients, individuals and children, every year. We have over 70 different serve lines at 40 different locations throughout central Massachusetts. We have been providing crisis response services, among many different types of behavioral health services, for over 20 years. And we have been a part of the CBHC, a certified behavioral health center on the national level for the last 2.5 years. The CBHC at the state level, in Massachusetts, rolled out with the redesign. We just received an award this past month which helped position us well to be designated as the central Massachusetts for this region.

Much of this is focused on how to get individuals access to care. The point of really trying to meet someone where they are at when they are in crisis, is not only to just address the

crisis at that time but also to connect them with the services they need as a follow up. This is where a lot of our service lines come into play. Not only have we been providing crisis response in the community for over two decades now but we also have a large continuum of services, including early intervention, outpatient services for children, adolescents, there are 42 different schools, mental health support, behavioral health support, counseling to kids in different areas of our communities. We also have the largest outpatient clinic here in central Massachusetts and a number of recovery coaches and peer supports and a lot of the wraparound services we know are critical to someone being able to engage in recovery and treatment and their ability to stay in treatment. It is hard for people to think about their treatment and their health when they are concerned about where their next meal is going to come from or where they will stay for the night or any other basic need we know are social determinants to health and have a huge impact on their success. In six different programs we have we do a lot of outreach and case management, street outreach. We have worked with individuals experiencing homelessness for over two decades as well, through our homeless outreach advocacy project. We continue to provide housing, we support over three hundred individuals in the community, just through housing alone, that includes our Y beds and beds for those who are in recovery. Early intervention age 0-3 years all the way up to geriatric services. We are in multiple nursing homes supporting individuals with behavioral health services and needs.

The crisis response model really fits in with our overall access goal and our strategic priority. Through our emergency services teams, we have both the contact for the emergency services here in Worcester County, for adults and youth, and have had it for many years, as such we have already been dispatching out to the community. When people contact us regarding a child in need or a spouse needing support, we go to homes, we go to emergency departments, we have even met with people at Burger King. It is wherever people will feel safe to talk. We have a full line of certified clinicians and psychiatrists that can help support individuals around the clock. That is the model in terms of pervious history around crisis response.

So far as what the future will look like, this grant is really going to give us the opportunity to build out something that will fit our community. It is a community problem which will take a community solution, so we are really excited to be collaborating with the advisory committee which has been formed. We have ideas, thoughts, and frameworks. We have had the privilege of working with a consulting firm that has worked with other states, including the state of Georgia, building out their crisis response model. We had been working with them on a different line of work, internally, but they have been able to be a huge driver helping entire states in implementing these pilots in different communities. It finally came to a point where we wanted this across the state. We feel like we have some really good expertise in terms of what it looks like in other places. Our goal is to go and visit a couple of sites where these models have been successful. That is to take and learn and come back and tailor what the city of Worcester needs. We will do that by way of engaging with the advocacy commission.

One thing I would like to say is that the community voice is very important. To have individuals who have interfaced and have called 911 and it hasn't gone well, have previously fallen in and out of services because of gaps in treatment or lack of providers. We want to hear their voices. We have, internally, what we call our client and family advisory council, but the voice of the community is critical to making something that works for our community. Those are the voices we definitely want to leverage in addition to the advisory committee, which

encompasses a number of providers and organizations doing a lot of similar work to what we do. They have different levels of expertise.

Peers is another piece that is really important for the framework we are building out. We are interested in learning what the other communities are doing but I think there is just nothing like being able to connect with someone who has been in your shoes and who has walked the mile in some form or fashion. We have seen it be really successful in other crisis response teams. In our youth mobile crisis intervention teams, we now have family partners who go out and dispatch with the clinicians to hospitals and schools or to homes. These are individuals who have had a child who has been in crisis and then got into the work because they understood what it was like to be that parent, having a child who needs support. It is really transformation, what we see happening, when you have that peer-to-peer relationship. We would look to do the same thing with individuals suffering from substance abuse disorders and really connecting them with people who have been in recovery. In the crisis response team, the wraparound support through case managers, coordinators, and other individuals, that not only help them get into treatment but also wrap them up tight to keep them in treatment and to keep them engaged because it takes a lot to get in and a lot to stay in. The peer-to-peer relationship and support, even after we link people to health through our community, its making sure that they that support so that they know they are not alone and not the only person going through it.

We are in the beginning stages, and it is a planning process. We look forward to getting feedback from the community so that we can make sure this is a model that can work for everyone.

Commissioner O'Callahan: For those who are not familiar with this topic, can you tell us a little bit about what you are looking at in terms of the model? We heard a little bit about how 311 will work, but how will this crisis response model look? What do you envision the process looking like and how will it interface with 311 and other existing systems that we have?

Tamara Lundi: We are looking at a couple of different ways. One model, where they call the number in within the dispatch call center and they dispatch out this response team, no police, they just sent out the team clinicians and support workers. There is a need for that knowledge to exist within that call center to know who needs to be dispatched out, whether it be police officers, the team, or another form or mixture of the two. Another model that we have seen is that there could be a line that goes directly to that team and that team could be partnered with that police department, sort of imbedded in that police department. Another model has that call line go directly to that team and they are just dispatched out. I think that what will work for the city of Worcester, our community, is something that we need ongoing conversations and different taskforces, things of that nature, it is still to be determined what would be the best way to do that. That is where the feedback and input from the community and from different organizations and stakeholders would be helpful.

Dr. Castiel: I think some of the visions we have are certainly a response along with police but also they could also be the sole person who goes. A lot of it also will depend on trails. Our emergency management is handled by Charles Goodwin. The calls go directly to him, and he

would then decide who is being dispatched at the time. We would like to be sure, at least on behalf of the city, that there is a clinical response to the call.

Charles Goodwin: So far as working out the response, that is kind of what I mentioned before, our goal of having clinicians working with our 911 dispatchers. Right now, when we take a call for mental health, or substance abuse, its an ambulance. Sometimes it is police as well but ultimately it results in a medical response and that is how we have always been trained; bring ambulance and fire to the scene to get them to the ER to be evaluated. Ultimately, the goal is to work with our clinicians, in a situation where they work closely with our dispatchers, to review calls like that, to determine if that is a call that clinicians can respond to and then we could transfer that information over for them to go out and respond. Also, we would have the interface where there's a good relationship with all of our 911 dispatch and our call takers we're going to call comes there not where we are not sure or where we need more information. No matter what happens with 988 and 311 coming in, 911 is always the backup plan for everybody. Ultimately, that is what is taught from elementary school on and engrained into your brain. If there is an emergency, or somebody needs help, you call 911. i foresee that to continue very long time to come, even with the implementation of 988. I foresee a lot of people having them built into their head where if they see someone in crisis, someone who needs help, they will call 911. I want our dispatchers and call takers to be prepared for that. I want them to be ready for that so that they can identify a call like that when it happens, to be able to work to get the information to the clinical who then go out and help that person who is in crisis, at that time.

Commissioner Lopez-Alvarez: I follow a lot of people on social media that are advocating for hotlines for mental health, etc. Somebody recently posted that the mental health or suicide hotlines automatically call the police and send those police to the people. As such, they are pretty much saying not to call them. At this point, I am viewing it as a situation where people may not get the help because they do not want to deal with a police enforcer. Now, is it guaranteed that the police are always going to show up? As Charles stated, it's pretty much a case-by-case basis. The best I can do is to just say, call. My question has been answered. The police will show up if they need to.

Charles Goodwin: To comment, right now there is not a guarantee that police will show up to every call. Ultimately, if you were to call the suicide hotline, or 988, right now, they only contact us, 911, when they feel that there is an imminent threat to someone's life. So, if someone is going to harm themselves, or has already begun to harm themselves. otherwise, like with the day-to-day calls when someone is in crisis, looking to talk to somebody and get help, then they do not call us because they are able to handle that through the phone. In cases where someone is in crisis and needs help, they first determine if they're going to call us, then we determine if there is a threat there.

Commissioner Shemitz: My question goes to the availability of human resources. Given the critical shortage of behavioral health care workers, how are you going to go about being able to meet the needs where they already seem to be under met? There seems to be a mismatch between the needs and the availability of resources.

Tamara Lundi: two things, partnership and pipeline. For partnerships, leveraging I like the resources we have internally and also partnering with other organizations who do this work. Earlier today the advisory committee had a call with diplomats from multicultural and connecting with other clinicians who have more capacity. We can do more together than we can apart. Otherwise, we are going to have to build it. With this being a planning year, this runway will be really helpful because we will need room to back up and straighten up to become prepared for this model.

Commissioner Shemitz: it's also complicated in terms of cultural sensitivities, we are really diverse in Worcester, and I don't think that simply having someone who is credentialed to deal with cis white males in crisis is necessarily going to be the same person who is going to be able to deal with more complex issues ranging through a variety of different cultures. How do you go about preparing for that and addressing that, in a way that is going to move the community forward?

Tamara Lundi: we have been working with a very diverse population for a very long time. I have mentioned that we work with individuals having experienced homelessness, over 40% of the individuals who come into our behavioral health care are individuals experiencing homelessness. Investor, over 40% of the population are minorities. In comparing our current staff with the demographics of the city, from a race and ethnicity standpoint, we either meet or exceed the city comparatively. This is work we have done for a long time; I would say in terms of working with diverse populations. But there's always a lot more to learn, so that is why I have mentioned the consulting firm that we have been working with for about 8 years now, called Vince Randolph Brown. They came in around 2015, or they started a lot of work from the ground up with us, as an organization, on how we can help individuals from diverse backgrounds. To give some context, we have, internally, focused on making sure we are able to provide cultural and linguistic services matching international standards. We are constantly working on diversifying our offerings, but we still have a lot more work to do. That is a strong focus of ours as one of our five strategic priorities around health equity.

Charles Goodwin: just to add to that, for everyone to get a feel, we understand that it's not only a diverse community that we are working with, but also, we are in a time where it is important to utilize our resources as most effectively as we can. We are doing data analysis on our end as well. We are working on identifying mental health, substance use, or abuse responses, and comparing does current cause that clinicians are not responding to with our social vulnerability index. We do this to determine where those clusters are occurring and where we will need to focus the most of our resources. We want to utilize the data to make sure we are responding appropriately two areas of different minority populations for making sure we are culturally sensitive to the areas that need us and so that we can work with those different populations to make sure that when we respond we understand, kind of, what is going on. As more than just a call, is there something that is going on in those neighborhoods, or in that population, that is causing an influx in calls? We might April to identify some of this through that data analysis to make sure that we are using all and the resources that we can to the best of our abilities. We are

very fortunate to have such tools at our fingertips and to be able to take our call volume for police, fire, and EMS.

Commissioner Robinson: Mr. Goodwin, if I call 911, what question should I be ready to answer when I get on with the dispatcher if I see someone in crisis?

Charles Goodwin: the first questions they will ask every time are: “where are you?” and “where is this occurring?”. Because we rely on cell phones which don't always work the way we want them to, “where are you?” is so important because if you lose signal and we can't get you back on the phone comma if we at least know you are we can just send everyone. After that, we would want to know who you are, your phone number in case we have follow-up questions, and then what is going on. If there is someone in crisis, do you know who they are? Do you know if this has happened before? Do you know the extent of their crisis? Is this a situation where it is more of a mental health crisis which requires someone they need to talk to? Is this a crisis where they are thinking of harming themselves? That would require a different response, or other immediate intervention. How far has it gone? Are there weapons involved or are there risks to any of the public safety responders that get there?

Ultimately, we have some of the best public safety responders in the country, in this beautiful city that we have, they are never going to shy away from going in and helping people. We do like to make sure they are prepared for what they are about to walk into. So, a lot of the questions that we ask really have to do with what is going on and what risks and or threats there are as well as a little bit about the person that is involved in that crisis so that we can identify them a bit better. If you know their name and we are able to look up to see if we have worked with them, or helped them, before, we will. If you do not know who they are, but you know a little bit about whether or not this has happened before, it helps our responders to prepare. If there's any information on what an initiated the crisis, they will probably ask about that as well. Once we get responders either on the way, or on scene, there might be further questions and we may ask that you stay there she talked to those first responders. This is because we are all humans, and we are not going to think of every single question every single time. When they get on scene they will have more questions than we had over the phone. As dispatchers we want to ask everything that we possibly could to keep them as informed as possible. We also want to make sure that you, as the caller, are also safe. We want to make sure that you do not put yourself in harm's way. the last thing we want for anyone who calls 911 is here to put us in harm's way just to get us information. So, if it is not safe for you to get any of that information and you have to stay away, that is what we want you to do.

Commissioner Hopkins: my question is around logistics because Mr. Goodwin already talked about his organization holding this call. I am curious as to how the handoff happens, if there is a handoff, on the phone to the clinician. If the clinician is in route, how do they get there if they are not riding in a police car or an ambulance?

Tamara Lundi: I think that there are systems in place that we can leverage. I don't want to say that this is exactly what we are going to do because Charles is also part of the advisory group for planning. Currently, when we receive calls for individuals who are in crisis it goes through our

call center here at CHL. We have a 24/7 line where people can call and they dispatch out clinicians. I do not know if this is the route we want to go, but there could be a tag team type system between the emergency management call center and our call center. There could be a direct line from the emergency management call center into our triage base. We already have that mechanism in place where we can already see where our clinicians are when dispatched and out in the community and we know about how long it takes them to do an assessment. The clinicians call back to our call center and say that they have started an assessment or have met with a client. If it is after hours we try to dispatch out in teams so that no one goes out alone. There is more work to be done around logistics but I think mechanisms exist and that may be the fastest way to get a person on scene.

Commissioner O'Callahan: what do the credentials for the clinicians look like and is it a combination of a clinician and a medical professional or some other combination of outreach with some other emergency responder?

Tamara Lundi: One model that we have seen is a clinician with a trained EMT or a trained nurse. The model that we currently use in our youth mobile crisis is a clinician and a person with lived experience. They will dispatch out together. Another model through the CDHC, for the adult side, is a clinician and a peer professional support worker. The support worker would connect back after the crisis intervention and stays connected with them to ensure they get moved into services to avoid them falling by the wayside. There are other models that exist. The one in Atlanta is for a clinician and a police officer. If there is not a need for a police officer then the clinician can go on their own. So, there are a few different ways I have seen teams composed and talking it through with the various stakeholders and community members will help us figure out what works best for Worcester.

Commissioner Robinson: Do we have anything in the public schools that teaches children how to deal with crisis?

Dr. Castiel: One of them is called Handle with Care. If a police officer enters a house, perhaps for a report of an overdose, and there are children in the house, they will leave a message with the school liaison officer to let them know. The plan has been to have wrap around services to be given to the families. That is still in the works. There is also a group called Worcester Acts, these are all funded, they respond to police crisis and school crisis if they need intervention. A good portion is having, say DCF or the police department, to be able to refer along with those schools over to Worcester Acts. They have clinical people there to deal with trauma issues.

Commissioner O'Callahan: We had the police department come talk to us last month and one of the discussions was around how this whole process will interface with CIT officers or just police in general. Is there consideration around how CIT or WPD would interface? How will the process change from what has been happening before?

Dr. Castiel: I think the police are really excited about this process. In the times that we have met, to put the Crisis Intervention Team together, they have been very excited. The goal for

police has been to try train all their staff in crisis intervention. That may not be completely done yet, but that is their goal. They are excited about having clinical people. They want clinicians there in a timely manner and with this plan that will come to fruition. Having clinicians respond to calls with them would be ideal. Some of the issues in the past have had to do with the time it takes for a clinician to get there. They feel that at that point they are going to take them to the emergency room or to Community HealthLink. They are looking forward to it as much as we are looking forward to it.

Commissioner O'Callahan: Numbers have come up before in terms of capacity. Do we have a sense of what that capacity would look like? What is the ideal number of clinicians we would be looking to hire for this?

Dr. Castel: I know we are looking to hire people of color to be responsive of this. Working with Charles and looking at how many calls he gets a day will help us to determine how many clinicians are needed.

Tamara Lundi: The data that we saw come out of the work of the WPI students, we did, I think about 17,000 calls within a two year period, that could have been responded to by non-police first responders and I think what we have to get a sense of is what is the average amount of time it takes to respond when you do get on-site. Right now, when we dispatch out, we do clinical evalations. The other thing, I think people don't necessarily fully understand about emergency service contracts is that we are not staffed, nor are we funded, like the firehouse model. Here, if someone calls and you go out for an hour long assessment, you get paid for that hour long assessment. This model will help us get toward having people staffed around the clock, whether you are being called to intervene for 20 minutes or 2 hours, it is opening up that sort of billing opportunity.

Commissioner Yang: Who is on the advisory board and how did you pick the members?

Tamara Lundi: It is a draft advisory board, we had a meeting with the group that was a part of the Crisis Response with the Mayor's taskforce and there are a number of individuals from that committee that is also apart of the advisory board. In addition to that, we reach out to connect to individual stakeholders, EMTs, police department, different local organizations. We are trying to make sure we have representation across the board.

Commissioner Yang: Are there patients on the advisory board?

Dr. Castel: There are people with lived experience that will be part of it.

The commission could help by spreading awareness and be helping the advisory board gain feedback and input from the community.

4. Notice: Due to the 2020 State Election Redistricting, your polling location for the 2022 State Primary on Tuesday, September 6 may have changed. POLLS OPEN 7 a.m. – 8 p.m.
www.worcesterma.gov/elections

5. Adjournment
Our next meeting will be September 12, 2022, at 6pm in person at City Hall and over Webex.