Critical Juncture

*A Report to the Community
from the
Mental Health Task Force*

Milwaukee, Wisconsin

2004

Critical Juncture

A Report to the Community from the Mental Health Task Force

Dedication

People from all walks of life came together to make the Task Force what it is today, a growing and vibrant force for change in Milwaukee. This report is dedicated to three specific groups of individuals. First, this report would not have been possible without the kind and generous support of the staff and trustees of the Faye McBeath Foundation, which enabled us to secure the services of Jan Wilberg as writer, consultant, and facilitiator. Thank you Jan and thank you Faye McBeath for your encouragement and guidance.

Second, we would never have made much of a public splash without the hard working core group within the Task Force who did all the heavy lifting to make our two major public events such wonderful successes. You know who you are and my hat is forever off to you. Finally, this report is dedicated to all the people who turn to our mental health and law enforcement systems at times of great need in their lives. May this report and the ongoing work of the Task Force bring us all closer to a community where the help people need is available, is respectfully provided, helps people along in their recovery journeys, and makes us all proud.

Tom Hlavacek, Milwaukee Office Director
Wisconsin Coalition For Advocacy
6737 W Washington Street, Suite 3230
Milwaukee, WI 53214
(414) 773-4646 Voice/TTY tomh@w-c-a.org

Critical Juncture

A Report to the Community from the Mental Health Task Force

Table of Contents

Executive Summary

The Mental Health Task Force (MHTF) is a coalition of 43 entities – consumer groups, community service providers, state and local government, and health care providers. The MHTF is *dedicated to identifying issues faced by people with mental illness and facilitating improvements in mental health services and programs in Milwaukee County.*

The MHTF was formed in 2003 to address the alarming number of emergency detentions at Milwaukee County's psychiatric hospital.

A fact-finding effort that included focus groups with dozens of key stakeholders led to a Community Summit attended by more than 300 people. As a result, strategic efforts focused on three primary areas:

- Training for law enforcement to improve officers' crisis intervention skills and build partnerships with community resources;

- Establishment of a Crisis Resource Center that would provide immediate assessment, limited treatment and referral for persons in crisis.

- Enhanced crisis prevention services – a wide range of services including greater opportunities for peer support, better crisis planning, strengthened jail diversion, and increased access to consumer-run services of all types.

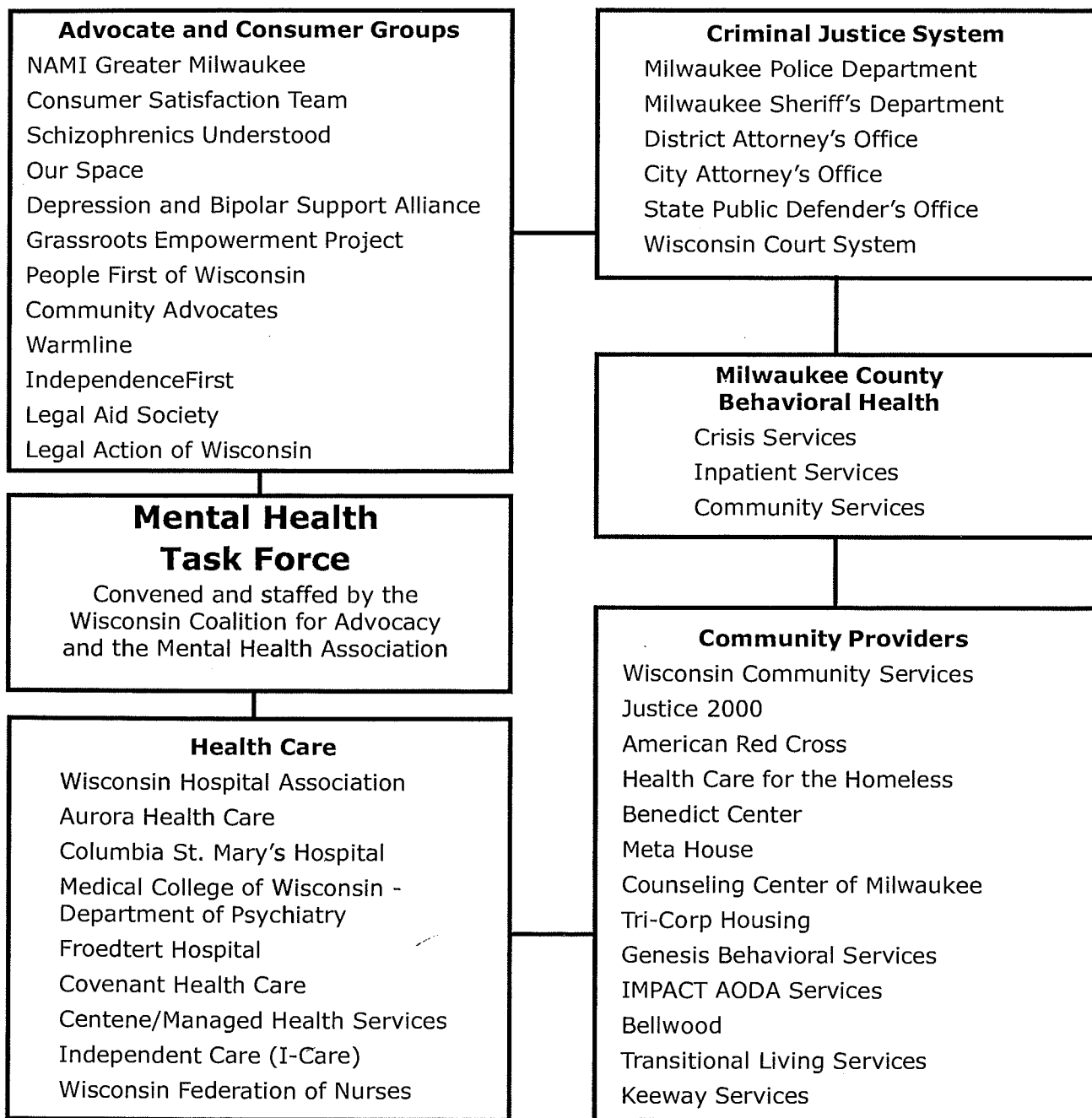As a result of the MHTF's efforts, important changes are already underway:

- Community attention has been focused on the issue of mental health crisis through an extensive series of Milwaukee Journal Sentinel articles and other media efforts.

- An agreement between Milwaukee County Executive Scott Walker and four hospital systems will result in a 150% expansion of the county's crisis respite program.

- The Milwaukee Police Department agreed to train 1,800 officers in strategies for working with persons with mental illness.

- Other signs of progress point to a willingness of public officials, service providers and consumers to continue to work together to identify and solve mental health problems in our community.

What is the Mental Health Task Force?

Diverse, Inclusive, Focused

The Mental Health Task Force (MHTF) is a coalition of 43 entities–advocates and consumer groups, community service providers, state and local government, and health care providers. The MHTF is *dedicated to identifying issues faced by people with mental illness and facilitating improvements in mental health services and programs in Milwaukee County.*

Advocate and Consumer Groups
NAMI Greater Milwaukee
Consumer Satisfaction Team
Schizophrenics Understood
Our Space
Depression and Bipolar Support Alliance
Grassroots Empowerment Project
People First of Wisconsin
Community Advocates
Warmline
IndependenceFirst
Legal Aid Society
Legal Action of Wisconsin

Criminal Justice System
Milwaukee Police Department
Milwaukee Sheriff's Department
District Attorney's Office
City Attorney's Office
State Public Defender's Office
Wisconsin Court System

Milwaukee County Behavioral Health
Crisis Services
Inpatient Services
Community Services

Mental Health Task Force
Convened and staffed by the Wisconsin Coalition for Advocacy and the Mental Health Association

Community Providers
Wisconsin Community Services
Justice 2000
American Red Cross
Health Care for the Homeless
Benedict Center
Meta House
Counseling Center of Milwaukee
Tri-Corp Housing
Genesis Behavioral Services
IMPACT AODA Services
Bellwood
Transitional Living Services
Keeway Services

Health Care
Wisconsin Hospital Association
Aurora Health Care
Columbia St. Mary's Hospital
Medical College of Wisconsin - Department of Psychiatry
Froedtert Hospital
Covenant Health Care
Centene/Managed Health Services
Independent Care (I-Care)
Wisconsin Federation of Nurses

Start-Up: The Mental Health Task Force (MHTF) was convened in late 2003 by several individuals who were deeply concerned about the growing number of emergency detentions at Milwaukee County's psychiatric hospital and the growing number of people with mental illness caught up in the criminal justice system . Organized initially to share information and identify key issues, the MHTF quickly developed a fact-finding strategy that involved a series of intensive focus groups and one on one interviews. In addition, two work groups, the Mental Health Courts Work Group and the Street Diversion Work Group joined forces with the MHTF.

Community Summits: The Milwaukee Mental Health Summit held August 24, 2004, at the Italian Community Center in conjunction with the UWM Center on Urban Initiatives and Research, was the culmination of several months' research and discussion. Attended by nearly 300 people, the Summit engaged elected officials, consumers, and providers in a spirited reflection of critical gaps in crisis intervention services. The Summit was extremely successful in bringing all the critical stakeholders to the table for an open and thorough discussion of the gaps, opportunities and strategies.

A second Task Force event co-sponsored by NAMI and the Behavioral Health Division, held September 23, 2004, featured Major Sam Cochran of the Memphis Police Department, the principal force behind that community's highly successful Crisis Intervention Team (CIT). Speaking to a packed audience of 240, Major Cochran described the formation of the CIT in 1988, current operation of the program, and the ongoing partnership between the Police Department, NAMI, mental health providers and consumers. Major Cochran's appearance in Milwaukee continued the positive momentum generated by the Summit and helped the MHTF begin to focus on the need to replicate the CIT model in Milwaukee.

> **The Mental Health Task Force Summit received high scores from participants**
>
> - 98% said that the Summit increased their awareness and understanding of the topic somewhat or a great deal.
> - 99% said they would use the Summit information either personally or professionally.
> - 98% rated the Summit as Good or Excellent.
>
> **Representative Comments:**
>
> "We need to turn talk into effective action!"
>
> "This was an intensive summit. I am happy I served on the Task Force and was able to participate in today's program."
>
> "It was a good start. There must be major commitments...to make this more than a day of networking and conversation."

Strategic Focus: By fall 2004, the Mental Health Task Force focused on three primary areas for further research and advocacy:

1. **Law Enforcement Training:** The Milwaukee County Sheriff's Department and the Milwaukee Police Department participated throughout the year in the MHTF. Special efforts to broaden involvement included meetings with the Intergovernmental Coordinating Council, which includes all of Milwaukee County's municipalities' mayors and councils, and the Milwaukee County Law Enforcement Executive Association, which includes all the municipal police

chiefs. By the end of the year, the MHTF had obtained the commitment of the MPD to implement a new mental health training module in early 2005.

2. **Crisis Resource Center**: The notion of a triage center—a place where police officers could take a person at the point of crisis for immediate assessment, limited treatment and referral—has become increasingly popular. The Memphis Triage Center functions as a resource to CIT officers, providing both medical and mental health care in a secure environment. Replicating this model in Milwaukee would be expensive and complex and will require much more study and analysis to move forward.

3. **Crisis Prevention Services**: Several initiatives fall into this category including increased crisis respite beds, improved crisis prevention planning for individuals, strengthening jail diversion programs, and increasing access to a variety of consumer-run services, including drop-in programs and the Warmline.

MHTF Directions: In December 2004, the Mental Health Task Force began a process of self-assessment—looking at its membership, operating principles, structure, and future directions. This process, to be continued in 2005, will help the MHTF become a community coalition that is effective, inclusive, and sustainable over the long term.

A critical first step

Strengthening the Mental Health Task Forrce was the development and adoption of seven guiding principles. These principles will shape the Task Force's work:

Guiding Principle 1: Leadership

The Mental Health Task Force will be the leading voice and take courageous stands on issues of importance to people with mental illness in Milwaukee County. We will serve as organized, strategic, and proactive agents for change on the issues we address.

Guiding Principle 2: Task Force Mindset

The Task Force is committed to the concept that everyone is equal and everyone plays a role. Consumers of mental health services will have a strong voice and leadership roles in all aspects of the Task Force. Task Force members will strive to set aside self interest for the good of the overall organization, and will follow through on their commitments.

Guiding Principle 3: Recovery

The Task Force will take a Recovery orientation in all aspects of our activity, including maintaining a strong consumer-centered focus and working to ensure that Recovery principles are incorporated in all elements of mental health system reform and service delivery.

Guiding Principle 4: Commitment to the Community

The Task Force believes that people of all ages with mental illness deserve high quality services delivered in community settings of their choosing. We also promote the concept that the entire community needs to be responsive to and accountable for all its members, including those with psychiatric disabilities.

Guiding Principle 5: Respecting Diversity

The Task Force membership will strive to be reflective of the Milwaukee community, and will work to continually improve our cultural competence across all racial, ethnic, sexual orientation and disability-related cultures.

Guiding Principle 6: Education

The Mental Health Task Force will serve as an educational resource to the Milwaukee community, including the general public, elected officials, the media, and public and private mental health service delivery systems on the issues faced by people with mental illness. In all our communications we will strive to reduce stigma and stereotypical attitudes that create additional barriers for people with mental illness.

Guiding Principle 7: Communication Hub

The Task Force will serve as a coalition of coalitions, sharing our information and resources broadly and serving as a clearinghouse for best practices in mental health service delivery.

The Mental Health Task Force's Work:
Listening, Organizing, and Advocating

Listening

Prior to the Summit in August, the Mental Health Task Force convened several meetings and focus groups to gather the insights and suggestions of community stakeholders—people directly involved in the issue of mental health crisis. Community meetings, focus groups and in-depth interviews were conducted—all with the goal of obtaining the most current, accurate and meaningful information about the issue.

Community meetings and focus groups:

Mental Health Consumers and Consumer Groups: April 5 and May 2, 2004

Criminal Justice System Groups: April 13, 2004

Department of Health and Human Services, Behavioral Health Division staff: April 27, 2004

Community Mental Health and AODA Service Providers: July 12, 2004

Milwaukee Police Department staff: July 21, 2004

In-depth interviews:

Paul Radomski, Director, Community Services Branch, and Michael Kreuser, Chief Financial Officer, Milwaukee County Behavioral Health Division, July 9, 2004

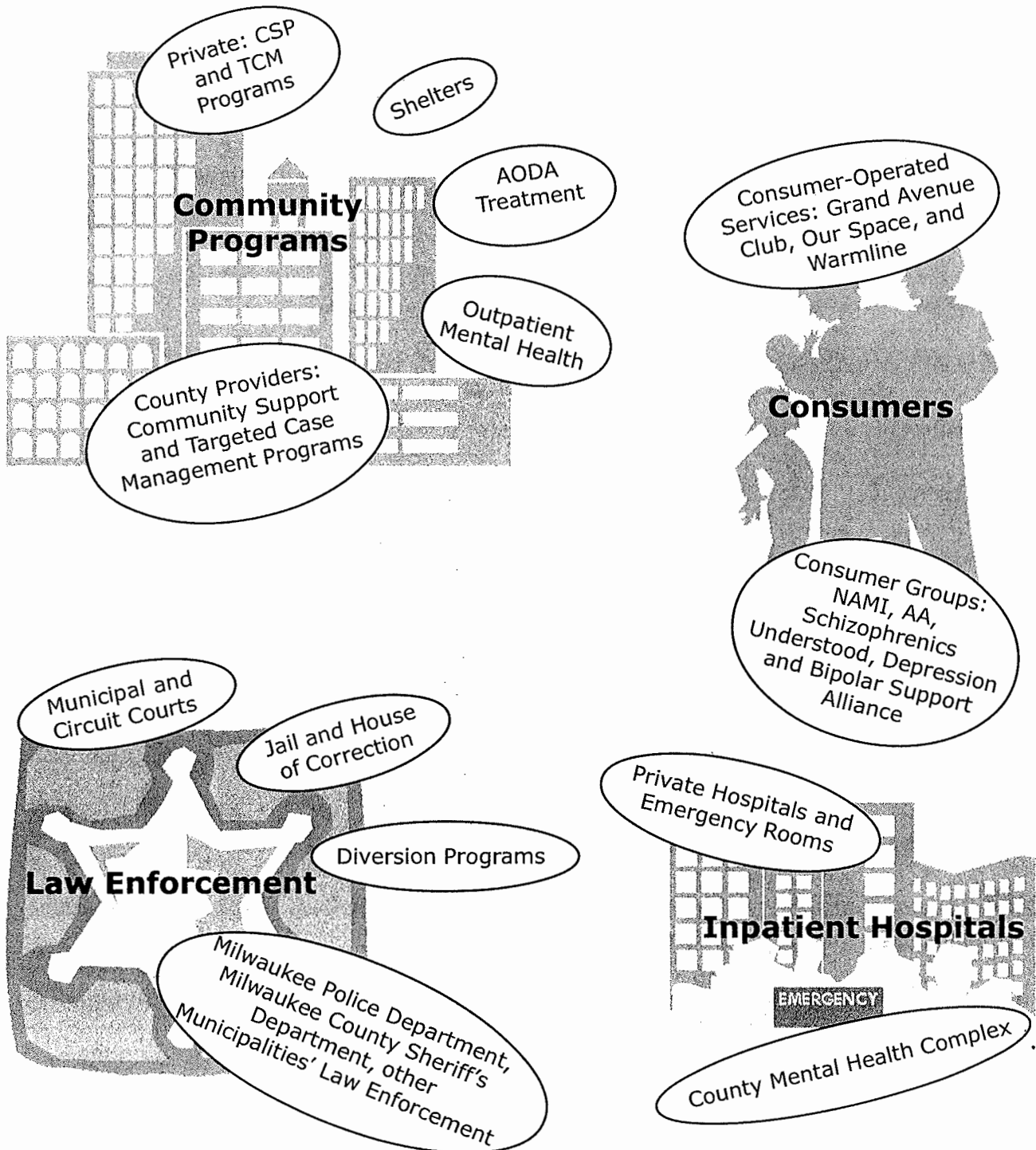William Bazan, Vice President, Wisconsin Hospital Association, July 30, 2004

The focus groups and interviews yielded a wealth of information and valuable insight. This information is summarized in the following section, **Findings**.

Please consult Appendix A: Focus Group/Interview Notes for detailed information and comments.

Findings

The research conducted by the MHTF revealed a simple and very distressing truth: Milwaukee's crisis intervention system is fragmented, overburdened and costly.
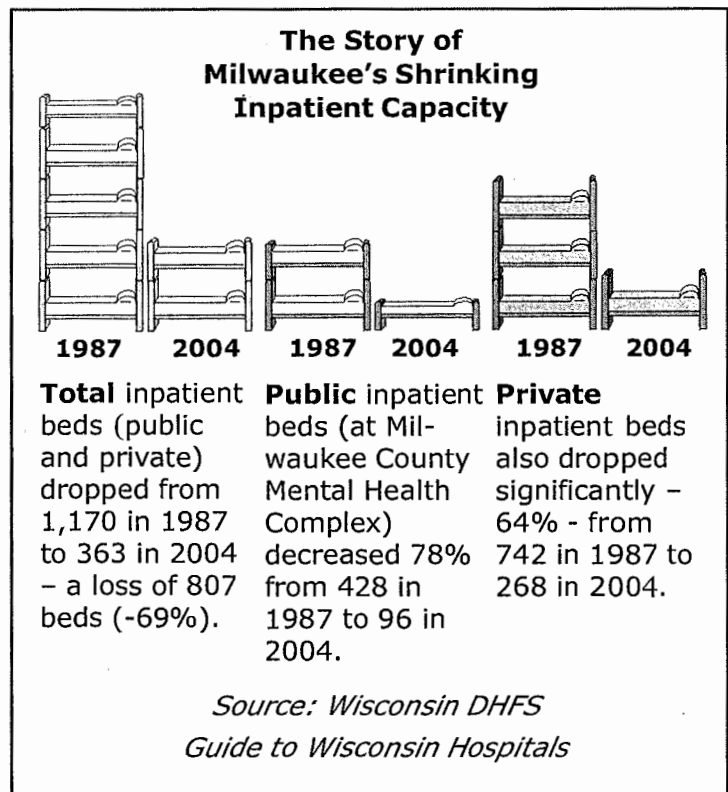
Milwaukee's Disconnected Systems

Community Programs
- Private: CSP and TCM Programs
- Shelters
- AODA Treatment
- Outpatient Mental Health
- County Providers: Community Support and Targeted Case Management Programs

Consumers
- Consumer-Operated Services: Grand Avenue Club, Our Space, and Warmline
- Consumer Groups: NAMI, AA, Schizophrenics Understood, Depression and Bipolar Support Alliance

Law Enforcement
- Municipal and Circuit Courts
- Jail and House of Correction
- Diversion Programs
- Milwaukee Police Department, Milwaukee County Sheriff's Department, other Municipalities' Law Enforcement

Inpatient Hospitals
- Private Hospitals and Emergency Rooms
- County Mental Health Complex

Do our systems coordinate or collide? Too often, services are provided in "silos" – disconnected from each other and inaccessible to many consumers.

Here are the major findings:

1. **First responders are not mental health professionals**. Law enforcement officers are the most frequent first responders to mental health crises. In the MPD, only about 60% have had specialized training in mental health issues and the training they received was a one-time episode more than four years ago (following a highly publicized case). Law enforcement officers readily admit that they feel hamstrung by both their limited knowledge and their limited legal options when dealing with crisis situations.

2. **Law enforcement officers face a Hobson's Choice**. Law enforcement officers see few alternatives in a crisis intervention situation. The Milwaukee County Mobile Crisis Team which could function as an on-site resource for law enforcement is not adequately funded or staffed. Although many officers try informal means of diffusing crisis situations, the most frequent resolutions are transport to the Psychiatric Crisis Service (PCS), the County's psychiatric ER, or incarceration in the Milwaukee County Jail as a result of outstanding warrants or a new criminal charge.

3. **Good crisis prevention is as important as effective crisis intervention.** Consumers, advocates, mental health providers – all reiterated the need for good crisis planning for each individual with mental illness. A good crisis plan that identifies formal and informal supports, financial resources, medications, and current service relationships could help first responders reconnect an individual in crisis to his/her support system rather than start the deep-end process (Jail or PCS) in motion.

4. **Community's inpatient capacity has dwindled**. The community's inpatient and emergency psychiatric service capacity has been shrinking in recent years. This is primarily due to the decision of several private hospitals to reduce or eliminate inpatient beds and psychiatric services in their ER's. The result has been a further narrowing of options for people experiencing mental health crisis.

5. **County's resources are committed to community services.** Diminished options in the private hospital system force more and more people to turn to Milwaukee County Psychiatric Crisis Service for assistance. The 'provider of last resort', Milwaukee County has a legal obligation and a century-long tradition of providing care to people turned away from other institutions. However, over the past ten years, Milwaukee County mental health services have been shifted to place a greater emphasis on the community-based support programs people with mental illness need and want rather than inpatient services.

The Story of Milwaukee's Shrinking Inpatient Capacity

| 1987 | 2004 | 1987 | 2004 | 1987 | 2004 |

Total inpatient beds (public and private) dropped from 1,170 in 1987 to 363 in 2004 – a loss of 807 beds (-69%).

Public inpatient beds (at Milwaukee County Mental Health Complex) decreased 78% from 428 in 1987 to 96 in 2004.

Private inpatient beds also dropped significantly – 64% - from 742 in 1987 to 268 in 2004.

Source: Wisconsin DHFS
Guide to Wisconsin Hospitals

The Scope of the Problem Is Significant

**The Scope of the Problem
Is Significant**

- 692,339 adults (18+) live in Milwaukee County.
- An estimated 5.4% or 37,386 adults have a serious mental illness such as:
  - Severe schizophrenia
  - Bipolar disorder
  - Severe depression
  - Panic disorders
  - Obsessive Compulsive Disorder
- An estimated 13,000 cases come through Milwaukee County Psychiatric Crisis Service each year. Of these, 8,000 (62%) are emergency detentions.
- Milwaukee County has 96 inpatient beds but average daily census (2004) was 109.

6. **The County cannot handle the volume of emergencies.** Milwaukee County Psychiatric Crisis Service and its inpatient hospital cannot handle the extraordinary volume of people seeking crisis services. As a result, competition for inpatient treatment has become common with clients feeling that they must "game the system" in order to receive the services they feel they desperately need. In other words, system-savvy individuals may be successful in obtaining help while others, who are less experienced or more disabled, are returned to the street.

7. **Consumers want to do more.** Consumers represent an important asset in the system. Consumer-run programs such as the Warmline, peer support, and drop-in centers are recognized as critical components of Milwaukee's mental health system. However, consumers' unique expertise and compassion are underutilized in terms of crisis prevention, intervention, respite, and peer to peer support. While consumers have successfully developed their own alternative programs, they have not been effectively integrated into existing crisis prevention or intervention services.

8. **The front door to the criminal justice system is wide open.** The criminal justice system lacks the front-door, pre-booking, screening and diversion services that could re-connect individuals in crisis with their support system. Pre-trial planning to package services or re-connect people with existing services is hampered by difficult cross-system issues, e.g. getting other service systems to respond in a timely manner. As a consequence, people in dire need of mental health services are in jail, without services and often without proper medication.

9. **Milwaukee's system has silos within silos.** For example, the County operates four different drug formularies: Jail, GAMP (General Assistance Medical Program), House of Correction, and Mental Health Complex. Programs and resources within the Behavioral Health Division – CSP (Community Support Program), TCM (Targeted Case Management), IMD (Institutions for Mental Disease), Shelter + Care, and others – have a variety of eligibility requirements and provider systems. Public benefit programs such as Medicaid (T19), Medicare, SSI, SSDI, Badgercare, and veterans' benefits are an alphabet soup of regulations, prohibitions, and limitations. Few people – consumers or providers – are capable of successful navigation of this complex, bureaucratic system.

The public mental health system has increasingly become a community-based (non-inpatient) system over the past fifteen years, reflecting a national trend of de-institutionalization.

Crisis Services
Crisis Intervention Service Mobile Crisis Team
Crisis Walk-In Center
Psychiatric Crisis Line
Psychiatric Crisis Service/ Admissions Center

Hospital Services
Inpatient Services
Nursing Home (Long Term) Services

Funding Sources	
	(Mil.)
Total System	$140.0
Community Aids	$27.0
Tax Levy	$34.0
3rd Party Billing	$31.0
MH Block Grant	$ .7
Community Options	$ 1.4
IMD Relocation	$ 6.0
Wraparound	$30.0
AODA grants	$ 8.0
Miscellaneous	$ 2.0

Milwaukee County Behavioral Health Division
Mental Health Services

Community Services
SAIL (Service Access to Independent Living) - assessment/referral unit which establishes consumer eligibility and refers to:

Community Residential
    Targeted Case Management (TCM)
    Community Support Programs
    (CSP)
    Day Treatment
    Sheltered Work Community
    Employment
    Outpatient Treatment
    Representative Payeeship
    Subsidized Housing
    Safe Haven for homeless persons
    Benefit Advocacy Services

10. **Change is possible.** Reform efforts within the Behavioral Health Division have focused on revamping the County's substance abuse treatment system and better aligning those services with mental health resources. Law enforcement, mental health providers, consumers, and the private health care system recognize that the current system is not working and have chosen problem-solving over finger-pointing. This convergence of interest is evidenced in the number and diversity of people attending the Mental Health Task Force Summit in August 2004 and the sustained involvement of organizations in the MHTF since that time.

Organizing and Advocating

Based on its focus group research and the input from participants at the MHTF Summit, the Task Force developed a comprehensive list of short-term and longer-term recommendations for action. These recommendations, which are presented in detail in Appendix B, reflect the need to hold the entire community accountable for the resolution of this serious problem.

Recommendations are included for the following: federal, state and local government, mental health consumers and consumer groups, private hospitals, community mental health service providers, county employee union, funding community, media, and the university community.

The overarching recommendations:

1. **Invest in recovery and crisis prevention**– by empowering consumers to help their peers, providing better training to CSP and TCM staff, and building recovery principles and prevention into each person's care plan.

2. **Train the first responders** –building capacity within law enforcement agencies throughout Milwaukee County to better understand people with mental health issues and developing practical, effective strategies for crisis intervention.

3. **Hold everyone accountable**– every level of government, public and private mental health providers, consumers, elected officials, law enforcement – each holds a piece of the puzzle.

4. **Aggressively manage resources to serve the public interest** - obtaining new resources is important but so is better managing existing resources to achieve better results. This means reaching across silos in order to improve the overall system.

5. **Recognize consumers as experts** – the power of peer to peer support is immeasurable. This tremendous power – the power of knowledge, the depth of compassion, the commitment to recovery – is our community's greatest asset.

Signs of Progress

Community Attention

A new and strong light is shining on the issue of mental illness. Largely due to the Mental Health Task Force's effort, media attention has substantially increased with several in-depth articles appearing in the **Milwaukee Journal Sentinel**, the metro area's largest daily newspaper.

Dave Umhoefer, "County offers plans to reduce mental care delays," June 28, 2004.

Bob Purvis, "Man's beating death dismays advocates," July 9, 2004.

Meg Kissinger, "Community is failing mentally ill, panel says," August 22, 2004.

Meg Kissinger, "Mental health care meeting draws 300," August 24, 2004.

Jennie Tunkieicz, "Police mental health training helps families cope," September 2, 2004.

Meg Kissinger, "Mental health advocates ask if death was avoidable," September 7, 2004.

Patrick Marley, "Thousands with mental illness still lack proper care in prisons," September 11, 2004.

Jennifer Wittwer, "Mental health" Many local needs, not enough resources," September 19, 2004.

Meg Kissinger, "Shooting death becomes a plea for training," November 21, 2004.

Dave Umhoefer, "Mending mental health care," September 21, 2004.

Dave Umhoefer, "County workers leaving in droves," September 25, 2004.

Dave Umhoefer, "Medical care for poor gets funding," September 26, 2004.

"Move on Mental Health"
Editorial
Milwaukee Journal Sentinel
August 25, 2004

"A Tuesday conference on improving the treatment of the mentally ill in Milwaukee drew more than twice the number of people expected, and more than 100 had to be turned away, from lack of space. The reason is simple: Milwaukee is failing its mentally ill......

The problem...is a lack of coordination among mental health provider, a shortage of outpatient services, and inadequate training for police. And unless steps are taken to correct this problem, it's a good bet things will deteriorate more...

The remedy will not be inexpensive. But the alternative will cost even more and in the long run be highly detrimental...

Now all that's left is for everyone to get moving."

Local television and radio coverage including extensive coverage on local public radio also helped raise the visibility of the crisis in mental health services. The national press took notice of

Milwaukee's activity on this critical issue with articles appearing in several internet publications including www.PoliceOne.com, www.mentalhelp.net, www.devereux1.org, www.massfreedomcenter.com and www.MSNBC.msn.com.

Why is this important? Previous news coverage of mental illness tended to focus on two distinct components: stories about incidents involving an individual with mental illness; that is, reports of specific situations involving the intersection of a person in mental health crisis and a law enforcement response, usually with a negative or even fatal consequence; and stories about the budget difficulties of public institutions, such as the Milwaukee County Mental Health Complex.

However, recent articles have taken a different tack, focusing on policy issues and promising approaches. The frequency and depth of news coverage kept the issue on the front burner just as county government reached the final stages of its 2005 budget development.

Expanded Crisis Respite Care

In September 2004, Milwaukee County Executive Scott Walker and representatives of four local hospital systems announced a plan to share the cost of expanding Milwaukee County's crisis respite care program from 8 beds to 24 beds in 2005.

Two things are remarkable about this development:

- **First**, four hospitals systems - Froedtert Memorial Lutheran Hospital, Aurora Health Care, Covenant Healthcare and Columbia-St. Mary's – pledged $500,000 which was matched with a $250,000 commitment in Milwaukee County's 2005 budget.

  Why is this important? Creatively addressing Milwaukee's mental health crisis requires strong public-private partnerships. This respite care joint venture is a good first step and can provide a model for other, creative initiatives.

- **Second**, expanded crisis respite care will expand our community's capacity by 150% in 2005! In 2004, 221 people were served at the 8-bed Crisis Respite House, an average of about 18 people per month. The second 8-bed crisis home will be opened in February and the third 8-bed crisis home will be opened in June. This new capacity means that an estimated 553 people will receive respite care in 2005, 332 more than in 2004. In 2006, when all three homes are fully operational, even more people will be served (an estimated 666 people).

  Why is this important? Good crisis respite care is an essential community resource. Respite care expansion has the potential to actually prevent some people from going into crisis in the first place and can provide a less costly and more homelike setting for people already in crisis. In addition, these homes may give the system a chance to try out some new methods of involving consumers in peer support and mentoring roles.

Law Enforcement Training

The Milwaukee Police Department, by far the largest law enforcement entity in Milwaukee County, will train nearly all sworn police officers in strategies for working with persons with mental illness, particularly people experiencing mental health crisis. Starting in January 2005 and extending over several months, the Milwaukee Police Department in cooperation with the Milwaukee County Behavioral Health Division and local mental health consumers will provide four hours of training to 1,800 police officers working on the streets of the City of Milwaukee.

This is a major system improvement for two reasons:

- **First,** by training 1,800 officers, the Milwaukee Police Department has recognized the need to raise the knowledge and skill level of virtually its entire force – more than 90% of officers will receive this valuable training!

  Why is this important? Police officers are the community's first responders. They respond to crime, domestic violence, and a broad variety of other emergencies, including a high number of incidents involving persons with mental illness experiencing crisis situations. Officers with greater understanding and skills will have an immediate, positive impact on how crisis situations are managed.

- **Second,** the Milwaukee Police Department's agreement to collaboratively develop and present a new training module illustrates a dramatic cross-system initiatiave that will have a major and long-lasting impact. By opening the door to partnership with the Milwaukee County Behavioral Health Division, community providers, and advocates, the MPD is demonstrating its commitment to a community-wide problem-solving effort.

  Why is this important? Hear the sound of silos being torn down? This is a very important development– for new relationships, new ideas, new approaches, and better results.

Other Signs of Progress

In a mental health system as large and complex as Milwaukee's, change comes in many shapes and sizes. Sometimes, even the smallest changes can make a significant difference – in preventing crisis situations, making better decisions at the point of crisis, and improving access to effective alternative services that can divert people from deep-end psychiatric inpatient hospitalizations or unnecessary incarceration.

What are some of these small, but very important changes?

- Milwaukee County Behavioral Health Division is receiving a state grant to improve crisis respite for persons with mental illness and developmental disabilities. In addition, the state crisis grant may provide the County with seed money to expand consumer-run services and test some new consumer-centered approaches to crisis intervention.

- MCBHD is adding a psychologist to address the special needs of people with mental illness and developmental disabilities.

- MCBHD is also seeking state funding to establish a resource center to improve coordination for people with dual diagnoses.

- Representatives of the Mental Health Task Force met with Mayor Tom Barrett and Police Chief Nan Hegerty to discuss the MHTF agenda and solicit their support.

- MHTF members worked collaboratively with Milwaukee Police Department trainers to develop the training curriculum for MPD officers.

- The MHTF is seeking foundation support to send a contingent to Memphis for further study of the CIT (Crisis Intervention Team) model for possible replication in Milwaukee.

Other Cities:
What Can We Learn?

A National Movement

Milwaukee is not alone in facing a serious crisis in mental health services. Cities across the country have wrestled with the terrible consequences of system failure: unnecessary emergency detentions, lengthy jail terms and high court costs, and, all too often, deaths that could have been prevented.

The fact that many other cities have faced this tough problem and 'lived to tell the tale' gives us hope in Milwaukee.[1] It *is possible* to change systems' behavior, better educate service providers, including law enforcement, re-deploy scarce resources, and achieve better outcomes. Other cities have done this – so can Milwaukee.

Three Model Programs

Although there are many fine examples of innovative approaches, three projects stand out as especially relevant to Milwaukee's situation:

1. Crisis Intervention Team, Memphis Police Department, Memphis, Tennessee

2. Jail Diversion Program/Mental Health Linkage, Clermont County Mental Health and Recovery Board, Clermont County (Batavia), Ohio

3. Mental Health Probation Court, Maricopa County Superior Court, Maricopa County (Phoenix), Arizona.

Each model program addresses a different part of the crisis intervention continuum. The Crisis Intervention Team deals with street level intervention and diversion; the Jail Diversion Program is a pre-adjudication intervention within the jail; and the Mental Health Probation Court is a post-adjudication approach.

[1] Please see www.consensusproject.org for a detailed listing of program profiles.

Crisis Intervention Team (CIT), Memphis Police Department, Memphis, Tennessee

The Memphis Crisis Intervention Team (CIT) receives a great deal of national attention and rightly so. Based on the premise that police officers are the primary 'first responders' to mental health crises, the program focuses on increasing their mental health skills and knowledge. Devised by a community-wide task force convened by the mayor to address problems in the mental health intervention system, the CIT continues to function within a collaborative system involving law enforcement, the National Alliance for the Mentally Ill (NAMI), mental health providers, and the University of Tennessee.

Key features:

- Patrol officers volunteer to become CIT-certified, which is a great way to select those who truly want to increase their mental health skills and knowledge.

- At this time, about 25% of Memphis' patrol force is part of the CIT (totaling 213 officers). CIT officers receive extensive training in mental illness, medications, crisis intervention strategies, and community resources. The training also brings officers into dialogue with consumers and family members.

- CIT officers are available in each of Memphis' seven police districts. When calls are received involving a person with mental illness, a CIT officer is dispatched, becoming the officer in charge at the scene. S/he is able to use the CIT training to diffuse the immediate crisis and make an appropriate decision regarding transport to the University of Tennessee Medical Center.

- The Medical Center is open 24/7. If necessary, a person can be admitted within 15 minutes of arrival, allowing the referring CIT officer to return immediately to duty.

- Since the CIT was established, the Medical Center has increased its admissions by 40-50%; in other words, people who would formerly have been jailed as a result of a mental health crisis incident are now receiving mental health treatment.

> "If CIT could save the life of one consumer, one officer, if it could prevent the unnecessary criminalization of those who struggle and cope with their illnesses, if CIT could reunite families, if it could prevent incidents of injury and pain, if it could restore one person's dignity by measures of respect and kindness, if it could open opportunities to just one person, if it could open our hearts to see and understand the similarities of our hopes, fears, frustrations, dreams and passions...CIT, what's it worth?"
>
> — *Major Sam Cochran, Coordinator, CIT, Memphis, TN*

[2]Contact for the Memphis CIT: Major Sam Cochran, samcit@memphispolice.org, Coordinator, Crisis Intervention Team, Memphis Police Department, 201 Poplar Avenue, Memphis, TN.

Jail Diversion Program/Mental Health Linkage, Clermont County Mental Health and Recovery Board, Clermont County (Batavia), Ohio[3]

The Clermont County program is one of thirteen projects funded by the Ohio Department of Mental Health (ODMH) in 2000. The purpose of the ODMH initiative was to divert mentally ill offenders from involvement in the criminal justice system by connecting them to needed treatment and supportive services in the community. This initiative demonstrates the considerable power of state government to support new approaches through leadership and strategic funding.

Key features:

- The program is operated by Clermont County Mental Health and Recovery Board with funding provided by the Ohio Department of Mental Health and the Health Foundation of Greater Milwaukee. The project operates as part of a collaboration involving treatment providers, county and state officials, and court representatives.

- A case manager and intensive probation officer comprise the diversion team, linking individuals with mental health treatment services as well as providing intensive probation supervision.

- Between March 2001 and June 2003, the project served 270 people with serious mental illness who had been arrested on charges such as drunk driving, domestic violence, and theft.

- Program officials estimate a cost savings of $1.3 million dollars realized as a result of the drastic decrease in jail utilization.

- In 2003, the Clermont County Jail Diversion Project was recognized as a best practice by the National Association of Counties.

[3] Contact for the Jail Diversion Project; Karen Scherra, kscherra@ccmhrb.org, Executive Director, Clermont County Mental Health and Recovery Board, 1088 Wasserman Way, Suite B, Batavia, OH 45103

Mental Health Probation Court, Maricopa County Superior Court, Maricopa County (Phoenix), Arizona[4]

The Mental Health Probation Court is a post-sentencing model; that is, the program works with individuals who have been charged with an offense and are sentenced to probation. People referred to the program typically have experienced significant problems complying with the conditions of their probation. The Mental Health Probation Court, established in 2002, is a new component of an existing program called the Seriously Mentally Ill (SMI) Program, an intensive probation program for offenders with mental illness.

Key features:

*   The Mental Health Court Team is at the center of the program; the team includes a judge, probation officers, public defenders, district attorney, community providers, and other court and health care staff.

*   The Team develops an individualized plan for each person on probation with mental health needs; the plan details treatment services to be provided and establishes a monitoring system to insure compliance. In other words, the Mental Health Court concept uses the authority of the court to organize services and insure that probationers use services as planned.

*   The Mental Health Court Team concept is designed to hold the mental health treatment system accountable as well as the individual offender.

*   The SMI Program, of which the Mental Health Court Team is part, received the President's Award from the American Probation and Parole Association in 2004.

Common Theme - Collaboration

Almost without exception, successful programs evolved out of broad community collaborations involving key systems such as law enforcement, courts, and treatment providers as well as other institutions, consumers, and elected officials. Moreover, the projects continue to operate that way – drawing key interests together over the long term to implement, evaluate and modify programs with the goal of improving outcomes and increasing impact.

[4] Contact for the Mental Health Probation Court: Mary Robson, robsonm@superiorcourt.maricopa.gov, Mental Health Court Coordinator, 101 W. Jefferson, 5th Floor, Phoenix, Arizona 85003

Next Steps:
Milwaukee's Critical Juncture

Milwaukee is at a critical juncture. What has been accomplished so far is cause for celebration, yet much remains to be done. Real change requires the sustained efforts of the Mental Health Task Force and the continued commitment of key community systems – local government, the health care system, and mental health providers and consumers. This year's work represents only the first few steps in a very long community journey.

While there are many options for the future, the Mental Health Task Force has focused on five. These are ideas that have been discussed in depth by Task Force members over the past year:

1. Work to get CIT (Crisis Intervention Teams) initiated in police agencies throughout Milwaukee County including Milwaukee Police Department, Sheriff's Department, and all of the municipal forces. Adopt a strategy of incremental change – starting small and building for the future. Remember that it took Memphis three years to develop their initial level of CIT capability.

2. Consumers, consumers, consumers! There are so many ways that consumers can improve the mental health system. We want to look back in three years and see evening and weekend hours for the Warmline and drop-in centers. We want to see consumers hired as case managers and playing critical roles on crisis intervention teams. We want to see a consumer-run Recovery Education Center where people can come to learn more about the recovery process and develop their own recovery and crisis plans.

3. Obtain system-wide community buy-in on what a new Crisis Resource Center would look like, how it would be funded, where it would be located, what role consumers would play in its operation, and when and where it would be built!

4. Move beyond the issue of crisis and into other critical issue areas including employment, housing, school-based services, and elderly services.

5. Look more into the root causes of many mental health problems including violence, trauma, and abuse. What can the Task Force do to shine a light on these issues and help to prevent them?

A Constant Theme

A constant theme runs through these ideas—and others the Mental Health Task Force may pursue—and that is: We must educate policymakers, education the public, and educate ourselves so that we pull issues surrounding people with mental illness out of the shadows and into the light of day, and, in the process, we reduce stigma, we eliminate stereotypes, and we make the community more accepting of all its members.

Appendix A: Focus Group/Interview Notes

Mental Health Consumers

The MH has to be reformed along the lines of Recovery principles.
* A system based on Recovery principles would focus on people's hope and dreams instead of on their diagnoses and illnesses.
* Consumers know a lot about what works for them when they are at the point of crisis, but lack individual and systems-based support to put what they know to good use.
* Consumers do not have well-developed (or any at all) Crisis Plans.

Consumers in crisis are unable to access inpatient services.

The current process for inpatient admissions at the County is much more complicated and difficult than it was in the recent past – things have gotten far worse.

The current inpatient admissions criteria (homicidal suicidal standard) at the County forces consumers to try to "game the system" and act more dangerous to themselves or others than they actually are.

People have to sit for 6 to 18 hours in holding (observation) area waiting to be assessed for inpatient or for decision to admit to be made. Conditions in holding area are bad – overcrowded, dangerous people around.
* "I have been there 13 times to the County and I have learned the lies I have to tell to get in."

Interactions with police have usually made matters worse rather than better.
* Police will only take to jail or to the complex – there is no middle ground.
* Police do not talk to case managers, family, others who know the person.
* Police do not appear to receive enough training to be sensitive to people in crisis.

Being taken to the jail is the worse thing that can happen at the point of crisis – made to feel like a criminal, long waits for help, unable to access needed medications (different formulary).
* Current crisis alternatives to the complex in the system are not well-known and are underutilized.
* Consumers do not know about Crisis Respite that may be available.

The Mobile Crisis Intervention is also a mystery to consumers, they don't know about how to access it, how it might help.
* People who do know about Mobile Crisis have found it to be mostly a way to get people into the hospital, not as an on-site resource to help stabilize someone in crisis.

The role of consumer peer support in crisis intervention is underutilized.
* Consumers could play a role on Mobile Crisis teams, in PCS, and an expanded role at the day hospital.
* Consumer run organizations and drop-in centers need to be available in the evenings, at night, and on weekends.
* The consumer-run Warmline needs expanded hours (now only 7 to 11 PM)

Consumer run groups at AA, DBSA and SU (among others) could be better utilized by consumers and by the system.

* Not enough consumers are hooked up – many are totally out of touch of services or community support.

Community-based contracted mental health service providers need to improve the use of consumer/peer support in their agencies, and learn how to link clients to existing options for consumer support.

Other communities in Wisconsin and nationally have made better use of consumer/peer support in a variety of ways, such as respite homes, adult family crisis homes, safe houses, etc.

* There are relatively simple things that could be put in place for many people, like PRN med availability, having a core group of people who can come to stay at time of crisis (perhaps as paid crisis respite) such as family friends, church members, peers.

Criminal Justice System Groups

Many people with mental illness caught up in the criminal justice system are not connected to any supportive services.

* Many people are connected to supportive services, but police and court personnel are unaware of this.
* Many are homeless or will lose housing while incarcerated.

Many would benefit from treatment but none is available.

* Many have co-occurring mental health and substance abuse issues – often the system treats one issue but not the other.
* Substance abuse issues are often the cause for the interaction with the criminal justice system (nuisance crimes).

"Serial" ticket writing (one person had 12 tickets from one incident) reflect the fact that police feel they have no decent alternatives. Outcome: person does not show up, tickets turn into commitment proceedings, person can wind up committed.

* Police do not know what to do with person so they take them to the complex or to the jail.
* We need alternative to take people to instead of to the jail.
* Have potential Community Justice Center on the south side.
* Idea: Community Justice Center could also have a psych crisis component?
* Also need better Mobile Crisis to intervene in different ways.
* Once arrested, philosophy seems to be to presume at intake that the person will be held and charged instead of released and diverted.
* System is based on the fear that we will book and release the wrong person and something bad will happen.

We need a change in the institutional thinking of this city – more of a level of intervention before charges are made. Identify the person with mental illness early on and divert into something better than the current "morass" of court date scheduling.

At one time we had a better pre-booking intake screening process – that has fallen by the wayside. Now more people wind up in court system.

Once in court system, bad outcomes occur. People who have been adjudicated as incompetent may plead guilty.
- Even when the pre-trial system is working, things take forever.
- Pre-trial staff can put together a plan for a person (perhaps on a $100 hold) but then the SAIL process may take 60-90 days to process referral, person sits in $138/day jail cell the whole time – and possibly on the wrong meds.

Police need more training – training in the past has worked.
- Mental health work group now working on courts issues could be involved in training police.

Police in senior command positions need to know and understand people and programs doing diversion work.
- Would lead to better charge/not charge decisions.

Would allow legal system to focus on the cases that do need attention, crimes of violence and public safety, instead of nuisance crimes.
- Probation system for people with MI has problems – not well-funded, not properly trained, no MH background.
- Suggest pilot programs to move process toward a new model – one police district at a time.
- Court work group has good template that could be expanded to work with police.
- Judges, DA's, public defenders, pre-trial staff all involved in training and learning together.
- GAINS work in mapping people moving through the system is valuable information that has not been fully utilized.
- Problem area: information systems are lacking that would link arrest system with community mental health system. Goal of better information system would be to get this data to judges and prosecutors in timely manner to inform diversion work.
- Need better data in general about people with MI in jail and court processes. We know more about what they cost than we do about how they come into and move through the system.
- Need buy-in to new vision from Sheriff and Police Chief. Would be able to couple with already-existing buy-in from Courts personnel.

DHHS Behavioral Health Division

Bottom line: Milwaukee County will honor its commitment but we need private hospitals to step up to the plate also.

Need alternatives to divert from PCS at intake and to reduce census when full.

BHD staff has linkages to community and consumer groups, but we are inundated with work – no time to build on them or use them effectively.
- Crisis walk-in has gone from 400 to 558/month, inpatient from 3,400 to 4,000/year. Outpatient contracts are filled.
- Need better data on number of people with MI. Are we doing a better job at identifying people in the criminal justice system which results in more demand?
- Preconditions to crisis include inadequate case management and targeted case management, especially fur dual diagnosis with AODA.
- Preconditions include "barrage" of social issues people are dealing with, especially lack of housing or housing problems.

Lack of providers that take T19 in community hurts the ability to link people with preventative care so they wind up in crisis.

Agreement that we need more in preventative care – especially for people that are struggling but still functioning.

Police are a major part of the puzzle that needs to be addressed.
- They seem to have no alternative other than book or take to the Complex.
- Police need more training, and they benefit from it. Trained 1,850 people four years ago and reduced emergency detentions by 35%. We need to have alternatives to take people.
- Feel time is right – receptivity in new police chief.
- BHD staff working with NAMI to bring in Major Cochran from Memphis in September to talk about how they reformed their system.

Consumer attendees at meeting reported that linking with consumer groups was key for them in transitioning out of inpatient setting.
- General agreement that stronger linkages to consumer groups should be a priority.
- Need to brainstorm more roles for consumer/peer support in overall system, especially at crisis.

General agreement that reform needs to be along lines of Recovery principles.
- Need more alternatives. Have crisis 8-bed facility – not enough. Police need alternative place to take people that would link them to social services.

Alternatives brainstormed: better use of consumers and consumer groups, Community Justice centers with links to social services, building capacity of provider systems and networks.
- Alternatives should include a voluntary component – not just for people picked up by police.
- Need to look at successful models of the "intermediate step."
- Need to help consumers develop individual crisis plans.
- May have to look at changes to laws: no hospital required to take people but MCMHC is.
- Need to figure out funding (IMD vs. T19 issue).

Need community to support DHHS efforts to get private hospitals to the table.
- Will need to look ahead to 2005 budget process – can this group help when privatization issue comes up again?

Community Mental Health & AODA Service Providers

Precipitating factors for people with mental illness going into crisis include lack of housing, lack of food, lack of stability in overall life.

Systemic problems of "silos" – there are mental health silos, AODA silos, housing silos, not enough coordination among systems.
- People come in from a voucher system that says, "you get AODA treatment," even though person may have other equally important needs.

Key to a lot of the problems centers around **housing**. Providers often see people going right back into a bad situation that led to the crisis in the first place.
- Service system lack nuance. Some consumers are more ready to embrace change, others not. Need to better identify people ready/capable of change and triage them into a more nuanced modality.

Need better data on recidivism so we could identify those who will cycle through the system more frequently and design better intervention for them.
- Access to community mental health resources can be bewildering.

People almost need a "coach" – someone who can take a more comprehensive view and help negotiate multiple systems.

We could make more use of peer mentors in this coaching role – possible mental health "sponsors" as in 12-step programs.

Can we ever get to a prevention-oriented system, where people can be identified and helped before they get to crisis?
- Need better pre-trial diversion systems. LaCrosse has better pre-trial system, and a drug court – these would help.
- Poverty is a huge factor. People without economic means face additional steps before they are seen as "worthy" to receive services.
- Linkages to the shelters need to be improved.

Consumers need better pre-planning assistance in how they deal with crisis. Need better crisis plans, even things as simple as little cards consumers could carry to inform anyone of what to do in event of crisis.

Have to consider issues related to **violence** histories.
- Background of violence – sexual, domestic – in the lives of many women caught up in the system.
- There should be greater sensitivity to violence-related issues in whatever treatments are offered.
- Should be a factor in how community services are developed, for any person and for the system as a whole.

Better to develop services that address violence-related issues in the community rather than in institutional settings. The institution can sometimes replicate/mirror the original violence episodes, e.g. the use of restraints.

Insurance issues are huge.
- Fewer outpatient clinics accept T19, and those that do accept are establishing waiting lists.
- People call around a lot and don't get connected.
- Pre-approved paperwork for T19 is very daunting – make one mistake and it all is sent back.
- Merger of mental health and AODA at BHD.
- Administrative systems now merged. Data systems will merge soon.

How services are accessed in the community will change - Milwaukee County moving toward Central Intake.
- Moving toward having MH services available at all AODA sites.
- SAMHSA "Access to Recovery" grant would be big help in AODA system redesign and expansion.

A better system than we have now would include: neighborhood or community centers where people could access AODA and MH services; at least one of these centers would be open 24/7; and people would get access to housing and other related supportive services.
- One idea being considered is to convert one of the homeless shelters into such a community center.

Milwaukee Police Department Staff

We have limited options when we encounter a person with mental illness. We can go the Ch. 51 route or the arrest route. That means taking them to the jail or the Complex.

Taking people to the Complex has been very time consuming at various times lately. Officer may be tied up for hours. Officers cannot dispense medications.
- We need a triage system – some place we can take people where we can turn the person over to appropriate people and they can get access to services and help.
- One of our biggest problems involves homeless people.
- We encounter a variety of diagnoses in the homeless group – there is a lot of PTSD among Vietnam and Gulf War veterans.
- We have learned that homelessness may be a choice for some, but this creates a dilemma for us. There has been increased violence lately in homeless societies.
- There is almost always an inter-play between MH issues and AODA in the homeless people we encounter.

Many homeless people get into trouble during the day - aggressive panhandling, theft – we get many complaints from merchants and community. Municipal violations we issue do little to nothing to stop this behavior.
- This is a cyclical problem – people get picked up over and over again. We can become cynical.
- We have a very intolerant public and very few resources to hook people up to.

People who appear to be dangerous or who have made threats to themselves or others pose an added problem. Our officers don't feel qualified to second-guess the dangerousness of the situation so they err to the side of safety and detail under Ch. 51. "You really hate ambiguity out there."

We always have to be concerned about "suicide by cop" situations. We are looking at use of force alternatives such as Tasers.

Police engage in many "informal dispositions" – take person to Webb's for a coffee, try to get into a homeless shelter – but officers need to know this is OK.

Problems with private hospitals are worsening. They don't want to take people or it takes too long to process the person in the ER. In the meantime, person can be in bad shape or situation may be escalating.
- One person was left unattended because ER was busy – the person just walked away and police had to track down. Potentially very dangerous situation.
- Under the rules of Ch. 51 we need medical clearance before we can release a person from an emergency detention. If they walk from a hospital they are still under our detention but are now at large in the community.
- We think the County needs more Mobile Crisis capacity. Need at least two teams per shift. Interventions can be intensive and if more than one crisis is going on, the team cannot get free.
- We need training on dealing with people with mental illness and community resources. Past training like this has been very successful but there has been no such training for four or five years. During that time, there has been a turnover on the force of 500-600 people.
- Training needs to focus on empathy not sympathy, respecting the space of the person, gaining better communication skills to focus in on identifying the problem, teaching people to have "compassion, common sense, and a sense of humor."
- Training should include use of scenarios and role-playing.
- Need more supervisory training also.

One easy thing to do right now would be 15 minute presentations at roll call – continually educate. We also need uniform training across municipalities and the Sheriff's Office.

Could take training proposals to Milwaukee County Law Enforcement Executives group.

- The issue of whether it makes sense for us to create specialist officers to intervene in mental health situations is a complicated one. There are union issues, may require differential pay and days off. We have observed that some departments that went to the specialist model are now reexamining the idea.
- We also need better relations with community mental health service providers.
- Would be great if providers took steps to develop rapport with districts, meet with district captains, establish and maintain a dialogue.

Closing comment: we are always open to hearing evaluations of ourselves and our actions.

Paul Radomski and Michael Kreuser, Milwaukee County Behavioral Health Division

"Front Door" coming in through Psychiatric Crisis Services: 12-13,000 per year, 8,000 of these are emergency detentions.
- Inpatient unit: Have 96 beds, doubling up in some rooms. Average daily census this year has been 109.
- Also have 165 long term beds. There are 72 SNF (IMD) beds and 93 ICF MR (Hilltop) beds. Funding composed of $11 m. patient service revenue and $13 m. tax levy.

Outpatient – 3 contracted sites (2 at Medical College and 1 at Health Care for the Homeless) – 4,000 people seen per year. All indigent care, not T19. Majority of referrals come from 4th outpatient site which is County Crisis Walk-In Clinic.

Community Support Programs: 1,425 person capacity. Usually run pretty close to capacity; 10 state-certified CSP's, 2 county-operated with capacity for approximately 460 clients, 8 contracted out with about 950 clients.
- Targeted Case Management: At capacity now at 1,600. BHD creates capacity through utilization review. One county-operated TCM with 300 clients, 8 contracted TCM's with 1,300 clients.

Also fund variety of other things. Have HUD funding to subsidize approximately 275 persons having a mental illness and are homeless. Some of these vouchers subsidize housing for substance abusers and HIV positive or AIDS clients. Also have significant funding supporting CBRF's, community employment, club house, drop-in centers, etc.
- Overall budget is $140 million:

Community Aids	$27.0 (m)
Tax levy	$34.0
3rd Party Billing	$31.0
MH Block Grant	$ .7
Community Options Program	$ 1.4
IMD relocation	$ 6.0
Wraparound services	$30.0
AODA grants	$ 8.0
Miscellaneous	$ 2.0

- 8 contracted CSP's serving 950 people; $7.5 m. total funds, split $3.5 m. federal T19, $4.0 m. Community Aids.
- 2 County-operated CSP's serving 460 people; $6 m. total funds, split $1.5 m. federal T19, $5.5 m. Community Aids.
- 8 contracted TCM's serving 1,300 people; $2.6 m. total, split $400,000 federal T19, $2.2 m. local, most Community Aids, some tax level.
- 1 County-operated TCM serving 300 people; $1.2 m. total, split $200,000 federal T19, $1 m. local.
- Bottom line: federal dollars are only providing about 27% of overall CSP and TCM costs, not 60%.
- Outpatient system does not meet the needs. There is a backup of intake at the Medical College and Health Care for the Homeless; people coming out of inpatient county crisis programs are eating up all available slots, so limited or no resources for everyone else.

Private hospitals need to contribute some resources. Inpatient beds are one thing. Having psychiatric care available in ER's would also alleviate a lot of problems.
- Cost of medications increased by 30% at Medical College and similar increase for HCHM and BHD itself is growing problem.

Lack of unified formulary (there are 3 current formularies: GAMP, Jail, and Complex) is poor policy and bad for consumers.

We need alternatives in the community for crisis intervention.
- Also need better/more police training.
- Need to beef up crisis intervention capabilities of CSP and TCM programs.

MA CIS (Crisis Intervention Service) benefit: do not utilize as much as other counties. May be useful resource to help pay for new community crisis alternatives.
- New CCS benefit: sounds intriguing but still do not have enough detail of what rates will actually be. Also CMS (Centers for Medicare and Medicaid Services) has not given final approval of the benefit. Concern is that even though more federal dollars may be available, county match would go up correspondingly, so no cost savings. In fact, may be more costly. Milwaukee will probably apply but at present only see limited application.

William Bazan, Wisconsin Hospital Association

We believe the current crisis is about more than just inpatient beds – it requires a comprehensive approach to resolve and buy-in from a number of stakeholders.
- Private hospitals have 215 inpatient mental health beds – we are contributing major mental health resources to Milwaukee.

Beds that have closed and have been in the news have mostly been covered by resources put in place elsewhere in the community. Capacity created at Rogers Memorial is an example.
- Our hospital emergency rooms are not a good setting to deal with mental health crises.
- Most hospitals are not physically set up to deal with people in mental health crises in their ER's. Don't have a way to route people to separate part of the emergency area or elsewhere in the hospital to be treated.
- Other people in the hospital (patients and staff) become afraid of patients presenting with behavioral issues.

People get dropped off in handcuffs, handcuffs get taken off, and we have no security to deal with

situations that may develop.
- This is all happening in a triage environment where people with serious medical issues are being seen first. A person with mental illness may wait hours to be seen.
- Unmonitored people can and do leave the hospital. We cannot involuntarily detain them. All we can do is attempt to talk them into staying until they can be seen.

Our physicians do not necessarily have mental health expertise.
- Hospitals do not have a lot of access to psychiatrists and can't keep them on call – too expensive.
- Much of the mental health care we provide is not reimbursable.
- This adds to losses hospitals are currently absorbing. Area private hospitals lost $83 m. in 2003.
- Hospitals are generally moving toward working on the medical side of presenting problems rather than the mental health side.
- We see most of the solutions to current capacity issues being addressable at the Behavioral Health Division.

BHD could double the observation unit from 8 to 16 beds. Both the observation unit at the ER at PCS are T19 reimbursable. County Executive could make this a budget initiative for 2005.
- Attempts to create a "hospital within a hospital" are something we support and are using our connections on the federal level to try to accomplish.
- Private hospitals have not interest in coming in to the Complex or taking over any part of the operations there.
- County also has major workforce issues to confront, especially with psychiatric nurses.

Appendix B: Mental Health Task Force Preliminary Recommendations

Federal Government

- Approve 16-bed Medicaid (T19)-funded "hospital within a hospital" concept at the Mental Health Complex.
- Provide federal discretionary grants to reform system and build capacity (through SAMHSA, OSERS, HUD, others).

State Government

- Approve, implement and provide state funding for new CCS benefit.
- Provide state match for Medicaid CSP, Crisis and TCM benefits.
- Require any new contracts for SSI managed care to address crisis intervention capacity and develop crisis alternatives.
- Provide future crisis intervention capacity building grant to Milwaukee County alone (as opposed to making Milwaukee County apply along with a neighboring county) and increase amount of grant.
- Expand state funding for consumer-operated services and Warmline to allow for extended hours of service.
- Develop package of cross-disability and disability-specific crisis intervention initiatives for upcoming state budget debate.

Milwaukee County

- County Executive makes services to people with mental illness a higher priority in his budget and administration.
- County Board leadership takes on greater involvement in improving system including examining best roles/jobs for unionized county employees in system of the future.
- County Executive and County Board continue to explore best uses for existing county employees (working in county-operated community programs vs. working in other BHD roles such as inpatient, PCS, expanded mobile crisis teams, etc.).
- Develop and fund an array of cross-disability and disability-specific crisis alternatives to the jail and the Complex including a free-standing crisis triage center, expanded crisis respite, expanded Mobile Crisis, including the addition of consumers to Mobile Crisis teams, expanded use of consumers and consumer-operated programs in crisis prevention and intervention, and others.
- Better utilize/expand use of Medicaid T19 crisis benefit.
- Develop one unified drug formulary to replace the four different formularies now in use at the Complex, GAMP, Jail, and House of Correction.
- Provide intensive training and technical assistance to contracted CSP and TCM providers to enable them to better respond to crisis situations.

- Ensure greater collaboration between Behavioral Health Division and Disability Services Division on people with dual diagnoses.
    - County court personnel continue jail diversion work and connecting people to needed resources.
    - County Sheriff and jail personnel play increased collaborative role with BHD staff, community service providers, consumer groups and others to reduce reliance on jail and promote jail diversion.
    - Continue to emphasize Recovery principles in all aspects of service design and delivery.

City of Milwaukee

- Mayor takes on leadership role within City to promote new spirit of collaboration with other partners around mental health issues.
- Increase police training on dealing with people with mental illness and alternatives to emergency detention.
- City of Milwaukee Health Commissioner makes mental health a priority for his administration.
- Increase efforts on part of the Housing Authority to bring new housing resources to the table.
- Increase Community Development Block Grant support to help develop crisis alternatives.

Other Local Municipalities

- All local municipalities participate in developing and funding county-wide procedures and protocols for dealing with residents in crisis.
- Milwaukee County Law Enforcement Executives group should be involved in planning uniform training for all law enforcement units in the county.
- Intergovernmental Cooperation Council places more emphasis on issue of crisis intervention and prevention for residents with mental illness and other disabilities.

Mental Health Consumers and Consumer Groups

- Expand consumer-operated services such as Warmline and drop-in centers.
- Play key roles in police sensitivity training.
- Play more direct peer support roles in crisis intervention services such as being part of Mobile Crisis Teams.
- Help to establish, staff, and operate potential new and expanded crisis alternatives such as crisis respite, crisis safe houses, and crisis triage center.
- Establish better relations with law enforcement on the local level by meeting with district captains to establish and maintain dialogue.
- Help consumers to develop crisis intervention and prevention plans.

Private Hospitals

- Agree to increase inpatient capacity in targeted manner.
- Make psychiatric care more available to ER personnel.
- Work in collaborative nature with BHD on triage system for accepting referrals.
- Contribute resources to the establishment of a new crisis triage center.

Community Mental Health Service Providers

- Play roles in police training and crisis alternative development.
- Increase community staff capacity to respond to crisis situations.
- Managed care providers funnel savings from reduced acute care utilization into funding crisis alternatives.
- Become better equipped through training and technical assistance to respond to crisis situations.
- Assist consumers in developing crisis intervention and prevention plans.
- Establish better relations with law enforcement on the local level by meeting with district captains to establish and maintain dialogue.
- Incorporate Recovery principles in all aspects of service design and delivery.

County Employee Union

- Play role in system reform.
- Consider best uses/jobs of union employees in mental health system of the future (working in county-operated community programs vs. working in other BHD roles such as inpatient, PCS, expanded mobile crisis teams, etc.).

Funding Community

- Local foundations: create priority funding initiatives for capacity building, model program development, and system reform.
- Robert Wood Johnson Foundation: approve Health Care Financing proposal.

Media

- Produce in-depth series on mental health issues, including a focus on current status of service delivery, personal stories of people experiencing current crisis system, model programs in Wisconsin and elsewhere, and work of Task Force to reform system.

University Community

- Bring resources to bear on system reform efforts, including personnel preparation, student placements, model program development, data development, and research.

Appendix C: Mental Health Task Force Summit Synopsis of Group Discussions

In an effective, responsive and comprehensive crisis intervention system, what key features should be in the forefront? Concepts frequently reflected in group discussions: capacity, education, coordinated care and prevention/recovery

Key features:
1. Training and education: general public, families, schools, and law enforcement.
2. Integrate (holistic approach) health and mental health care. This requires coordination.
3. Greater capacity to provide crisis intervention services – respond quickly – as well as beds.
4. Create a regional "crisis center" for quick mental health connections – perhaps with inpatient beds. This creates a focus point for connecting all relevant players in mental health together, fostering collaboration, and integration of systems.
5. Better ways to obtain affordable housing.
6. More effective collaboration between court systems and mental health systems.
7. Focus on healing approaches, <u>recovery</u>, and family role – not just remedy an immediate acute condition.
8. Better systems of communication: providers, shared databases.
9. Jail diversion programs.
10. Resources.

Overall: Mental health issues should receive as much attention/resources as other medical health issues – parity in insurance, recognition, and resources. More collaboration among agencies involved in overall system is needed.

What values and principles should drive the system? Concepts frequently reflected in group discussions: parity, personalized service, respect, and collaboration. Fundamental: basic human right to quality medical and mental health care.

Access:
1. Adequate services of high quality are available.
2. Quality of services accessible to all individuals.

Treatment:
1. All persons involved in treatment – from physicians to law enforcement – are well trained in mental health.
2. Based on individualized plans, needs and recovery goals (no one size fits all) are consumer-oriented.
3. Respect is key.
4. Central role of the consumer – respond to consumer "desire"/consumer oriented.
5. Least restrictive treatment policies.
6. Proactive/preventive/early intervention focus.
7. Collaborative care/partnership greater than or equal to MH provider/consumer self-monitoring.