**Milwaukee Mental Health Task Force May 2015**
**Survey on Priorities for the 2016 Milwaukee County BHD Budget**

76 Individuals responded

Participants identified their role within the system, or perspective, and could identify as more than one.

| | |
|---|---|
| Person w/lived experience | 35% |
| Service Provider | 69% |
| Advocacy org | 29% |
| Law Enforcement | 3% |
| Family Member | 32% |
| Other | 12% |

1. I regularly attend MHTF meetings.
   YES 41%
   NO 59%

2. Over past year or two, access to community mental health services in Milwaukee county has:
   IMPROVED 21%
   DECREASED 40%
   STAYED THE SAME 39%

3. Over past year or two, access to crisis mental health services in Milwaukee county has:
   IMPROVED 17%
   DECREASED 30%
   STAYED THE SAME 52%

4. Over past year or two, access to inpatient mental health services in Milwaukee county has:
   IMPROVED 6%
   DECREASED 54%
   STAYED THE SAME 40%

5. Priorities for BHD 2016 Budget:
   a. Community Services
      1. Expand # of access clinics
      2. Expand geographical location of access clinics
      3. Decrease wait times/wait lists for community services
   b. Crisis Services
      1. Expand number of CRCs
      2. Expand to include 24 hour CRC intake
      3. Expand mobile crisis & CART
   c. Access to psychiatry
      1. Specifically for those with T19

d. Housing
    1. Further housing 1st model
    2. Expand resources available to offenders re-entering the community
e. Inpatient
    1. Improve quality
    2. Control costs
f. Peer Support
    1. Increase peer support presence in all service areas
    2. Develop peer run drop in and respite centers throughout the county
g. Case management
    1. Increase access
    2. Reduce wait time
h. Fully implement CCS
i. Other
    1. Transportation
    2. AODA inpatient
    3. Downsize hospital and reinvest in community services
    4. Further CIT training and training of other 1st responders
    5. Provided continued access to inpatient services
    6. Increased attention to special populations, including youth, families, elderly

6. Priorities in Community Services for 2016 Budget
    a. Housing
        1. Expand  continuum of housing options
        2. Expand housing overall
        3. Further the housing 1st model
    b. Peer Support/Peer Run services
        1. Develop school based peer services
        2. Increase use of peers in all program areas
        3. Develop peer run programs
    c. Case Management
        1. Fully implement CCS
        2. Increase capacity
        3. Decrease wait time
        4. Further ACT and IDDT programs
        5. End wait lists
    d. Crisis Services
        1. Increase mobile services, especially 3rd shift
        2. Provide 3rd shift intake at CRC
        3. Expand access points to more areas in the county
        4. Expand respite
    e. Prevention/Awareness
        1. Further CIT and training of other first responders
        2. Develop more caregiver resources
        3. Develop more family support resources
        4. Provide more school based services
        5. Provide community education and training
    f. Community access
        1. Expand access points for all programs to more areas throughout the county to allow for greater/improved accessibility

g. Other
    1. Health Insurance
    2. Transportation
    3. Access to psychiatry
    4. IPS employment services
    5. Co-occurring services
    6. Long term stabilization

7. Crisis Service Priorities for 2016 Budget
    a. Increase mobile capacity
    b. Community Crisis Prevention
        1. Walk in clinics spread throughout the county
        2. Respite housing
        3. Increased peer run services
        4. Timely access to medications
    c. Increased CRC capacity
    d. Other
        1. More specialty crisis services for elderly, youth, dual diagnosis groups (including developmental disability/ intellectual disability/MH), and homeless
        2. CIT training
        3. Maintain acute hospital capacity

8. Other
    a. Family and community resources
    b. Crease avenue for public access to Mental Health board
    c. Increase services for dually diagnosed individuals with cognitive disorder and mental health
    d. Improve communication between systems (i.e., police, sheriff, BHD, community providers, etc. )

## Over the past year or two, has access to community mental health services in Milwaukee County improved, decreased, or stayed about the same?

## Comments

- Lack of psychiatrists who take T19 or HMO coverage.
- Decreased due to funding & eligibility, also long waiting list for services.
- Columbia St Mary's is not accepting patients. Froedtert has psych services in New Berlin and Menomonee Falls. Difficult for people to get to providers. Lack of psychiatrists accepting T19 in the city. Shorehaven is too far and Rogers may not accept T19. Acacia provides TV Dr & client has difficult time talking/understanding TV interaction.
- Hard to find psychiatrists who take T19.
- Difficult to find good child or adult psychiatrists. Some clinics require that the therapist be from that clinic thus impeding the built up relationship that has already existed between therapist & client
- Access to psychiatric care continues to be a problem for my clients w/ Title 19 and Medicare
- Hard question- more attention is being paid to the issues publicly (media, MH Board) but significant changes are not evident and those in power positions do not seem to see the impact of BHD chornes (?) on providers and service recipients.
- There has been a slight increase in access in the last two years most of which has been in 2015. I believe the use of Peer Specialists are responsible for some up the increase access.
- Hospitalization options for people with serious mental illness have declined, although crisis resources seem to be improving.
- With the closing of BHD I still am not satisfied that the county is going to be able to address the mental health needs of consumers.
- With the changes expected in Milwaukee County in Mental Health care during the last year or so, I think community mental health access services has not improved. There has been too many questions of what ifs, where is the money, who is going to be the leaders in change, etc. Too many needs not enough service providers.
- There has seemed to be a focus on creating person centered, welcoming access to services.
- Still limited access to case management, outpatient services and housing
- Perhaps it is a little worse. What happened to the focus on community care?
- There has been more confusion due to insurance.
- Increase to some outpatient services has improved because of the access clinic and ACA - but it continues to be very difficult for people on Medicaid to access a psychiatrist. There continue to be long waits for the case management services provided by BHD (TCM and CSP). This is unacceptable - redesign was supposed to include significant expansion of community services.

- It seems like inpatient and institutional services have been downsized but relatively little has been down to expand community services.
- CCS has the potential to connect thousands of people with flexible recovery oriented services but the progress has been very slow.
- The north side and central city desperately need access points for community services such as a resource center and drop in centers to provide education and assistance re eligibility and enrollment.
- I would agree that the access to mental health services has improved in Milwaukee County, however there is a long way to go in making services accessible to all who need it. A primary concern is that those in need of psychiatric services, especially persons 18-59 years old who are diagnosed with an intellectual disability. Milwaukee County has long-term had a shortage of psychiatry resources and, within the resources we do have, finding a psychiatrist who is adequately equipped to work with the IDD population is extremely difficult.
- The availability of services and service options have increased
- periods of limited bed capacity reported at BHD, slow transition to accommodate community based service needs apparent
- There are long wait times for individuals who have been approved for community services through CARS. It is challenging for individuals with BadgerCare to find a psychiatrist or prescriber. If they are able to locate a provider, it can take several months before they have an appointment to be seen.
- There appears to be less access to psychiatric services as well as supportive services which keep people out of the hospital.
- I believe this has more to do with the affordable care act allowing for more access to mental health clinics.
- New patients with BadgerCare have little access to mental health providers, and no access within a reasonable amount of time. There are now 2 access clinics for the uninsured, but no place where newly insured patients can access mental health care.
- County CSP's were closed and patients were transferred into the new CCS level of case management before private agencies had time to recruit enough doctors and staff to take care of them. As a result, there are a number of individuals with severe mental illness destined for new CSP's or CCS who are waiting too long for their intake appointment at the new clinic.
- Still difficult for people to navigate the system. Most people not sure if they are eligible to receive services.
- In recent months, CCS has made a difference. However, prior to that expansion, there were few opportunities for assessment and treatment.
- I feel access to supportive mental health services has increased. Individuals are able to receive cases management, go to the Access Clinic, and there are a few more housing options available.
- Being a part of MMHTF has helped increase my awareness. Hard to tell.

- Access has increased but not fast enough. Big gap in outpt services & crisis alternatives.

- Improved but more needs to be done.
- Definitely increased & expanded, especially for youth
- except for CCS
- While capacity building is a priority, the importance of increasing the strength and width of services provided in existing programs is essential. Funding current services to the level that they are able to provide the intensity of service that patients require. CRS is a perfect example of funding group homes to the level that staffing can be added to support client recovery needs.
- lots of talk, most of the things that have improved have been in progress for years, did not come from current administration that takes credit
- Improvement has been related to more uninsured clients getting access to Medicaid benefits.
- Many providers no longer take state insurance and it is difficult for clients to access clinics that do accept their insurance. Often they are placed on waiting lists and rather than wait, they often just drop off because it is too complicated to get care.
- It has improved with individuals having access to health insurance benefits, however, there seems to be a shortage of quality providers to offer a full range of services that consumers are in need of. Consumers seem to be 'under served' in the same way that individuals are 'under employed' and can't quite get over the threshold of illness to long-term, sustainable wellness.
- Just about all services, if not all services, have developed significant wait lists, "back logs".
- It is very challenging to get someone enrolled in community services through BHD. We had one client who was in ongoing crisis beginning at the end of November. Despite a SAIL application being done at this time by the inpatient social worker, he was only assigned to a TCM 2 weeks ago. Without the support of the housing program he is a part of (to which his needs are beyond what we can provide), I am not sure where he would have ended up. In another instance, we were finally able to get our sickest clients on an emergency detention and on an inpatient unit at BHD. His needs are beyond what our housing program can provide for him and we insisted that he receive CSP services before coming back into our program. CSP services were not immediately available and he remained on the inpatient unit as a direct result of this. This was in no way cost effective.
- The wait times for CSPs has stayed the same and it is still very hard to find a psychiatrist in the community.
- the closing of beds at bhd did not result in more community services

## Over the past year or two, has access to crisis mental health services in Milwaukee County improved, decreased, or stayed about the same? Comments

- CIT police do a great job. Need all police/fire & rescue to be educated on a high level.
- Longer wait times for calls, CIT officers are not regularly available or we are told "not working" or "we don't have any" or "what does that mean" -by dispatch
- There has been a slight increase in access since the creation of CART
- As I stated in question 2 we have not come far enough to help people with mental health issues. I'm still waiting on the training that has been promised for CIT officers in Milwaukee.
- Shooting and killing of Dontre Hamilton was a killing of a mentally ill man. This is not the way to work with the mentally ill. CIT trained teams need to be formed. Not just CIT training where police participate to get on days for awhile and really do not want to understand mental health issues. Maybe the police (who are not really interested in mental health) should be required to take destigmatization classes and sensitivity classes on relating to the mentally ill. How not to escalate situations and requiring a Trained CIT Expert team to be called ASAp,
- I have heard several stories that long waits remain. For this vulnerable population this is unacceptable.
- Just close that place before more people are injured or die.
- We had a consumer who was not stable. Crisis was called over 3 times. The person did not refer the individual to services, but stated that he saw her 4 times within two weeks.
- There have been some positive steps with finally after all these years opening a north side crisis resource center - but given the tremendous need for community based crisis services, the pace has been very slow and doesn't reflect the major needs. Having 24/7 mobile crisis is still very important - not sure why the county is contracting with t a third party to do this (other than to save money) and it has been very slow to get underway and we hear about major difficulties recruiting staff. Law enforcement say things have never been worse. Have heard good things about the CART team from consumers and others who have had interaction.
- The recent addition of the Community Consultation Team for crisis assistance with persons diagnosed with an intellectual disability has been very helpful in our effort to better support these individuals in the community rather than in institutions. That said, there remains a significant concern with individuals diagnosed with dementia and a mental illness not being able to adequately receive the crisis management services they need in the community. We have experienced several times the scenario where: the individual is in crisis, the hospital will not assist due to the individual being medically stable and psychiatrically/behaviorally too complex and BHD will not admit due to the dementia diagnosis. This leaves the individual's supports at a loss of how to appropriately support the individual while in crisis and to help the individual return to their baseline.

- Appears to be more demand then there are services now or a decrease in services for clients with longer long term "crises/crisis support" services
- Still limited interventions available inadequate response times apparent still to many barriers in place for those genuinely in need of services.
- The addition of the CRC North has been helpful. It can be difficult to get Mobile Crisis to respond in a timely fashion. Crisis Respite wants people to be taking medication and have a supply of their medication to go there. This is a barrier to accessing this resource. The CART team has been helpful.
- It's harder to get people care when they are in crisis. PSC wait times are extraordinarily long which makes it harder to get people to follow through with getting treatment when they have to wait. They end up changing their mind before they are seen.
- There's been a recurrence of the problem with psychiatric patients having to wait in medical emergency departments and sometimes board overnight while waiting for transfer to PCS (BHD's Psychiatric Crisis Service). Problems similar to this are occurring across the country, and the Milwaukee situation escalated to a crisis between 2004 and 2007, when it adversely affected hundreds of patients. but the Milwaukee County Crisis Service spearheaded a solution and had the crisis completely resolved by around 2012-2013. Unfortunately, the problem has flared up again. Once again, PCS doctors do not have enough inpatient beds at their disposal and transfers from other hospitals are again being waitlisted at times. I also think that the shortage of inpatient beds at the Mental Health Complex has forced the PCS doctors to tighten admission criteria a little too much. Access to intermediate crisis services has improved with the opening of a second, community-based Crisis Resource Center. But these centers are not equipped to take highly dangerous or acute patients, nor are they funded adequately enough to take admissions on third shift.

- People who are sent out are sent back without receiving services. Very disappointing
- Getting mobile crisis to respond remains near to impossible, which is consistent with years past. The one time we did get them here, the responders were clearly better equipped to handle the crisis at hand and did a good job. There are no resources available to get clients immediate access to medications.
- I feel it has stayed about the same for adults. There was a significant need for crisis services (mobile, day treatment, and inpatient beds) for children and adolescents. I am not aware if this need has been met with the opening of Roger Memorial Hospital's Brown Deer campus.
- The addition of the CRC Capacity has improved the crisis services available. Milwaukee County needs more CRC's. The system to could benefit from a multi agency committee to evaluate the admission criteria for access to PCS especially for individuals who are on civil commitment.
- Never thought there was a crisis, just a report with an agenda

- Primarily due to the opening of another crisis resource center. This has been an incredibly valuable resource for crisis stabilization services for our clients and has

certainly prevent what would have otherwise been emergency room and/or inpatient admissions

- Again, insurance has changed the options that clients have. Since PCS only accepts uninsured, this results in the insured clients having few options other than Rogers, or Dewey Center. With the addition of the new clinic ( La Causa) there will be some better access to clients that live on the south side of Milwaukee.
- More services are available but it seems uncertain if consumers and community providers are well-versed in how these programs work and what they offer.
- It's really hard to get the mobile crisis team to come out in a timely matter.
- The addition of the CART team has been a helpful addition. Their hours and capacity, however, are still limited. I have only been able to contact the CART team directly and have not had luck accessing them through the BHD crisis line.
- There is still no Crisis Resource Center that will take people between the hours of 9pm and 9am.

## Over the past year or two, has access to inpatient mental health services in Milwaukee County improved, decreased, or stayed about the same?

- It seems there is less availability for beds, thus patients are put on out-patient care even if they need in-patient.
- Stayed the same with some improvements to faster action & more staff of diverse to meet populations needs.
- Not enough beds when needed for adolescents and adults
- The closing of Behavioral Health Inpatient Unit @ St. Mary's/Columbia in downtown
- As a last resort when in-patient services are sought almost no consumers meet criteria but other viable crisis resources are not offered.
- The numbers may be going down - people are ending up in jail with more acute psychiatric needs.
- Not enough hospital beds for inpatient mental health services. Other hospitals in and around Milwaukee are only going to set aside a certain number of beds.
- Inpatient care has decreased I believe. With the reduction in county beds and the death of a couple of people in the county hospital has not fueled trust in inpatient services. Where are the step down facilities for people to use during crisis? These need to be thoughtfully and carefully planned and not just thrown together to get funding. I believe more strategic planning and structuring has to take place.
- slightly
- In several cases, inpatient has been denied.
- Many people have shared concerns that it has become more difficult for people who are experiencing a mental health crisis to get admitted at PCS for either inpatient or observation. Law enforcement, family members, consumers, and some staff at the complex have raised concerned that the bar for medical necessity has been raised and that very ill people are being turned away and not connected with other mental health supports. Professionals who work with individuals in the criminal justice system have expressed concern about different practices at PCS which have resulted in turning away individuals who have an open warrant and that is often for minor charges related to their mental illness such as disorderly conduct. They are inappropriately ending up in jail and because of their symptoms may act out and end up with felony charges.
- We have noticed an increase in the willingness of BHD, both the Acute and Observation Unit's, willingness to collaborate with our organization to admit individuals when needed and to ensure better outcomes upon discharge. We continue to have difficulty maintaining that level of collaboration with the psychiatric units within the hospitals, as well as with Rogers Memorial. Frequently individuals in need of inpatient mental health services are being denied admission due to a variety of reasons, but the most common reason being that the individual is medically stable and too complex psychiatrically/behaviorally.
- Appears to be more difficult to access services
- Closure of long term care units, increase needs and risks within the community and limitations on bed capacity at BHD due to staffing issues

- Closure of long term care units, increase needs and risks within the community and limitations on bed capacity at BHD due to staffing issues
- It have become more complicated since many more people have health insurance. If a person is agreeable to being evaluated for an inpatient stay, there are many steps to assist them in that process. Discharge planning and referral to community resources appears to be more fragmented.
- for the reasons mentioned above. I do not see the private hospitals sharing the burden with BHD to improve access.
- The quality of inpatient services at the Mental Health Complex has increased, and the remaining private inpatient facilities have tried harder to serve the more difficult patients. However, the number of private beds has shrunk with the closing the psychiatric unit at Columbia-St. Mary's, and County has reduced its inpatient capacity from 96 to somewhere in the 60's. This is not enough to keep from going on wait list status for transfers from other facilities. The long-term care units are also being closed before adequate receiving facilities have been created in the community. There are some patients who are now rootless and suffering needlessly.
- After seeing many of our residents escorted by MPD and returning to the shelter within several hours we have virtually stopped trying to access BHD's services.
- Access to psychiatric crisis services has remained extremely inconsistent. I question the true motive behind PCS staff, when they return violent and aggressive individuals to the community because they are 'stable' (even though they threatened violence) or refuse to participate in counseling.
- I feel it has stayed about the same for adults. There was a significant need for crisis services (mobile, day treatment, and inpatient beds) for children and adolescents. I am not aware if this need has been met with the opening of Roger Memorial Hospital's Brown Deer campus.
- Same? Difficult, except for short-term stabilization (where they screw you)
- Needs to be more diverse utilizing community hospital beds for MH AODA service
- Decreased due to bed closures; however, I'm not sure this is entirely bad. Community-based services are preferable in my view in all but most serious situations.
- Access has reduced - with closing of beds, waitlists and staffing shortages.
- I would need more involvement to make a more informed opinion.
- will improve with Rogers opening Brown Deer hosptial
- If is very difficult to access service for a patient require acute stabilization and medical management. This is increasing more difficult especially for individuals who are on an involuntary commitment. They are often the individuals that need stabilization the most and have the most difficult time access acute care services. There is a missing service level in the system for individuals who have acute needs. The system could benefit from an intermediate level of care between acute hospital and the CRC. This level of care would have increase LOS.
- improvement in Access clinic

- Closing of inpatient beds at BHD was problematic at times. Availability of crisis resource beds in the community eased that somewhat.
- Units have closed and the number of consumers admitted inpatient has decreased - more on OBS, not admitted, or transferred to private hospitals due to no space.
- Now that more folks have insurance, they have somewhat better access to inpatient treatment.
- The county has eliminated many hospital beds without putting in place a robust community support system.

## What do you believe are the most important priorities for the 2016 Behavioral Health Division Budget?

- Crisis intervention
- 1) T19 psychiatrists 2) child psychiatrists 3) CSP medication administration & management 4) Increased transportation for T19 5) Improved transportation - long waiting time
- to increase it
- Proper implementation, monitoring & control
- Accessible services in the city transportation Available psychiatrist to provide service
- room for doctors who take T19 patients
- Quality inpatient services. There is a horrible stigma about County Mental Health facility due to all the problems that have existed for years; it is not felt to be safe, and the quality of services is poor in many cases.
- -Access to psychiatrists for low-income people (Title 19 or Medicare)
- -funding for intensive service enhancements such as peer support -seek creative ways to work with the full community on systemic change - not just well meaning people who ultimately are not heard by the stakeholder who has the access to $$
- AODA inpatient
- Expand CRC hours to include 24 hour intake (at least for CIT intakes) Expand to 4 CRCs Expanding mobile crisis Expanding CART with MPD and include CART for the Sheriff's Department as well. Expand Access Clinics CCS needs to be fully implemented Employment programs(IPS etc)
- Crisis services Housing Training of the police
- Access to psychiatrists, CCS, CSPs and TCM. Increase in affordable housing including supported, independent and transitional. Increase in mobile crisis services including with police. Development of peer run respite centers and increase in peer run drop in centers in multiple locations throughout the County. Reduction on focus of inpatient care and increase community based services.
- Community-based services. Down-size the hospital and provide services in the communities where people live, work, worship and recreate. A large hospital is not cost-effective or necessary for the largest segment of people living with mental illness.
- Community Access Points
- CIT training, better resources for consumers. Strengthen the social service net work. Relieve the load on already overloaded case workers, and TCM's
- Building or renovating buildings to serve as crisis centered safe places during crisis. Hiring local providers for staffing new structures and older places. Provide stipends for people to increase their educational background to help relieve shortages of professionals. (From Psychiatrists to peer specialists) and not privatizing services from out of state corporations. Initiatives in education for destigmatization of the mentally ill and addiction. Working collaboratively in the Milwaukee County community, of the various non profit and for profit groups, for increasing the care, ethical treatment and respect for people with the disease of the mind.

- Continued support for CCS Community-based crisis stabilization Expansion of the Crisis Mobile Team
- Providing more community supports
- Access to case management/SAIL and outpatient services
- The increase of community based services.
- Increased funding for crisis mental health services. Increased funding for community mental health services.
- Long term stabilization.
- Advance the Milwaukee County system redesign that has been called for in many reports by investing in a major expansion of community services and community based crisis services. Ensure continued access to inpatient services for people with mental illness who rely on county funded services. Without quality housing, mental health cannot be maintained. Continue to build on the positive efforts to date to expand access to housing and to advance a Housing First model.
- Services should not just be based in the community, they should be community driven.
- Housing options for both long term and short term re-entry of offenders being released from correctional facilities.
- Increase amount of services in the community and community education to reduce stigma and increased supportive services for individuals and their families
- The BHD budget needs to reflect a priority in providing greater services within the community from outpatient to inpatient services if needed. Priorities need to be placed on increasing available service to individuals and families who need them, much less planned for or spent of facilities in Wauwatosa, (which is not truly within the community either)Intervention before prior to need for hospitalization and swift transitions to outpatient services following a crisis treatment episode, is much more cost effective and has a greater impact on overall successful recovery and safety in our community
- More funds for Community Case Management, TCM and CSP slots.
- Decrease the wait time for community services. Individuals who have been approved for services are being lost in the wait list process.
- Downsizing the hospital and transitioning to a smaller capacity Transitioning the focus from the hospital and expanding its scope to truly include community services Improving Q & A for all department areas and programs, with a specific emphasis on inpatient
- Improving community supportive services. There are a lot of homeless people who do not get the case management services they need because the wait list for services is so long, even if the people are appropriate.
- Easy Access or community members and agency referral sources
- Open an ACCESS center for people with Badger Care.
- When speaking to the Milwaukee Chapter of the Wisconsin Psychiatric Association, County Exec Chris Abele said the top two priorities of his administration were fiscal responsibility and helping the most vulnerable members of our society. The most vulnerable individuals with mental illness today are those with severe or treatment-

refractory mental illness who don't respond easily to the preferred model of community-based treatment. They are individuals who visit ER's and PCS hundreds of times and are victims of the revolving door of brief acute care. I think the most important priority for BHD is to join with community partners to create a high-level, multi-agency work group that looks at the treatment of individuals who are falling through the cracks and tries to come up with solutions for them. These are the most vulnerable member of our society now--the ones who don't neatly fit our prevailing philosophy of what's supposed to work. The budget should allocate resources to this work group in creating the kinds of housing and programing that the most challenging individuals need.

- PSH for those dealing with severe mental health issues and homelessness.
- Quicker access to psychiatrist
- Housing for those with MH issues and very low income. Also age appropriate recreational opportunities.
- acute people who need longer term care and people being released from jail without medication refill or a psychiatrist
- Milwaukee County should take a leadership role in ensuring individuals who now have insurance can navigate the system and get treatment, rather than just refusing them service because they are insured. Individuals with severe mental health issues often 'sun-down' and become more symptomatic in the evening. It is critical for reasons of safety and human kindness to increase Mobile Crisis teams in the evening. I don't know what the right process is, but Milwaukee County has the access to systems that could be helpful in helping the community providers ensure that individuals in need of psychiatric medications can get their prescriptions written and filled in a timely fashion - before symptoms escalate.
- Continued access and education of public service workers, including first responders
- Access to psychiatrist.
- Rehabilitation & Recovery Model-based -Model is short-term Assessment Program at CWC
- Expansion of CCS & array of services
- Community-based services - outpt/case mgmt. Community-based crisis services Peer-run resources
- 1. Hospitalization - short & stabilize: Timely, Friendly, & Discgarge 2. Community CRCs & housing available 3. More case management - TCMs, CSPs, CCS - More array with case management
- Crisis intervention and community education/advocacy.
- Expansion of community services Control inpatient costs
- 1. Ensure that the system maintains adequate acute services for individuals enrolled in services. 2. It is important to expand capacity clinical treatment services like ACT, Partial Hospitalization and OP while increase the strength and funding of current programs. Current program require ongoing increases in funding to keep pace with raising cost of providing health care and retain adequate staffing. Increasing the funding would allow current agencies to employ more clinical treatment staff supporting the

increased needs of patients living life in the community. 3. Service need to continue to grow that are recovery-bases, trauma and co-occurring capable. 4. Dedicate more resources to the development of CCS Capacity Building tool that provides members assistance in coordination and access to care. This would fundamentally become the Adult Wraparound Model supporting the total health of patients. 5. Increase funding to support priorities set forth by SAMSHA including integration of primary and behavioral health care in addition to trauma, recovery and additional treatment. Total Health Approach. 6. Develop psychiatric homes where agencies can access integrated, coordinated services from single providers changed with providing the accurate level of care for patients level of function and wishes.

- NOT the building. Ongoing support for those are now in the community.
- expand community based services at all levels possible in the community
- More consumer access to mental health treatment both inpatient and outpatient.
- 1. Continue to fund community based services 2. Expand community crisis response capabilities, especially MUTT and CART 3. Expansion of peer run, community based services.
- Community based crisis services.
- Less waiting for CCS, TCM, CSP referrals and the need for all levels of housing for clients that have no income, small income, or need support.
- Housing programs for individuals who are in need of transitional living to work on recovery and long-term wellness. Also, more community based programming that offers peer support. Increased utilization of peer specialists - to include funding to train peer specialists in the county and programming to support individuals in obtaining and maintaining employment. To meet the needs of individuals who don't necessarily need long-term case management and supported housing but who do need a stable living environment and meaningful/purposeful work in the community.
- MORE COMMUNITY SERVICES WITH LESS BARRIERS IN OBTAINING THEM!
- Quality community mental health services - eliminating the waitlist that currently exist for such services. Providing immediate access to such services can help for a better transition from the inpatient to community setting.
- Community redesign to a model of greater access
- Increase community services budget. Increase mixed use housing for those with a mental illness. Make services more accessible- which means putting in place many clinics in various locations across the city.
- Peer support services
- Increased attention to child, youth and family mental health services -especially earlier intervention
- increasing access to crisis and emergency services
- Using CCS correctly to the fullest extent Increasing reimbursement rates for residential treatment--the numbers have been stuck for more than a decade Increasing opportunities for safe housing for those receiving substance abuse/mental health services.
- expand community services. Hire qualified, competent staff

- Increase/improve access to psychiatric services
- Having resources at the inpatient level, crisis services and community-based services
- The need to invest in community mental health services

## Please note any community services that should be prioritized in the 2016 budget.

- more inpatient facilities
- -transportation is poor - long wait times, clients miss appointments -housing
- Health insurance Student support services that cater more to students with behavior issues
- more accessible psychiatry
- -More case management (SAIL) & Housing opportunities
- School-based peer support & counseling services stigma reduction in schools and families
- ACT Peer Support IPS CCS
- Housing CIT
- Expansion of CSP, TCM and CCS programs to prevent wait lists. Availability of peer run drop in centers in multiple locations throughout the County. Access to psychiatrists within a reasonable amount of time.
- Peer Run drop-in centers in neighborhoods across the city where people can go and receive Peer Support from Peer Specialists or other peers. Create a safe space for sharing their fears, dreams, goals and encourage and support peers in reaching their goals. This would lower the admission rate to the hospital and promote a truly person-centerred, trauma-informed care approach to Recovery. Admission to hospital should be a last resort, not the first.
- Community Access Points for care where needed. More CIT training and additional community crisis teams
- Resources for caregivers, family. More community service centers for Mental Health consumers.
- More services for co-occurring AODA and mental health issues. In and outpatient care. More services and providers for the communities of color with culture sensitive care. More education with first responders who have contact with the mentally ill, drug users and co-occurring clientele of how to serve and care for these individuals.
- Comprehensive Community Services, Affordable safe housing
- Housing
- Housing
- CSP and Targeted Case Management, peer counseling, drop in centers, IPS employment services
- Would like to see more drop-in centers, especially on the north side.
- Long term stabilization.
- Providing increased staff for community services to aggressively implement CCS and enroll to capacity; staff to provide more robust quality assurance for community programs. End waiting lists for community services. Establish community resources centers on the north side and central city which can be entry points for learning about mental health, about services and programs, and to get assistance with determining eligibility and enrollment; Maintain and expand a continuum of housing options from

intensive support (CBRF) and respite, to supportive and transitional housing, and independent living. Should include expansion of the Housing First model proposed by the Housing Division. Additional benefits specialists for the Disability Resource center

- There should be some funding availlable for primary and secondary prevention to stop the need for more criaia and/or inpatient services.
- *Psychiatry resources, especially for the 18-59 year old population diagnosed with IDD
- The house of Correction has worked very diligently on establishing a system for health care enrollment prior to offenders being released. The system is in place however there is no staffing available to accomplish this task. Currently case managers are enrolling only those that have not enrolled previously and this only occurs on a part time basis. A full time person could enroll or reestablish health care benefits for 80% of offenders.
- Increase amount of services in the community and community education to reduce stigma and increased supportive services for individuals and their families.....Targeting families, in particularly in education of young mothers and fathers and offering incentives to completing ongoing parenting and educational engagements as a way of prevention and early detection and intervention of mental health concerns (possibly great future benefits). Also, increased encouraged community and student involvement/input and use of technology to reach youth as an educational and engagement tool (increase community buy in and ownership).
- mobile crisis units, increased capacity for community based treatment with a greater number of community based Behavioral Health providers, increased opportunities for targeted case management services, shelter care and transitional housing opportunities as well etc.
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- TCM and CSP
- Increase CSP slots. Benefits assistance that uses the SOAR model. Establish a peer run respite center.
- Decreasing wait times for CSP and TCM programs Getting CCS up and running with increased enrollment efforts
- ACCESS clinic for INSURED patients.
- Third shift mobile team, third shift admission staff for the Crisis Resource Centers, and the challenging patient work group described in #5.
- A liason from BHD to work with the shelter providers.
- Transtional housing and more housing
- Housing
- Increase CCS services.
- Increase the availability of peer supports. Continued community education.
- ST Inpatient assessment Rehab & Recovery based model Mandatory CIT training (40 hrs)
- Certified Peer specialists Psychiatrists Employment models

- See #5.
- See above. Plus psychiatrists & therapist who take Title 19/Title 19 HMOs. No longer an uninsured but an under insureds.
- Emergency access & community living integration
- outpatient therapy and med management CSP (ACT model) supported housing employment services
- 1. Intermediate level of care as another alternative for acute inpatient. 2 Fully expand and implement CCS across Milwaukee County. 3. Expand CRC models who have mobile crisis capability geographically accessible throughout the Milwaukee County.
- Mental Health awareness training's for the public as well as human service workers, law enforcement, and state and city officials.
- 1. Peer support 2. Community based crisis response
- Community based crisis and case management services.
- More AODA/MH treatment providers so clients can be seen quickly. More organized activities in the community for stable clients.
- More community based programming offering social and recreational activities for individuals to build a larger community of individuals living in recovery. Support for employers to embrace the recovery model to enhance and promote systems level change.
- All levels of community case management/support; the ability to provide "bridge scripts" by the Access Clinics so folks aren't running out of meds before they can see a provider; DECENT affordable/supportive housing.
- Community Support Programs - it seems that many of individuals receiving TCM services would be better served by a CSP (and likely would be if they were not in such a resource strapped community as Milwaukee). I realize that resources are scare, but providing the appropriate level of community support would help decrease crisis services for these individuals and reduce staff turnover in TCMs.
- all of them.
- Community Support Programs, Targeted Case Management Programs, Respite Centers, Housing, CCS services
- Community aware events that support consumers and their families.
- early childhood mental health consutlation school based mental health services
- respite houses
- See above
- crisis services trauma-based treatments employment transitional housing/supportive housing
- Outpatient mental health/aoda treatment. Improved access.

## Please note any crisis services that should be prioritized in the 2016 budget.

- shorter wait times for admissions
- more services & crisis teams available
- -Mobile Crises Teams
- Expansion of mobile crisis  Expansion of CRCs  Expansion of CART to include Milwaukee County Deputy
- Increase intake coverage to 24/7 at Crisis Resource Centers. Increase number of mobile crisis teams working with police.  Develop peer run respite centers in Milw Co.
- More Peer Run Respite centers, where those experiencing a crisis can get the compassionate care they need to work through the crisis. This would be a golden opportunity for a better and greater spirit of collaboration between "professionals" and peers. Make it a "one stop" center where those in crisis can feel more in charge and less threatened.
- CIT training and additional community crisis teams
- Again the training with Police officers for CIT is absolutely crucial
- Police and mentally ill interaction.  Needs to have speciality CIT teams of officers on each shift who really care about citizens with mental illness and addiction issues.  These officers want to learn to give better services to help protect the ill and encourage working with the ill with respect and just ways.
- Crisis Resource Centers
- Walk-in centers
- Increase mobile crisis
- Providing them might be nice.
- Mobile crisis unit teams.  24/7 access to crisis centers...in multiple locations.
- Full assessment team to communicate with any peer support services.  Appreciation for peer specialist who walk with consumers on a day to day path.
- Develop community based crisis assessment capability including neighborhood crisis assessment centers and significantly expanded mobile crisis response teams - including peer specialists.
- *Increased Crisis Services for persons dually diagnosed with dementia and a mental illness
- Mobile crisis units , increased capacity in access clinics in central city northside , & southside  Reduce wait times and coordinate with increased # of community based providers  etc.
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- Expand mobile crisis teams and continue working closely with MPD
- Review if current resources can be more flexible with who can be served, e.g. can an individual go to Crisis Respite who is not taking medication?
- Expansion of Mobile Crisis
- ACCESS clinic for INSURED patients, so that crisis services are less in demand.

- Milwaukee County has a state-of-the-art crisis service based on the New York CPEP model (Comprehensive Psychiatric Emergency Program), which integrates multiple components: a psych ER (PCS), observation unit, mobile teams, crisis line, urgent care clinic and community respite beds. It's a hidden gem of our healthcare system. The latest literature (see Zeller, West Jour. Emerg Med) shows the cost savings that derive from a dedicated, regional psychiatric emergency service. Preserve it. It's better known and more highly regarded outside of Milwaukee than it is in Milwaukee. Top emergency officials from Illinois, Minnesota and Nebraska have visited to learn about best practices in psychiatric emergency care. Its location in immediate proximity to adult and child ER's is particularly crucial, especially in light of all the concerns raised about medical care in the County patient population. I think the Crisis Service's headquarters and PCS should be kept at the Milwaukee Regional Medical Center, while expanding mobile outreach and community crisis bed capacity for the less severe cases. There is always room for improvement, and the Crisis Service's ongoing program and staff development should also be prioritized.
- Crisis services for the elderly, an area that services need to be increased. We have seen an increase in 60+ residents with significant mental health issues.
- Connection to medications for those with Title 19 coverage.
- Expand hours of 2 crisis resource centers
- More Respite housing for those who just need a break away from stressful situations.
- As described above -- Mobile Crisis. Find a way to better utilize crisis stabilization houses.... right now making clients eligible (on meds) is laid on the shoulders of case managers in community settings, who may not have the right access to supports or knowledge of mental health issues.
- Expanding the mobile crisis teams
- Improved training for Dispatchers (including fire & EMT)
- crisis resource respite adult foster homes for respite
- Mobile capacity crisis resource centers Training in crisis intervention for other service systems, e.g. homeless services, churches
- Our goal should be prevent crisis. A complete array of services should help.
- Night time crisis support
- mobile alternatives to PCS - creative
- 1. Maintain acute inpatient capacity to the suggested level in the HSRI Capacity Study report. 2. Negotiate with general medical hospitals a collaboration creating opportunities for med/psych capacity.
- Out reach
- crisis resource centers need to be open 24/7 to accommodate all shifts if we expect police to use these resources
- Mental health crisis services.
- 1. Mobile response 2. Crisis stabilization beds as emergency room and inpatient diversion resource
- 24/7 mobile crisis teams

- More staff available to respond to the need. Mobile Crisis team cannot go out on every call, and despite the MPD having trained officers, it appears to be a lack of concern for homeless clients who are often treatmed as criminals instead of people with a large assortment of needs.
- Quicker mobile crisis response times; seeing if PCS would writer more scripts for clients so they don't run out before they can either see their provider or find one (most community providers are booking weeks out).
- Mobile crisis team (partnership with MPD and specially trained CIT officers)  Additional CRC beds
- Mobile units should be at least 3 for county
- Crisis Resource Centers,  Emergency Clinicians, Crisis Mobile Teams, CIT Teams
- Pre-crisis peer support
- resoring MUTT's dedicated team for MPS
- more availability for psychiatric medictions at low or free cost
- AODA and mental health  Having crisis workers be available for community-based services 24/7 - a team of two that can go out on calls
- Expansion of mobile teams and CIT training

## Other suggestions?

- more family & community services than can assist our young population with positive solutions & can get them on the right track and keep them there.
- Less hospital - more community-based services. We've been talking about this for years now and for some reason the BHD has this "strange and weird" control over the services people living with mental illness receive. The BHD hospital needs to be torn down, replaced with a smaller hospital and more monies put into community-based services. People do better when they are surrounded by a loving, familiar, place where they can heal, grow, and recover. Recovery does happen!
- TRANSPARENCY Collaberation
- Access to SAIL
- Open another crisis diversion site.
- More peer support on crisis team.
- The Mental Health Board is new so understand still in learning mode. For the Board to be successful, they need independent staff who report to the board and can provide research assistance, financial analysis, assist with meeting logistics, and be a liaison to the public - supporting requests from the public to the board, and responses from board members. At this time, there is no way for members of the public to contact the board - that is shocking and unacceptable. The MHTF would never have support such a structure - the board has oversight over hundreds of millions of public dollars and must be accessible to the public to answer questions as well as consider input.
- build greater bridges that result in actual services to community members in need of them, work with existing community based resources for support the vision for redesign of effective community based mental health and substance abuse services presented at the end of the Mental Health Redesign process by the Cultural Intellegence Action team is the most practical and compassionate map to follow for our communities needs. While utilizing existing facilities as well as building partnerships with community based providers for both inpatient and outpatient treatment needs we come much closer to actually supporting positive change and a more compassionate as well as practical behavioral health care system.
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- More CIT follow up training.
- I have been experiencing difficulty with mental health DX paired with lower IQ. The low IQ disqualifies people from being in a CSP, but the mental health DX (or even dual DX)

keep the individual from being served by disability services appropriately. This leaves a lot of very vulnerable homeless people without a proper entry point into mental health and supportive services.

- With better access to mental health providers, the demand for crisis services would be less, as would other community problems that come with a lack of mental health care.
- The Crisis Service is something to build on. It already pays for itself, but if it added a telemedicine capacity it could provide much-needed psychiatric emergency services around the state, as well as developing a new revenue stream to help support the mission of BHD.
- more efforts to include family members in the clients' plan of care would be nice.
- Somehow we need to come together as a community ... not Milw. Co. against community agencies. There are too many providers who are unable, uninterested or ill equipped to effectively serve people suffering from mental illness. We need someone to take the lead. Milw. Co. has not done that yet.
- Improved software & communication systems for differentiating Mental Health situations (for police & fire) - at Dispatch Centers ACT LIKE A REGION - New County Executive in Waukesha
- If ongoing services are available (treatment, meds, peer supp. case manage.) less crisis should occur.
- Investigate alternatice therapy & rehab services, i.e. hypnotherapy, organic farming, music, etc. (partners)
- Inspire a coordinated, non-adversarial, professional partnership with the system stakeholders supporting the future development of the mental health system in Milwaukee County. The system leaders including the County Executive, DHHS Director and BHD Administrators have been very effective in improving and supporting the system. Because of their leadership the system general has shown results promoting improved health outcomes for patients.
- Increase capacity for access to psychiatric services and free or low cost medications
- More education within the community to inform and assist.
- Figure out a way to get rid of all the waiting lists.
- More Peer Support and Drop-in Centers
- I do believe in peer support and the services that peer specialists can provide; however, how we employ and utilize peer specialists is something that I cannot support. There are trainers who are training that don't understand the concept, employers who employ who don't understand the concept nor understand what it takes to support a peer specialist and now we have gotten away from the true model of peer support. It saddens me that we have monopolized on this service provision and destroyed its integrity along the way.