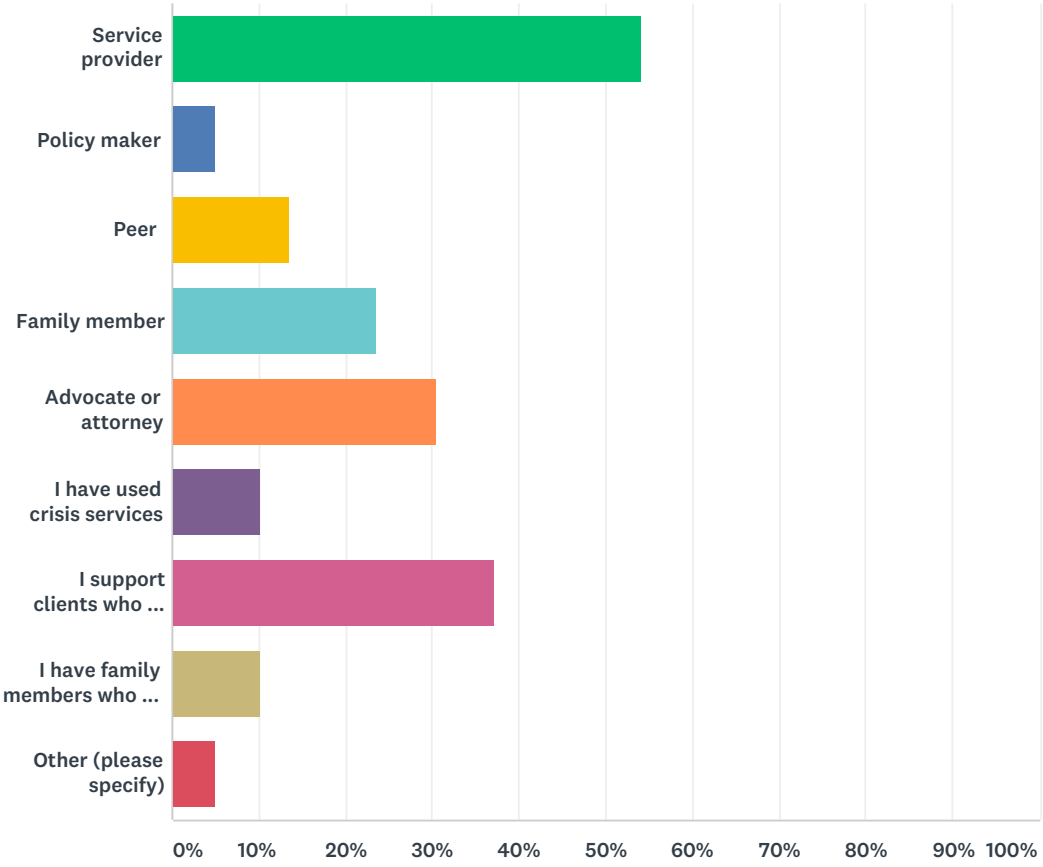
Q3 What is your role? Check all that apply

Answered: 59 Skipped: 1



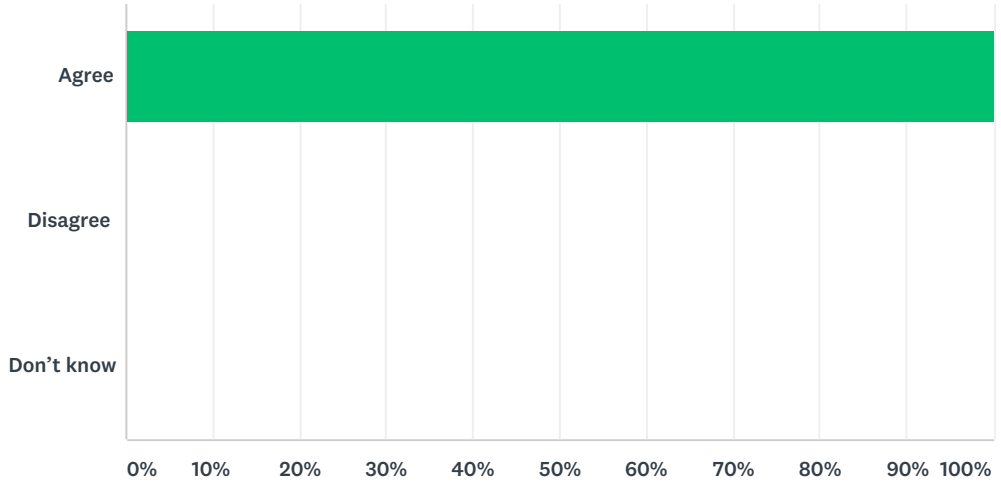
ANSWER CHOICES	RESPONSES	
Service provider	54.24%	32
Policy maker	5.08%	3
Peer	13.56%	8
Family member	23.73%	14
Advocate or attorney	30.51%	18
I have used crisis services	10.17%	6
I support clients who use crisis services	37.29%	22
I have family members who use crisis services	10.17%	6
Other (please specify)	5.08%	3
Total Respondents: 59		

#	OTHER (PLEASE SPECIFY)
1	housing
2	Community member

3	Friend of murdered Mother who could not get the help she needed in time despite years of seeking answers. No one ever told her she could file for guardianship of her adult son.	

Q4 The report recommends that Milwaukee: “emphasize and invest in crisis prevention and resolution at earlier stages of a crisis, before more intensive, costly, and potentially restrictive interventions are required. Toward that end, substantial improvement and expansion of community-based resources like crisis resource centers, mobile crisis teams, crisis stabilization houses, and community-based access clinics is recommended, as well as the creation of enhanced crisis communications, navigation, and patient tracking systems." Do you:

Answered: 60 Skipped: 0



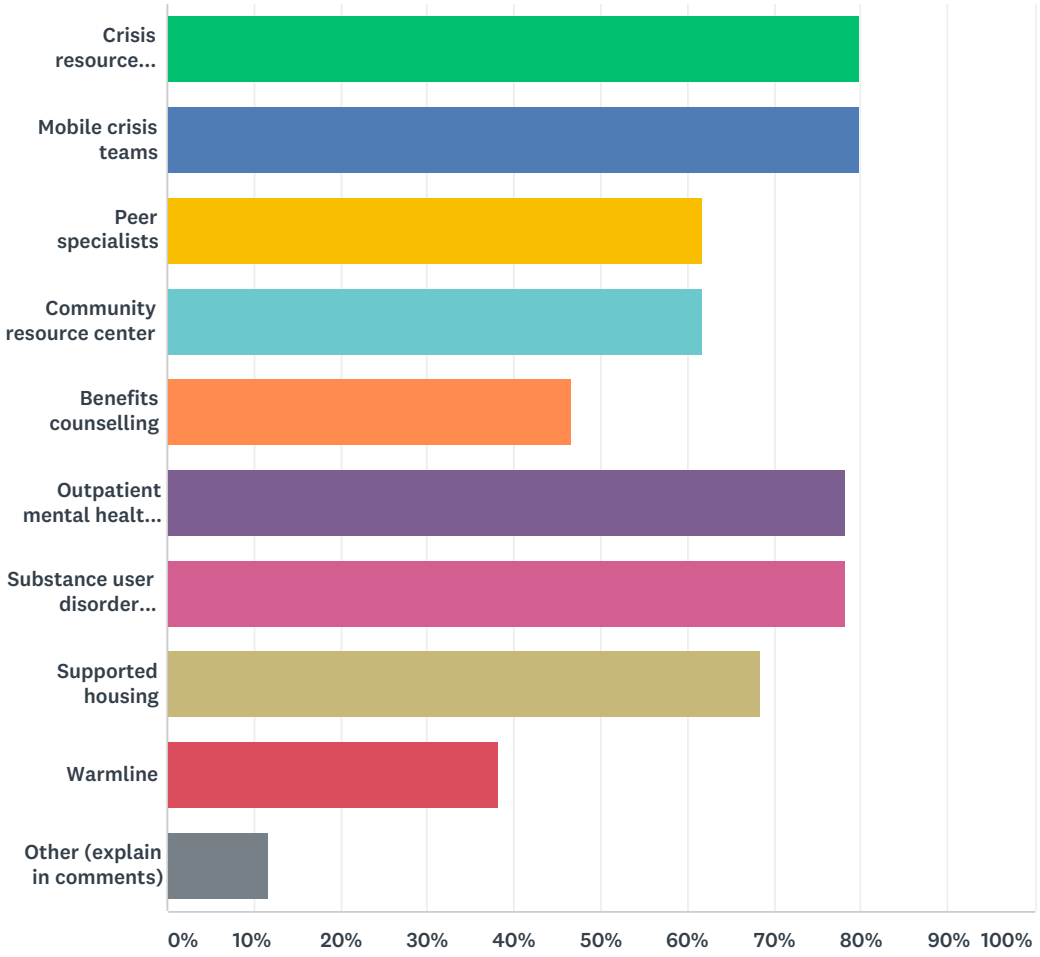
ANSWER CHOICES	RESPONSES	
Agree	100.00%	60
Disagree	0.00%	0
Don’t know	0.00%	0
TOTAL		60

#	COMMENTS
1	I strongly support this recommendation but worry about the timelime and the dollars. Progress to date in expanding community crisis services has been modest - we have seen some very positive incremental changes (additional CART teams for example), but not the system transformation that is needed. We continue to have a system that is fragmented, siloed, confusing, and difficult to access.Any redesign must provide for navigators to support people in accessing services, and to engage them as partners. There is consensus and good intent around the philosophy of "no wrong door" but our community has a long way to go to actualize that vision. Significant expansion is needed by both the private and public (county) sectors and that includes additional investment, as well as leveraging key partners such as the FQHCs. It's important to develop a detailed road map of the needed resources and partners, with timelines and fiscal estimates. Most important - stakeholders must be at the table including those who use crisis services, advocates, providers, family members, and participants must be representative of the diversity of our community,
2	The elephant in the room is the workforce shortage. Not enough psychiatrists, APNPs, or social workers and case managers.
3	It has been my experience that there is such an enormous need that the goal is to deny services to those that really need help because there is no funding to help them, or place to house them.

4	Sounds good but somehow that money never seems to make. it into the community. The unions are always more important than sick people who need help. Don't get me started on the politics of this issue over the years. Everyone counts as more important then the people who need medical care. If mental illness was cancer this would be a non issue. It is and has been clear for years that the whole BHD inpatient mess did very little to protect ill people.	
5	We need many more crisis mobile teams who can assist/assess clients.	
6	Not enough resources available.	
7	I truly believe if someone reaches out early it can help the person and be cost effective in the end	
8	I believe it is always in better practice to try to alleviate a situation earlier on versus waiting until it becomes out of control. I think Milwaukee investing in preventative methods will in the future become cost effective.	
9	The problem is when a crisis mobile team is determined appropriate, then the operator tells you they don't have any teams they can send out. The intent to prevent is good but will you really staff for the volume and complexity of service needed?	
10	However, there will still always be a need for inpatient services for individuals as well	

Q5 As the crisis service system is redesigned, what types of community-based services and supports should be prioritized? Check all that apply:

Answered: 60 Skipped: 0



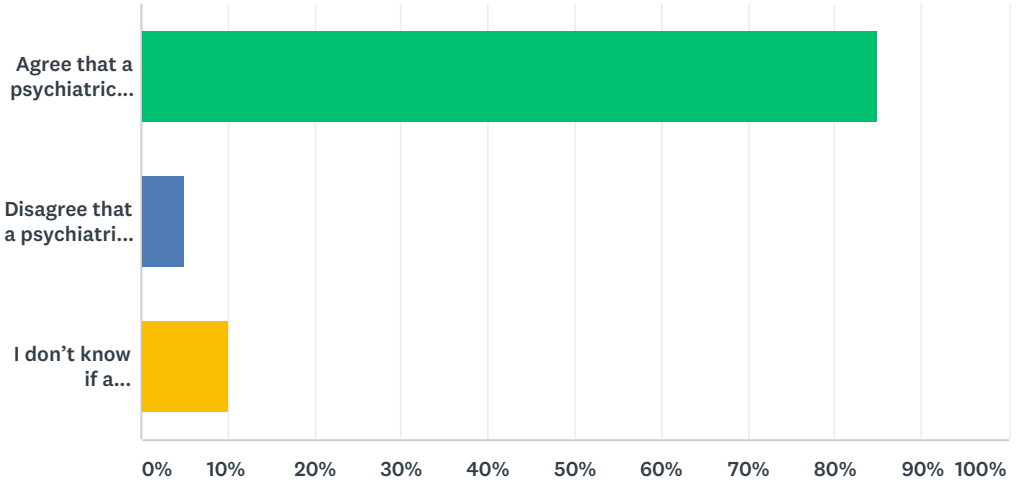
ANSWER CHOICES	RESPONSES	
Crisis resource centers	80.00%	48
Mobile crisis teams	80.00%	48
Peer specialists	61.67%	37
Community resource center	61.67%	37
Benefits counselling	46.67%	28
Outpatient mental health services	78.33%	47
Substance user disorder treatment	78.33%	47
Supported housing	68.33%	41
Warmline	38.33%	23
Other (explain in comments)	11.67%	7

Total Respondents: 60

#	COMMENTS
1	It would be helpful to have longer term temp housing for people who are waiting for benefit approval as being homeless is very stressful.
2	System navigators will be key. These can be embedded in all community services including those listed above and many more, but there will be a need for central coordination and support of the navigator function and related resources. training for first responders in law enforcement and emergency rooms is also a top priority, Community resources must also address how to meet the needs of people with developmental disabilities (such as autism) and co-occurring mental health needs. There should also be coordination with the Family Care MCOs who play some role in crisis coordination and prevention. Needs of older adults with dementia must also be addressed.
3	The community also need more crisis stabilization and less burden in billing under DHS 34. The county could share its license with trained providers.
4	Expansion of Crisis Stablization housing centers with stays longer then 30 to 60 days. Possibly as long as 6 months.
5	Supported housing would decrease the need for hospitalizations, on site staff could address issues before they a crisis.
6	Well-all are important! In terms of deciding, perhaps prioritizing based on funding that would be available, how could existing services be expanded and looking at "low hanging fruit" to achieve success at having those items in place. Push hard to the philanthropic community and/or build a fundraising capacity to carry out the plan and not be so dependent on tax roll dollars and other vulnerable sources of income. How can Medicaid fund and support these activities as well (housing for one)?
7	There is a significant gap in services available between outpatient mental health and in-patient/hospitalization. Many individuals do not qualify for (or have funding for) inpatient mental health even if it is available in the community. IOP or Day Tx for Mental Health would be beneficial.
8	Lack of housing for those to go in general and/or after treatment.
9	"Crisis" comes in many flavors and hues; they ALL need to be able to be addressed in every way possible.
10	Although all of these areas even the ones not checked are supports needing to be prioritized. We have to keep in mind there is no one size fits all service when addressing different people with different situations and offering services for same people with same situations (e.g. heavy utilizers). I believe that each area has its pros and cons for the way one can be prioritized when becoming a community-based service. I believe that mobile crisis teams from my experience has not been thorough in their need to respond but could be useful if they were available.
11	all are critical.
12	Medication/prescriptions. Psychiatric treatment. Detoxification and follow-up assessment. Brief hospitalization for med. stabilization
13	Clubhouses - Grand Avenue Club in Milwaukee
14	Given the shortage of psychiatrists and extended waits/delays to be seen, we need the access clinic to be available to those with Medicare and Medicaid.
15	There must be follow up and I also think a family resource center, guide or SOMETHING must be set up. there are too many families in need and they don't know where to turn or how to get help.

Q6 The report recommends that “A dedicated psychiatric emergency department still will be needed as part of the continuum of psychiatric crisis services." That facility is expected, however, to serve a much smaller number of persons than BHD’s current psychiatric emergency department and a narrower population limited largely to individuals on petitions and those who require highly specialized, intensive care for their complex needs.What is your perspective on the need for a dedicated psychiatric emergency room in Milwaukee?

Answered: 60 Skipped: 0



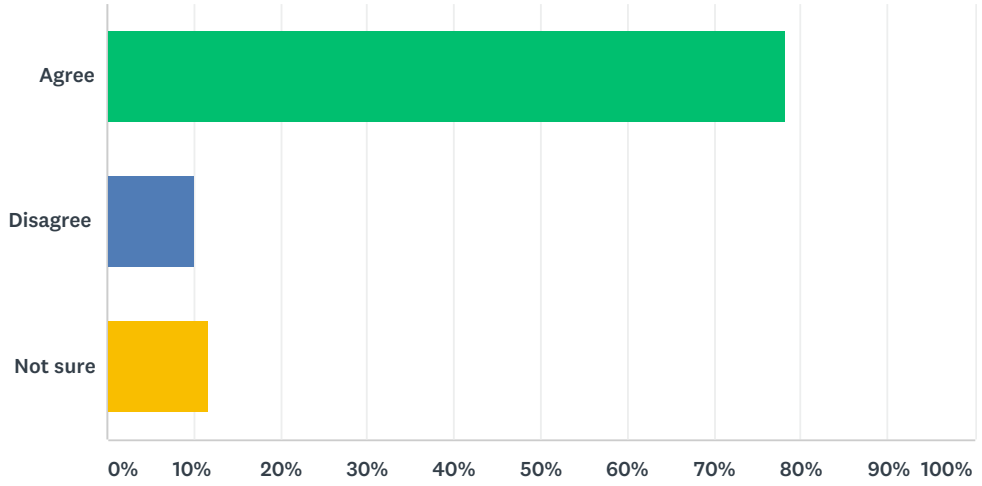
ANSWER CHOICES	RESPONSES	
Agree that a psychiatric emergency room is needed.	85.00%	51
Disagree that a psychiatric emergency room is needed.	5.00%	3
I don’t know if a psychiatric emergency room is needed.	10.00%	6
TOTAL		60

#	COMMENTS
1	Why can't this need be allocated across all of the healthcare systems and have all of the ER's be an access point for any healthcare issue, including mental health?
2	While I can see value in a psychiatric emergency room, I worry that it will result in other hospital ERs deflecting their responsibility and we will have PCS all over again. I also worry that not enough community capacity will be in place resulting in overreliance on the emergency room, as well as people in crisis ending up in jail because there are not options available. The system must also factor in how to serve people with developmental disabilities such as autism and co-occurring mental health or behavioral challenges.
3	This is hard one as it's a cultural shift. The community knows PCS and what ever hospital becomes the psych ER will be known as the "new PCS." All the hospitals need to enhance their crisis mental health services.
4	Do not stop this service. We need a dedicated psychiatric emergency room in Milwaukee. I have been a social worker In Milwaukee for 20 years. It is essential.
5	I believe more than one location is necessary.

6	What is a best practice for this type of service? What is being done in other urban and large metro areas to accommodate psychiatric emergencies? Once something is built you will have to live with it and not just a duplication of what is already available that doesn't seem to work well.
7	And there it is! The mentally ill are so unimportant that emergency crisis services be restricted even more than now. Are there no prisons or workhouses? Expect the suicide rates to rise. I guess saving people with cancer is a very good thing but saving the lives of mentally ill people seems not to be a priority. Hmmm, brain disease - cancer are both killers but mentally ill people are ignored by our community. Perhaps we should just keep chucking them into the jail/prison system. That costs more and is horribly draconian but that is what we do to "Those People" the human beings that suffer with mental illness.
8	Yes, a dedicated psychiatric emergency room is needed and plays a critical role in the community. Especially if someone is not connected with any other providers they may not know where else to go. However, having multiple locations that are more accessible would be beneficial.
9	Many r in crisis and need Emery care.
10	But not passed on to private hospitals.
11	Yes for those with extreme crisis situations.
12	I strongly bring to the table the idea to use three or four of our most utilized hospitals; St. Joes, Mt. Sinai, and one or both of our south side hospitals St. Luke's or West Allis. Each one will operate as a sub-ER area on site. I believe no matter what mental health services are set up in Milwaukee people with mental health needs are always going to go to the ER. Most hospitals have unused areas that can be converted to Specialized areas to accommodate and treat these individuals. There they can have mental health counselors, psych nurses, peer specialist and other supports to provide the treatment needed. If there is exceptional cases then there can be a wing of the hospital designated to treat these individuals. It is contradictive to say they want to treat mental health like a medical condition if they are treating them separately. Hospitals are large enough to support mild to moderate crisis. For severe cases than they can be directed to another facility. I also think that mobile crisis and other staff could rotate their shifts between hospitals so the services are integrated and consistent and it is not a practice of north and south being better than the other. Mental Health facilities of any kind will still pose the risk for being stigmatized and underused compared to regular ER services. If they were to set up an adjacent Mental Health ER center within the three hospitals and call them North, South and Central after a patient has been assessed and treated a treatment plan of aftercare can be created illustrating what they will need. Information for the plan will be shared amongst the ER and partnering services so treatment remains consistent amongst patients and depending on what is going on with the patient a plan will be put in place for them to follow up with a psychiatrist. Depending on availability a patient can be referred to one of the crisis or community support centers depending on their acuity they can stay at one of those community based locations until a psychiatric appointment or medication stability has been achieved. Mobile crisis teams can assist with transport and/or other staff can work as short term crisis coordinators.
13	This is simply re-creating the past
14	Don't want the services to become social institutionalizes that undermine the services to the individual.
15	Needed for stabilization of medications and connection to appropriate services.
16	We obviously need a place for people to go in a time of real emergency need. It must be accessible for all.
17	There are times when someone's mental illness is acute and inpatient treatment is necessary. These services should not be narrowed to those on petitions. While many do not experience acute stage of illness, the prevalence of 1 in 5 affected still makes for a significant number of individuals who will experience crisis. This is further necessary given the shortage of crisis mobile teams.
18	Yes, it's needed. A young man who threatens his mother is not "better" in 72 hours. This fallacy must be changed. Any monetary incentive for reduced numbers should be abolished. It does NOT mean we are successful. It means we have left folks to their own devices with often disastrous results. .

Q7 The report recommends "An increase in private hospital emergency department service capabilities." Do you:

Answered: 60 Skipped: 0



ANSWER CHOICES	RESPONSES	
Agree	78.33%	47
Disagree	10.00%	6
Not sure	11.67%	7
TOTAL		60

#	COMMENTS
1	I think all of the healthcare systems should be a point of access for all community members. They are already being sought out by community members but are often turned away or given poor service.
2	having increased capabilities at private emergency rooms is very important. Our community members should be able to go to the private hospital of their choice to get help, just as they can for other medical conditions. It will be important for the private ERs to have the additional training and resources to respond in a recovery oriented trauma informed manner, and to have the staff support to provide assistance with connecting people to other community services. That has not traditionally been a focus for emergency rooms so it will require culture change and new resources and roles.
3	I disagree. however, I know that privatization is going to happen with my say in it. I think one central place has been better. If the other hospitals will actually step up and take psychiatric emergencies and actually provide treatment, then I am fine with this. But, there has to be a dedicated psychiatric program at these hospitals.
4	Crisis services should not be in same immediate care area as regular emergencies due to patient sensitivities.
5	These entities have plenty of resources to make it work.
6	I have concerns that a private hospital will cream the least involved people leaving BHD to handle the most difficult cases.
7	Any additional service we can add is important
8	No..they are burdened and the county does not work that well with them.
9	As long as I they have the resources and expertise and don't just discharge without a plan in place

10	I only disagree because we need more public Emergency Department service capabilities due to private hospital services will not be the only answer for patients in my opinion. Privatization is not the answer. Other counties have public services available like Dane county has Mendota available.
11	Would like to know more what this is.
12	Please see question 6 comment. We should make the best use of our hospitals.
13	They need to step up and do what private hospitals do most everywhere
14	PCS needs to be available for all. As a psychiatrist who has worked in the ED, non-dedicated EDs are ill equipped to deliver the care and the resources needed. They do not have the training or the support staff that is currently present in PCS from psychiatrists/therapists/nurses/SW.
15	These EDs are already overextended and not well equipped for mental health needs. I would expect an extensive amount of pushback as well from these departments in this community. We need psychiatrists and other well trained mental health professionals on the front line vs. Emergency room personnel.
16	private hospitals need to be willing and good partners in serving BHD population.
17	"Recommending" doesn't require. The average wait time in ER's combined with the intensity of the ER environment stands to further escalate mental illness crisis.
18	Obviously all hospitals have emergency rooms but my concern is that people with severe and persistent mental illness are best serviced by staff with expertise in mental illness and regular ED's don't have that.
19	People in crisis have been placed at bus stops rather than admitted to BHD. Why? Wish I knew. We have an epidemic of mentally ill people who can choose not to take medication and help themselves. We have community based residential options that are unacceptable options to family members who then put themselves at risk to maintain person at home. People have the crisis mitigated and are sent away. It's a vicious circle.

Q8 What concerns or questions do you have?

Answered: 24 Skipped: 36

#	RESPONSES	
1	Why are the healthcare systems in our community so resistant to increasing their service capability. They say they want to help and improve access; but the access only seems to apply to a certain population. Why is this acceptable and allowed?	
2	I have noticed that the CART team does not ED people because they have not "witnessed" the dangerous behavior. This should not be the case as the family member/LL/significant other will be the one's to testify to the dangerousness. We recently had someone with multiple visits by these individuals and they failed to take them to the hospital. This needs to be addressed.	
3	Concern: Will there be adequate expansion of community based alternatives to divert individuals from psych ED? Will the private hospital EDs do their fair share?	
4	As noted above, anxious for the next step - a detailed road map with timeline and fiscal estimates. worried that the timeline is not realistic and the dollars are inadequate. Enlarge the stakeholders involved in the planning process and elevate the voices of those who use services. Stakeholders need to reflect Milwaukee's diversity. Need to consider specialized populations such as deaf and hard of hearing, intellectual/ developmental disabilities, and those experiencing dementia. Hope that the county will not re-define their target population in a very narrow manner. What is the model for serving our youth? If people are in crisis but do not meet the criteria for an emergency detention, what strategies will be used to engage them in treatment and to offer supports? How will this plan meet the needs of people with substance abuse needs, as required by Chapter 51 How will this plan support families? Our systems are complex. How will people know where to go and how to access services? Will there by navigators? What is the front door for people – who don't go to the ER? How will this plan support diversion from jail?	
5	Two years is not enough time and we have difficulty with recruitment and retention in human services. Plus the shortage of psychiatrists is too significant to not address.	
6	None	
7	I believe that much of the work we do with our client has to happen in the community. I think crisis resource centers are great resources, but, they cannot take people that are actively suicidal or highly symptomatic. There has to be a place where people with no insurance or different forms of T19 can go and get actual care. The crisis clinic has been helpful in getting medication for people over the years. I also remember when the county had clinics of their own. I think establishing community clinics like this would be very beneficial. I like the idea of community based services. But, somehow, cost is always a factor and precious services are stripped away. In 20 years, I have seen many needed services disappear all in the name of re-designing and cost saving, and treating in the community. The BHD had some problems, but, I remember when it was thriving 20 years ago. People were served there. It was a place that underserved and uninsured people could go to get help.Please don't forget them in this redesign.	
8	I still don't understand why the new hospital will not be a place for emergencies. It seems logical to me that it be inclusive.	
9	Is law enforcement, emergency responders and the court system involved in these discussions and/or at the table?	
10	Increase number of psychiatrists and other behavioral health specialists. Increase Medicaid reimbursement rates for those professionals. More mental health resources available to schools as well as jails, prisons and police.	
11	Individuals have to wait to long in the community for MH care. There r limited therapy services. The system is designed to only provide help when it's too late the individual has to almost kill them or someone else in order to get help. Some Individuals should not be in the community because they are a danger but they force them in the community some have harmed Individuals.	
12	Abele is taking too long for this and the public is paying the price. We lack beds at BHD when in crisis and the private hospitals don't always admit patients when BHD would admit in the past. Please get going on this.	

13	More access to outpatient resources. More short term housing options. Crc needs to expand
14	How can more funding be geared toward this sort of intensive treatment?
15	The concern I have for Milwaukee County and their goals for the crisis redesign project is that they will spend too much money to plan and think and think and plan in order to build a state-of-art facility that is visually appealing, but will not operate in the manner in which it should. I have strongly expressed concerns with the issues Milwaukee has involving segregation, mass incarceration, racial inequities, and division. These are what continues to make a city/county like Milwaukee unsuccessful in the services they provide because they lack sharing power and investing in communities of color. Milwaukee operates primarily from a white middle class male mindset which many of our decision makers are predominately white males. There are discrepancies in shared cultural ideologies for the care and allocation of services for people of color. Facilitating trauma and white fragility trainings is not going to change the fact that Milwaukee needs to improve their inclusion practices so that people of color are not just middle managers. The report shows more than 50% of the population needing or receiving mental health services in Milwaukee County are black/African American as these are reasons why planning committees have such a hard time putting together services. Although, they invite the ideas of people of color, we have to consider the same freedom of financial resources, freedom to execute services and treatment strategies, and share in the role of leadership by trusting individuals who are not white to fully support the management of services because the ideas behind the services are not what you are comfortable with or perceive wrong because they are lack uniformity. Primarily, the history behind why many or most services offered by black and brown people are unsuccessful is because there is a lack of consistent resources to operate. As a very diverse county, if we operated under more shared or combined resources I believe we will see better outcomes. Milwaukee leaders always turn to out-of-state evidence based professionals who they themselves are white males servicing communities that are less than 50% black/African American. As a black female human services professional and mental health provider for 22 years, I have witnessed white people move to Milwaukee from neighboring counties or from Northern Wisconsin and given positions where they struggle with building rapport due to the absence of real life cultural competencies. Many times, the person of color loses out because it is automatically assumed that they discontinued services without really looking at reasons why. I have witnessed qualified people of color denied entry level positions in both public and private sectors due to possibly having the education, but not having experience. I have witnessed white people with no experience get hired and move quickly from entry level to managerial positions in short periods of time. I conclude, to understand racial trauma is to also understand racial inequities that affect both the consumer and professionals of color. Having one or two people of color does not provide the resources needed when facilitating a redesign as the best way to complete a crisis redesign is to begin a process of identifying the issues that have created the need for modernized culturally competent, trauma informed crisis services with the idea to truly implement trauma-informed and culturally competent services from the beginning to the end of the process. Milwaukee unfortunately is the national leader of racial issues, adding there are times when it becomes the rule verses the exception when affording opportunities to people of color candidates. One of the issues of racial inequities is the idea that being qualified translates into how well does this person assimilate to what is seen as the dominate culture. It has been evident that many organizations are starting to practice inclusion differently by steering away from the norm of how one is considered “qualified” in the framework of whiteness. Some hiring staff struggle with identifying what a knowledgeable black or person of color looks like outside of their education as to what they can bring to the table even if they do not have the experience but ambition and eagerness to learn as this is allowed for aspiring white people all the time. If we continue to ignore this issues of inclusion and not being included, we will continue to fail as a community.
16	my chief concern is why emergency crisis psychiatric services aren't a priority?
17	More needs to be done to pair up licensed mental health providers that are crisis trained, with law enforcement, to provide better interventions in the community.
18	As a parent of a daughter with mental health issues and a volunteer who takes calls from distressed individuals at NAMI, I know that many people rely on crisis services. For many people this is their initial contact within “the system “ and ANYTHING that can be done to make the process easier would be beneficial to the consumer.
19	That in fact it actually happens ASAP!
20	What is the level of investment in community services? Flexible services needed and investment in intensity of services-low caseloads, frequent contact. Many individuals are not voluntary but do not meet 51 criteria. How do we reach and serve them?

21	Must take a variety of insurance options. Many people have badger care or medicaid. Some have none and some have Medicare.	
22	While the plans have been well thought out, the projections of shifts in service are questionable. It all looks good on paper but I don't believe accessibility and system responsiveness will play out so neatly. I think there will be a lot of gaps in service, wait times and many who will go untreated. Given the prevalence, why are we accepting no additional tax levy? Where is the advocacy for increases to better serve the many with brain disorders? I'm also very concerned about how the redesign will serve the elderly who are vulnerable, living with a severe diagnosis and may experience crisis. Is one psychiatric nurse enough for Milwaukee County? I'm also very concerned about the unified entry of 211. When people are in mental health crisis, the added layer and time taken is frustrating and further, seems to inherently disrespect the caller's self knowledge and history of experience that makes them highly informed of what they need when in mental health crisis.	
23	The regular hospital ED's will rush to discharge individuals due to the staff's lack of expertise in dealing with individuals with severe and persistent mental illness' which will just create more problems for those individuals.	
24	Finding qualified people to staff a crisis response team will be a challenge. Follow up teams and services must be added once a person is no longer in crisis. We drop the ball here and people have been killed/murdered.	