

2022 SUMMARY OF ACTIVITIES

Kenosha action Roadmap to Inclusion,
Equality & Equity

*STRENGTHENING THE MENTAL HEALTH
SYSTEM TEAM*

1st & 2nd Quarters 2022 | www.kenosha.org



TABLE OF CONTENTS

Background.....	2
From the Chair.....	3
Purpose & Focus Areas	5
Discussion & Discovery	
- Focus 1	6
- Focus 2	13
- Focus 3	16
Other Reviewed Documents	18
Other Discussions & Lesson Learned	19
Conclusions	20
Recommendations	21
Team Information	21
What's Next: Mayor John Antaramian	22
Special Thank You	23
Appendix / Attachments.....	24



BACKGROUND

In June 2020, Mayor John Antaramian convened a small group of area faith-based leaders that he meets with on a quarterly basis. He asked the group to help with creating a long-term response to the killing of George Floyd and if they could help with creating a plan to address systemic racism in the city of Kenosha.

The Kenosha Action Roadmap to Inclusion, Equality & Equity is a framework, a call to action and a beginning to a plan to address racism in key areas in the city of Kenosha. The Roadmap will be driven and maintained by teams comprised of diverse group of individuals and led by community ambassadors.

From the beginning, it was clear that this plan must be developed and owned by the community and not the city of Kenosha. City Administration was instrumental in creating the concept and a catalyst for convening the leaders to begin the work on the roadmap.

This document provides a summary of activities for the Strengthening the Mental Health System Team in Phase II (1st & 2nd quarters of 2022).



*Roy Peebles , Senior Pastor
Turning Point Life Church
Kenosha, Wisconsin*

FROM THE CHAIR – PASTOR ROY PEEPLES

JUST THE BEGINNING

This summary of activities provides an overview of the work of the Strengthening the Mental Health System Team. The Team met in 2022 between January and June.

The Kenosha Action Roadmap to Inclusion, Equality & Equity is organized around seven main topic areas or “pillars:” They are Strengthening Community-Police Relations, Strengthening the Mental Health System, Developing Future Leaders, Creating an Equal Criminal Justice System, Creating Equal Employment Opportunities, Creating Quality Education for All, and Creating Equal Affordable Housing Access.

The first stage of the plan will be developed in phases between 2020-2024 to lay the foundation for the long-term plan to address identify systemic racism related to the key focus areas or “pillars”.

ACKNOWLEDGMENT

I wish to thank Mayor John Antaramian for asking me to continue to lead the work on developing the plan for the Kenosha Action Roadmap to Inclusion, Equality and Equity. In Phase I, we launched the first of the seven teams – Strengthening Community-Police Relations. It was created to begin to review, access and recommend ways to strengthen community policing and trust among law enforcement officers and the communities they serve. We found engaging with law enforcement officials, technical advisors, youth and community leaders, and nongovernmental organizations to be both enlightening and rewarding process. I again thank the Mayor for this honor.

TASKS

In Phase II, the work of the Strengthening Community-Police Relations Team continued picking up where the team ended in Phase I and we launched the second of the seven teams – Strengthening the Mental Health System (SMHS). In addition, we added subject-matter experts to the team. This brought a more dynamic dialogue to the meetings.

For Phase II, each team decided to remain as one whole team and not break-up into Sub-Teams in each focus area.



APPRECIATION

The work that has been done so far is a remarkable achievement that could not have been accomplished without the tremendous assistance provided by the members of the SMHS team, and Jack Rose, Chair – Strengthening the Mental Health System. In addition, I want to thank Katherine Marks, City of Kenosha Community Outreach Coordinator, for her leadership, and her support of the operation and administration of the work of the Teams.

Most important, I would especially like to thank the community members, law enforcement officers, behavioral health staff, healthcare professionals, stakeholders, and civic leaders citywide who stepped forward to support the efforts of the Team to lend their experience and expertise.

The passion and commitment shared by all to building strong relationships between the citizens, organizations and government became a continual source of inspiration and encouragement to the teams. The dedication of our fellow team members and their commitment to the process of arriving at consensus around the recommendations is also worth acknowledging. The team members brought diverse perspectives to the table and were able to come together to engage in meaningful dialogue on emotionally charged issues in a respectful and effective manner. I believe the type of constructive dialogue the teams have engaged in will serve as a stepping stone of the type of dialogue that must occur within teams as we roll-out the other focus areas.

THE EXPERIENCE

While much work remains to be done to address many longstanding issues and challenges — this experience has demonstrated to us that fellow citizens and Americans are, by nature, problem solvers. It is my hope that the information included in this document is a meaningful contribute to our city’s efforts to increase trust between citizens, government and the community that we are all are responsible for.



SUMMARY OF ACTIVITIES

STRENGTHENING THE MENTAL HEALTH SYSTEM TEAM

PURPOSE

The purpose of the Phase Two - Strengthening the Mental Health System (SMHS) Team is to review the current mental health system in the community and provide recommendations to improve its awareness to the community and the availability of requisite treatment. The team is well aware and acknowledges that the responsibility for community mental/behavioral health is under the purview of Kenosha County Government Kenosha County Human Services with respect to organization and budget. The City's role was that of a convener bringing powers to be to the table. However, the City and County can work jointly in this ever increasing problem on the society. A prime example of this is the collaboration between the City and County establishing the Crisis Prevention Center located at 1202 60th Street in 2017. The community must use all available mental health resources wisely and continually seek to increase the inventory of available resources. The team was composed of subject matter experts in the behavioral and mental health field and there was a mix of ethnic backgrounds and genders.

FOCUS AREAS

Focus Area One – Available Behavioral Health Resources. The team felt its first focus was to research and review what the existing mental/behavioral health resources are in the community and look at possibilities to improve the public and primary care providers awareness of available resources and the programs/resources that are in planning process for the future.

Focus Area Two – Update on Kenosha Community Health Center. The team wanted to explore and learn about the expanding role of the Kenosha Community Health Center (KCHC) as a critical participant in the community with the initiation of the new Pillar Health, opened in June 2022, which provides an integrated medical, dental and behavioral health services in one place located at 4006 Washington Road in Kenosha.

Focus Area Three - Lack of Psychiatric In-Patient Beds for Behavioral/Mental Health Individuals. Due to the lack of in-patient psychiatric beds for behavioral/mental health individuals in Kenosha and the high costs with transporting patients to and from out-of-the-area behavioral/mental health facilities, the SMHS Team felt it was extremely important to learn if there were plans to provide in-patient psychiatric unit beds in Kenosha or much closer than what currently exist for Kenosha County residents. Research showed there are opportunities to access in-patient beds at Lake Behavioral Hospital in Waukegan, Illinois, the Granite Hills facility in Milwaukee, Wisconsin and the potential of in-patient beds at the former Palmer Wing at Froedtert South - Kenosha Campus. Currently, the community relies heavily on the Winnebago Mental Health Institute in Oshkosh, Wisconsin. The Institute which is used for involuntary behavioral and mental health cases is approximately two and half hours each way from and to Kenosha. This creates hardships for the people living with the mental illness and their families, as well as the transport costs by local KPD and KSD resources for involuntary admissions (Chapter 51).

DISCUSSION & DISCOVERY

Focus Area One – Available Behavioral Health Resources

A part of the Team’s work included reviewing and discussing the presentation by “Kenosha County Behavioral Health Resources” developed by Kenosha County Division of Aging, Disability & Behavioral Health Services (KCDADBHS) that covers the various available behavioral health available resources, funding sources and future plans (*see SMHS - ATTACHMENT A*).

Kenosha County Division of Aging, Disability & Behavioral Health Services is one division of Kenosha County Human Services. A lion’s share of the Division’s services are contracted out and one of largest providers of behavioral health services is Kenosha Human Development Services (KHDS).

Note: There are several other community providers for residents to access.

The presentation included the following:

Behavioral Health Resources and Programs

- Crisis Services, KHDS Crisis Prevention & Intervention Center, 1202 60th Street Kenosha. In 2021, 10,440 crisis contacts.
- Behavioral Health Resource Center or Mental Health and Substance Abuse Resource Center, at KHDS main office, 3536 52nd Street, Kenosha: 2,898 contacts with 203 intake for long term care (LTC) programs in 2021. Screens for CCS and CSP services which are deep-end mental health services.
- Emergency Mental Health Detentions (Chapter 51), there were 250 emergency detentions in 2021. Managed by jurisdictional law enforcement agency and approved by adult or juvenile crisis. Filtered through KHDS Crisis Prevention & Intervention Center.
- Crisis Case Management, KHDS Crisis Prevention/Intervention Services, 1202 60th Street, Kenosha: 98 clients served in 2021. Stop gap between acute crisis. Crisis management is able to stay with an individual with a mental health or substance abuse diagnosis until enrolled in long term case management, such as CCP or CSP, or engaged in outpatient treatment . A person can stay involved with Crisis Case Management up to 6 months.
- Medication Management Program, 4 clients served in 2021. KHDS works with pharmacies to help people enroll in Medicaid program in addition to work done at Job Center, 8600 Sheridan Road, Kenosha.
- Residential, 41 clients served in 2021
- KARE Center, KHDS Prevention & Intervention Center, 1202 60th Street, Kenosha; a sixteen-bed community based residential facility for adults providing crisis stabilization (used as a divergent in lieu of in-patient psychiatric stay for those transitioning to a level of less restrictiveness outside of a psychiatric unit and used for social detox: 572 clients served in 2021; 902 admissions in 2019 pre-COVID.
- Sunrise Clinic, housed at KHDS, 3536 52nd Street, Kenosha, Provider: Dr. Mathew McCarthy, Psychiatrist,. A behavioral health clinic offers psychiatric assessment and medication management.
- Bridges Community Cener, 5718 7th Avenue, Kenosha; drop-in center for adults recovering with mental illness: 302 groups held with 799 participants in 2021.
- Diversion Programs, provided by KHDS, 3536 52nd Street, Kenosha; provides treatment court and jail diversion for adults with a mental health diagnosis who have been charged with misdemeanor non-violent crimes; 36 participants in 2021.
- Long Term Care Programs – CCS (Comprehensive Community Services) and CSP (Community Support Program), at KHDS, 3536 52nd Street, Kenosha. Both are long-term recovery based case management and service facilitation. Difference is CSP has a specific diagnostic criteria of a type of serious mental illness: 222 enrolled n CCS as of December 31, 2021; 85 enrolled in CSP as of December 21, 2021.
- CADTP (Comprehensive Alcohol and Drug Treatment Program), Professional Services Group, 6233 39th Avenue, Kenosha: provides case management, therapy and medical assistance treatment and other evidence based interventions to reduce relapse and recidivism of persons with opioid and/or alcohol addiction: 105 admissions into the program in 2021.

Grants

- Emergency Crisis COVID Grant: provides the TAPS (Therapy Addressing Pandemic Stress) Program and Recovery Housing. In 2021, 71 individuals received assistance through TAPS and 48 people served through recovery housing. Individuals in CADTP received up to 6 month housing assistance.
- Medication Assisted Treatment (MAT) Program – funded by a variety of grants. A grant provides treatment and therapy for those seeking to recover from an addiction.
- TAD Grant (Treatment Alternatives and Diversion) Program: provides coordination for those in this diversion treatment program. It is a multi-stage program for those with behavioral health needs who are in the criminal justice system. Individuals in diversion & treatment court received assistance.

Future Plans

- Move towards pro-active system.
- Marketing plan – Kane Communications Group has been hired to market the resources Kenosha has and identify the needs of communities and the way they want to receive information.
- Resource Center vs. Crisis – The focus of the system has been reactive, by focusing on providing resources, support and options to the community, the hope is to reduce the need for crisis, hospitalization and recidivism.
- Residential Resources – Kenosha County Behavioral Health Resources (KCBHS) have been focusing on developing local, residential options for those who need continued support after a hospitalization.
- In-Patient Beds – KCBHS have been in the process of a contract with Lake Behavioral Hospital in Waukegan, Illinois to provide in-patient beds. This is a closer geographic option for transporting individuals in Kenosha needing acute mental health services which benefits the client, the community and law enforcement's time. Illinois Senate passed a bill #1966 that allows psychiatric facilities in Illinois to accept and honor mental health law from other States. Wisconsin has been working with Michigan and Minnesota not with Illinois or Iowa. In process of developing a contract. The number of in-patient beds available will be over 120 beds. There is the potential of getting in-patient beds in Kenosha.
- Diversion Options – Expanding access to criminal justice diversion programs for those who qualify. This focuses on treatment for those with behavioral health needs who are in the criminal justice system.
- Community Outreach – KCBHS is hiring a Behavioral Health Outreach Coordinator in April 2022. This person will focus on keeping the community updated on resources and services and work closely with the Resource Center.
- Human Services on the Go! - There are 6 events planned for 2022, with a kick-off with the National Drug Take Back Day scheduled for April 30, 2022. Includes Narcan training, Narcan available and resource tables. Locations are Kenosha Building at Highways 50 & 45, UW-Parkside and KHDS. Partners include KPD, Sheriff Department, UW-Parkside Police, Behavioral Health, KHDS, law enforcement agencies and Public Health.
- Substance Abuse Coalition/Opioid Task Force – a continued collaboration to focus on the substance use within the Kenosha community.

OTHER AVAILABLE BEHAVIORAL HEALTH RESOURCES IN KENOSHA

National Alliance for Mental Illness (NAMI) – Kenosha County

Another example of a great behavioral health resource is the National Alliance on Mental Illness (NAMI) of Kenosha County that continues in the community outreach over the years as a grassroots approach by an all volunteer entity. NAMI is located at 5718 7th Avenue. The phone number is 262-652-3606, email address is info@namikenoshacounty.org and the website is www.namikenosha.org. The organization provides advocacy, education, support and public awareness so that all individuals and families affected by mental illness can build better lives. All programs are evidence-based and are offered at no cost to the community. Staffing is provided by unpaid volunteers. There are no paid staff. NAMI – Kenosha continuously promotes recovery and fights stigma.

An example of what a collaborative effort can do for a community is to look at Kenosha's Crisis Intervention Team (CIT) and Crisis Intervention Partner (CIP) training programs that include Kenosha County Human Services, Kenosha Police Department, Kenosha County Sheriff Department, Gateway Technical College and NAMI Kenosha. NAMI Kenosha

County CIT/CIP Program is one of 5 Certified teams in the state of Wisconsin. Since sending the first officers to Appleton for CIT training in 2007 and starting the Kenosha program in 2010, the number of people who have completed the CIT training is 305 law enforcement personnel and 1,084 civilians. In addition, 84 individuals have completed the Advance CIT program.

Effective 2022, Nicholas Greco and Officer Luke Hofmann, KPD, are the co-coordinators for our CIT/CIP/Advanced CIT programs. The cost is \$7,000 for a five-day CIT course. This is at no cost to police departments. NAMI Wisconsin recently released a grant to provide \$7,500 per department to assist with back pay and overtime. An additional \$1,500 is available to offset the cost of the advance CIT one-day training.

CIT training gives police personnel an additional resource to add to their toolbox to deal with people with behavioral health issues.

Following are some of the benchmarks that NAMI - Kenosha County helped to achieve:

- 2005 started a public forum program for circuit court judge candidates regarding behavioral/mental health. Public Forum held in-person sessions in 2005, 2009, 2012, 2017 and in 2021 held a virtual session via ZOOM.
- 2007 - KPD first attended CIT (Crisis Intervention Team) training in Appleton
- 2009 - in June, representatives from Kenosha attended Lake County mental health court to learn about their process.
- 2009 – in August, first shoe list for “Walkabout Rewards” was provided
- 2010 - CIT/CIP program begins at Gateway Technical College (GTC) – Kenosha Campus
- 2010 - NAMI – Kenosha rep on Families First Screening Committee
- 2010 - First Oxford House opened in Kenosha
- 2013 - BHTC gets underway
- 2013 – NAMI -Kenosha/YMCA program pilot
- 2014 – Established the Martha Hollowell Scholarship (\$190K); 7 scholarships issued
- 2018 - Rideabout Rewards program started
- 2018 – the opening of the Crisis Prevention Center/new KARE Center on 1202 60th St (former Gateway Mortgage building) City/County collaborative effort
- 2020 - KHDS relocated to 3536-52nd Street (City/County Collaboration) and the introduction of Sunrise Clinical Services

Counseling Services in Kenosha County

Kenosha Human Development Services’ Mental Health and Substance Abuse Resource Center, 3536 52nd Street, Kenosha, provided an informational only document that the Team reviewed (*see SMHS - ATTACHMENT B*). The document contained a list of counseling services in Kenosha County that included:

- agency/services name
- phone number
- address
- when phones are answered
- wait time to first appointment
- urgent slots available
- whether they serve mental health individuals
- whether they serve substance use individuals
- ages of children served
- whether they accept medical assistance and HMOs or Medicare
- whether there is a sliding scale or self-pay reduced fee
- are in-home services offered

- is there medication management on-site
- are bilingual services offered
- is group or individual therapy offered
- if the agency has a website and the web address

Treatment Court

The Kenosha County Treatment Court is an intervention program for adults living with a severe and persistent mental illness who have pleaded guilty to one or more crimes. Treatment intervention is structured around the authority and personal involvement of the judge and a team of Treatment Court professionals. Kenosha County is one of two counties in Wisconsin that deal with dual diagnosis cases (*See SMHS – ATTACHMENT C*).

Hispanic/Latino Community Outreach

Outreach to the community in an attempt to increase mental health awareness in many different venues. The awareness begins with education. People must be educated about mental illness to increase their awareness. NAMI Kenosha County has attempted to improve this awareness. Team members began working with NAMI to expand outreach to groups in smaller settings to establish the requisite to foster community. The goal was to consider ways to outreach in both the African-American and Hispanic/Latino Communities. An important point was for the outreach team to know that beside knowing the language it is better to know about the culture of the targeted population and the best way on how to approach them.

The Team was curious to learn if there are community engagement and informational sessions with the Hispanic community as with educational outreach. Members learned KHDS does not host community engagement and informational sessions. However, they response to calls for mental health services but not specific outreach.

On the other hand, the Team found out that Aging & Disability Recourse Center does. They have a minority outreach worker and their job is to solely reach out to under-served populations, specifically the Hispanic population which at present is the hardest to reach. They are fluent in Spanish and have full access to behavioral health resources. Mode of outreach includes neighborhood specific work instead of large outreach events, worker has a strong connection to Hispanic churches, connects with grocery stores, target individual groups., offers health and wellness classes in Spanish. The Outreach Worker has bilingual staff and volunteers that staff classes. Worker has connected with Gateway Technical College instructors in the English - as a Second Language Program to share information about behavioral health resources with students in the program. It was suggested the Outreach Worker connect with Kenosha Literacy Council to heighten the awareness of their students about behavioral health resources.

A team member with experience with the Hispanic/Latino community volunteered to assist with community outreach opportunities with the Hispanic/Latino community in Kenosha. He researched barriers that exist for the Hispanic/Latino community. The barriers noted are: 1) language – members of this community feel why should they go to community meetings if they don't understand what is being said; 2) the lack of bilingual mental health staff in the AODA field – it is difficult to find a Hispanic therapist with an AODA background and who can understand the language; 3) lack of language interpreters who understand the subject matter – it is most beneficial to the client and provider when the interpreter has knowledge of mental health and AODA; and 4) mistrust of community and not necessarily of an organization or institution – community members need someone in the community who does outreach and who has credibility in the Hispanic community.

The volunteer started a pilot network for mental health work in the Hispanic community. The idea is to start working with 10 Hispanic families. Five families will be dealing with mental health issues within the families and five families will be supporting families that are dealing with mental health. A team will use persuasion to get members of the Hispanic/Latino community to volunteer to be a part of either group. More than information is needed to connect with this community – there needs to be understanding. The goal is to connect with families so the family members can teach the team how to help them. For example, teach the Team what to say, how to say it and who to work with in the community who is credible. The scheduled date to work with the first five families was early to mid-May.

In addition, the volunteer pointed out that in general outreach workers for community organizations need to talk to the Hispanic/Latino community and not just give them a brochure/flyer. The perception is people inform this community in paper form but don't speak to the Hispanic/Latino community and invite them in-person. However, Behavioral Health staff have experienced the Hispanic community doesn't want to meet in person or sign documents with their name on it but may respond if feedback can be anonymous. Once the network has been established, the ask will be made to see if the network would be willing to work with Behavioral Health staff to get survey/questionnaire to Hispanic/Latino families they will be working with.

It was shared by a Latino member of the SMHS Team, that ninety-five percent of the Hispanic/Latino population look up to and value people in authority. It is something to remember when reach out to and approaching this population and a non-member of the Hispanic/Latino should consider bring a person of influence or authority with them when trying to connect with this community.

African-American Community Outreach

Another team member, began working with a local African-American Registered Nurse, to help build a team with diverse groups of people of color to create and get the messages out about mental health and local resource.

Handout: NAMI's Sharing Hope: An African-American Guide to Mental Health

NAMI has a handout "Sharing Hope: An African-American Guide to Mental Health". It is a NAMI resource and it can be provided to area facilities addressing mental health (see SMHS - ATTACHMENT D). Copies can be requested at contact@namikenosha.org or call 262-652-3606

Other Demographic Community Outreach

Other targeted populations are Caucasian older (60+ years old) individuals, young teens and primary care providers.

Caucasian Middle-aged Population

There is a need for community conversations around mental health among Caucasian adults who are 60+ years and oldert. While the community has a tendency to celebrate people battling physical health issues and they are called warriors there is a stigma when it comes to addressing mental health. It has been difficult and uncomfortable to have family conversations around mental health. It appears this group of older adults have a very difficult time when it comes to having a conversation about mental health issues.

Young Teens

There is a need for community conversations around mental health among the young teens and young adults. Youth in Governance wanted to choose behavioral health as a project but the group didn't get the support they needed. Young people want to have the conversation around behavioral health but the older generation must be willing to listen if there is to be a change.

A community behavioral health resource for young people is NAMI's Ending the Silence, an engaging presentation that helps middle and high school aged youth learn about the warning signs of mental health conditions and what steps to take if you or a loved one are showing symptoms of a mental health condition. The efforts of the Ending the Silence outreach in high schools within the health classes were accepted prior to COVID-19. When the school administration changed, the new administration chose to go in another direction.

Primary Care Providers

There is a need to reach out and communicate to medical doctors and providers that there are a vast numbers of available mental health resources in Kenosha. The challenge is because most people first discuss mental health issues with their primary doctor and these physicians and their staff lack information where to refer their patients when it comes to mental health resources. In addition, behavioral health staff may need to provide training or sessions to

medical doctors and providers to explain the various resources and how to use them. It was suggested that behavioral health staff should consider partnering with primary care providers to integrate mental health subject matter into preventative health care.

Barriers, Challenges, Stigma and Issues

The following were noted as barriers, challenges and/or issues related to community outreach focused on behavioral health:

- There appears to be shame associated with mental health in all ethnic groups throughout the Kenosha community. It is important to deal with that issue.
- People don't want to know or acknowledge that mental health exists in their families.
- There are so many levels of behavioral/mental health - suicide, on-going mental health issues – severe and persistent.
- Crisis is a measurement of outcomes of how well things are working upstream. Crisis should be used for the person with acute mental health episode not for those mental health professionals doing preventative care and it should be done by highly skilled and trained individuals who know how to handle acute crisis. However, crisis in the Kenosha community hasn't been working that way. In Kenosha crisis workers handle a vast amount situations – be the catch all, distributing bus passes and gas tokens and other things – this all needs to change.
- Question whether behavioral health should be wrapped around social determinants.
- Community consideration: is there need or should mental health services be centralized and organized to provide training on who to call, when, where and why depending on the type of mental health situation the person is experiencing. There is a need for a mindful and thoughtful plan to the mental health needs of the community.
- There is a need for community conversations around mental health among the young teens, young adults and older adults who are 60+ years old.
- Due to behavioral/mental health staff shortage, the question has arose – can mental health services be provided to meet the demand?
- Address the stigma of mental health treatment and educate community on current behavioral health treatment options.

Considerations for outreach efforts

- The Hispanic/Latino population demographics showed a low numbers of individuals in the programs. It may be contributed to language barrier and the lack of availability of bilingual staff. KHDS currently uses language lines, interpreters.
- Person answering crisis line is not always bilingual.
- In 2022, working with community activists in the Uptown area and through feedback from them, they found that the community is not interested in meeting in-person with anyone to give any information. Questions were provided in paper form.
- Found the Hispanic/Latino communities were more willing to provide information anonymously and not have their names or faces attached. Found it is difficult to get documentation from the Hispanic community. It was easier to get Hispanics to get vaccines through walk-ins than through signing up for a government program.

Outreach Activities

May 2022 – Mental Health Awareness Month

May is Mental Health Awareness Month. A vigil event was held on Wednesday, May 18th and the main speaker was KPD officer Luke Hofmann. City of Kenosha Common Council passed a resolution addressing mental health and why it

is important. Kenosha County created a proclamation for Mental Health Awareness Month. The last time an event was held was done pre-COVID 19 back in May 2019. This year's event kicked off with a walk starting at 5 pm from Bridges Community Center in downtown Kenosha to Civic Center Park. There was a reception and program with comments and awards. The awards include the Dave Wagner Advocacy Award and the Exceptional Volunteer Award. Dr. Ann Nudi, Herzing University, and nursing students from the school attended. KPD staff attended the vigil.

Marketing Plans

To improve and heighten the awareness of the many of behavioral/mental health services that are currently available and the programs that are in planning for the future, Kenosha County Behavioral Services is working with Kane Communications to develop a Kenosha County-wide

marketing plan focused on behavioral/mental health resources in Kenosha. The plan will include short messages to reach specific audience to connect them with local mental health resources.

Social media resources will be used to reach the various audiences including TikTok, podcasts, Facebook, etc. Other media resources planned are billboards,

Existing social media to include podcasts, discussing normalizing a conversation around mental health. In addition, generational mental health in families and obstacles faced by different ethnic groups dealing with mental health.

The team discussed eliminating the term "under-served". It was noted people who are generally categorized by that term don't see themselves or their relatives as the people referred as "under-served o high risk. The members felt it is equally important to stop using the term because there are tons of mental health resources in Kenosha but few people are accessing these resources. Marketing outreach efforts will help heighten awareness of available behavioral/mental health programs and services.

Focus Area Two – Update on Kenosha Community Health Center.

The team wanted to explore and learn about the expanding role of the Kenosha Community Health Center (KCHC) as a critical participant in the community with the initiation of the new Pillar Health, opened in June 2022, which provides an integrated medical, dental and behavioral health services in one place located at 4006 Washington Road in Kenosha.

KCHC presented a presentation “KCHC Overview of Services” (*see SMHS - ATTACHMENT E*) that included the following. Kenosha Community Health Center, a nonprofit organization offering to the under-served citizens of Kenosha County, Racine County and Walworth County comprehensive healthcare which enable their patients to maintain their well-being by addressing health disparities and providing access to all. Services include medical, dental, behavioral health and pharmaceutical. KCHC is a FQHC (Federal Qualified Health Center) which means 1) KCHC receives funding from the Health Resources & Services Administration to provide sliding fee-scale services; 2) a stand-alone organization that is held to 190 high standard of federal regulatory requirement (similar to hospitals) in order to receive funding; 3) has patient representation on their board of governors; 4) receives reimbursement for services provided to medicare/medicaid patients; 5) providers credentialed; malpractice insurance through FTCA; and able to provide 340B Drug Pricing Program discounts for patients needing pharmaceutical services.

The presentation defined what a FQHC is not and how the community maximize the FQHC dollars, such as FQHCs receive a special designation from the Bureau of Primary Health Care and the Centers for Medicare and Medicaid Services that allows them to get reimbursed for care provided to medically under-served populations or in medically under-served areas, like rural areas and inner cities. Primarily funded by the Health Resources and Services Administration (HRSA) under Section 330 of the Public Health Service. It was stated that better performing FQHCs have demonstrated the more they do, the more self-sustaining they become and the more services they can provide. In addition, collaborations and partnerships are the key to strategically positioning growing FQHC services and resources in the community.

It was mentioned that City of Racine has been trying for years to set-up a FQHC in their community. The process to become a FQHC is a community has to put together a case, and then a proven period to show the need. It is a rigorous process that takes many years to become a FQHC. In 1995, the Kenosha community moved forward with FQHC process which eventually made Kenosha eligible to receive a large number of federal dollars to take care of medically under-served groups.

KCHC has been in the Kenosha community for 26 years. Service provided in six (6) locations with 5 sites in the City of Kenosha, 1 site west of I-94 in Silver Lake and a mobile care unit.

CEO reports to a board of directors and KCHC has a patient advisory group made of patients that guide development of services. Growing group to mirror community population. KCHC is evaluated on how well the organization mirrors the communities they serve.

The 2020-2021 year marks sufficient changes at KCHC. Such as having a more experienced and diverse board of directors, new executive and mid-level leadership, improved service model with focus to patient and family experience and expansion of services, provider recruitment and organizational partnerships.

Community needs assessment showed significant gaps to care access. Noted were 1) unmet medical care; 2) unmet dental care; 3) unmet prescription medications and 4) unmet mental health services. The extent of KCHC 's outreach to the high-risk vulnerable population has been broad, there remains a significant gap in those not routinely assessing care. KCHC has set out to address the gap by adapting services to better meet identified needs. KCHC estimated there are 30,000 people county-wide who are not accessing medical, dental and behavioral/mental health care on a regular basis. A HRSA requirement is KCHC must show how they are addressing the gag and who they are working with. Working with the Strengthening the Mental Health System Team is a part of bridging the gap.

Service areas in Kenosha, Racine and Walworth Counties are defined by HRSA (Health Resources and Services

Administration) scope of services that includes community assessment – define needs and the scope defines by zip codes where most of the patients reside.

Dental access provided at the 14th Avenue location (38 operatories) and Silver Lake (3 operatories). Medical and behavioral health access and enabling services are provided at all locations. Mobile care services are expanding KCHC reach. A new located is planned for 2022.

Enabling services \ KCHC “Patient Support Services” Program includes health literacy (case management), translation/interpretation, health education, case management, patient care advocates and insurance eligibility assistance.

The 2020-2021 team was the turn around group for KCHC. Rebuilding the foundation included expanded access through service growth, set a new bar for comprehensive quality and stabilized workforce, improved employee engagement, improved operations and established new academic partnerships.

The sustainable model for the future includes KCHC is planning to strategically grow all services within all service areas within the HRSA scope, plan to work with community partners to move appropriate patients into the FQHC care model and new service design is underway and continuously shaped by community feedback. It is important to note KCHC gets 30% of revenue from grants and in order to survive KCHC make it on the operations of Medicare/Medicaid population. Have to have enough volume in the health center in the right places to keep the doors open. Successful FQHCs have found when you get to a certain size and scale you have to keep your doors but now are able to build more resources. Hope to get to scale by reaching a minimum of 30% people not accessing services.

KCHC has plans underway to reset the current KCHC model in 2022.

The new KCHC site is located at 4006 Washington Road. The building was purchased and opened in July 2022. Services include medical and dental facility. Long-term current dental building on 14th Avenue will be for specialty dental. Planning to have a behavioral health site in the future.

Additional strategies underway to address gaps in unmet needs, such as building awareness and expanding services in Kenosha County at Silver Lake location, expanding services to children and adolescents (i.e. Seal-A-Smile program expanding reach) and partnering with area hospitals.

Kenosha Community Health Center (KCHC) Behavioral Health Program

Data was provided for un-duplicated KCHC behavioral health patients from 2017 to 2021 for encounters (includes medical, dental, behavioral health and enabling services, average encounters per patient, COVID tests included and not included in the numbers. It was mentioned that 10 years ago dental encounters were at 50,000 and the decline started in 2016. Highlighted was behavioral health encounters. The numbers were: 2,671 in 2017, 1,011 in 2018, 1,347 in 2019, 1,212 in 2020 and 1,734 in 2021. In 2017, there were 6 KCHC behavioral health providers and team declined to 1 by 2020. KCHC’s behavioral health team is poised for growth. The team has grown to a staff of 5 and may be doubled or tripled in a few years.

Based on community size, overall encounters should equal 65,000 to 70,000 each year. In 2021, overall encounters (patient visits) equaled 42,000. Have 15,000 un-duplicated visits should be closer to 24,000 for community of similar size. There is a way to go and grow.

A baseline was provided for the existing KCHC behavioral health program. Included are 1) DHS certified outpatient clinic; 2) improved access and shifted to evidence-based treatment with targeted therapies; 3) counseling services are patient directed and goal driven to return to natural supports and community; 4) recently added psychiatric NP prescriber – will expand psychiatry as referral grow and 5) many areas for potential growth based on need (child and adolescent, substance abuse; CHP, etc.)

KCHC is currently working on finding their niche in behavioral health. They are accessing the full continuum of behavioral health care by looking at community behavioral health primary care, KCHC’s behavioral health, specially behavioral health care, residential treatment and inpatient treatment. KCHC believe their niche will be somewhere between primary care and specialty behavioral health care. The community partners were listed as physical health

systems, crisis services, recovery supports, community/social services agencies, housing resources, first responders/law enforcement and jail/courts.

Primary medical and behavioral care services are available for: behavioral health screenings, individual therapy services and psychiatric medication management.

Behavioral care locations are: KCHC – Kenosha Clinic, 4536 22nd Avenue, Kenosha, WI 53140; KCHC – Silver Lake Clinic, 903 S. 2ndStreet, Silver Lakes, WI 53170; and KCHC – Pillar Health Clinic, 4006 Washington Road, Kenosha, WI 53144.

Insurance accepted includes: most commercial insurance, Medicaid, and Medicare. Uninsured individuals are welcome.

KCHC asked the SMHS Team to help them think of where can KCHC add the most value to address the behavioral health needs of the Kenosha community at this time?

Focus Area Three - Lack of In-Patient Beds for Behavioral/Mental Health Individuals.

Due to the lack of in-patient beds for behavioral/mental health individuals in Kenosha and the high costs with transporting patients to and from out-of-the-area behavioral/mental health facilities, the SMHS Team felt it was extremely important to learn if there were plans to increase the number of in-patient psych unit beds in Kenosha with better access than what currently exists.

The Team discussed Chapter 51. Pursuant under Chapter 51 of the Wisconsin Statutes, allow for the pursuit of involuntary commitment and treatment of a person who is mentally ill, drug dependent, or developmentally disabled and who is shown to meet dangerousness criteria as outlined by statute. Members learned that because there are no in-patient psychiatric unit beds in Kenosha that from April 2021 to January 2022, the locations where were people were sent and number of people was : Aurora (Wautwatosa) – 4, Rogers Memorial (Brown Deer) – 6, Rogers Memorial (Oconomowoc) – 1, Rogers Memorial (West Ellis) – 6, St. Lukes (Racine) – 7, Regional Medical Center (Watertown) – 1 and Winnebago – 139.

The regular and overtime costs for KPD to transport clientele was \$77K in 2021 and the majority - \$73K was associated costs for transporting individuals to Winnebago. The amount does not include Kenosha County Sheriff costs. The long trip impacts the individual, their family and KPD.

For example, KPD explained that it takes two officers approximate 6 hours round-trip (2.5 hours trip to Winnebago, 1.0 hour for drop-off in Winnebago and 2.5 hours return trip to Kenosha). The costs are represented as overtime hours and the additional loss is 2 – 4 officers per day. Not included in the \$77k transportation cost because it is hard to track are the associated costs for how many officers are called in to backfill staffing for the rest of coverage for police services while those 2 – 4 officers are transporting Chapter 51 individuals.

There are several contributing factors when identifying a psychiatric reception facility, those are determined by the information shared by the local Emergency Department to be reviewed by the receiving facility.

The common intake process for CSP (Community Support Program) and CCS (Comprehensive Community Services) starting is Behavioral Health Resource Center with logic screen. The process is State driven. For Diversion & Treatment Court, a referral comes from Public Defender's Office or District Attorney's Office; Sunrise Clinic, anyone can access; Bridges is membership driven and CADTP (Comprehensive Alcohol and Drug Treatment Program) a person contacts the Professional Services Group. The main access point is Crisis Center is used by individuals in distress, need action and immediate help. The Resource Center is used by people looking for resources, no action needed at that time but information is required. NAMI receives calls. Individuals mostly referred to Resource Center or if extreme case referred to 9-1-1 to ask for a KPD CIT officer.

As the work is being done to provide or increase access for in-patient beds for Kenosha individuals the organizations involved are looking at the following:

- ☐ the process
- ☐ building relationships
- ☐ admissions
- ☐ discharges
- ☐ quality of care

There are a number of considerations for in-patient psychiatric beds. If all anticipated potential psychiatric in-patient beds sites become to available to Kenosha County residents, there will be an excess of about 240 additional psychiatric

in-patient beds between the Palmer Project in Kenosha), Lake Behavioral in Waukegan), Illinois and Granite Hills facility in West Allis.

On another note, the status of Granite Hills in-patient psych facility in West Allis was mentioned. When fully operational it will have a capacity of 120 beds. To date, Granite Hills has not had a joint commission go through the facility. At this time they can serve on 5 – 6 clients until joint commission goes through. It is anticipated that Granite Hills will be able to accept voluntaries and chapters. It should be understood that Granite Hills will be used much like Roger Memorial. People will be able to go there as long as they are insured – there is no Kenosha County contract. The only contract the County has is with Aurora Psych and Ascension Racine. At this time, it is not know what type of insurances will be accepted by Granite Hills until after the joint commission is done. This facility will have an adult unit, child/adolescence unit and geriatric psych unit. It will be similar to the Lake Behavioral facility. Granite Hills is a joint venture of many hospitals in Milwaukee County and is in response to the closure of Milwaukee County Behavioral Health ending at the end of 2022.

It was noted that KPD being able to take individuals to Granite Hills or Lake Behavioral are a plus because it reduce travel and overtime costs associated with taking individuals to and from Winnebago. A KPD Captain does serve on the Chapter 51 Committee and keeps KPD up-to-date.

It was brought to the team's attention that staffing shortages in Wisconsin related to behavioral health staff is a problem. A unit in Tripoli, Wisconsin, medical complex, closed due to staff shortages. All providers may likely experience staff shortfalls.

OTHER REVIEWED DOCUMENTS

SAMHSA Guidelines & Toolkit

SAMHSA publishes guidelines, toolkit to strengthen crisis care in America's communities (12/08/2020).

The Substance Abuse and Mental Health Services Administration (SAMHSA) has published "[Crisis Services: Meeting Needs, Saving Lives](#)," a compendium detailing crisis intervention services, best practices and related components of crisis services, for use by a wide array of community leaders and health care providers to work toward better outcomes for Americans in crisis.

The book is composed of SAMHSA's "National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit" and related papers on crisis services. The toolkit reflects relevant clinical and health services research, review of top national program practices and replicable approaches that support best practice implementation. The related papers address key issues relevant to crisis services, homelessness, technology advances, substance use, legal issues impacting crisis services, financing crisis care, diverse populations, children and adolescents, rural and frontier areas, and the role of law enforcement.

To view, click <https://www.samhsa.gov/newsroom/press-announcements/202012080500>

Handout: Availability of Walk-in and Crisis Outpatient Treatment Services in the United States by Nina Robertson (see SMHS – ATTACHMENT F)

The U.S. health care system is failing those with serious mental illness due, in part, to the lack of outpatient mental health crisis services available around the country, according to a study recently published in *Psychiatric Services*. Hospital emergency departments are considered the front line services when triaging a mental health crisis. These settings are unable to provide adequate resources in a timely manner, which highlights the necessity for outpatient mental health crisis services to manage acute and subacute psychiatric events.

Outpatient mental health services offer various, specialized methods for individuals experiencing a mental health crisis such as verbal de-escalation, psycho-therapeutic strategies, outpatient and inpatient referrals and treatment planning. This novel study published in *Psychiatric Services* examines the lack of these outpatient services in the form of walk-in services and crisis services around the country. The authors look into expansive policy options to remedy this national issue

Analysis indicated that nearly half (42.6%) of all U.S. mental health facilities did not offer any mental health crisis services between 2014 and 2018. A third of all facilities offered emergency psychiatric walk-in services and just under one-half provided crisis services. Only 25% of all facilities in the United States provided both emergency psychiatric walk-in services and crisis services.

Between 2014 and 2018, walk-in and crisis services availability declined by 15.8% and 7.5%, respectively. N-MHSS data showed that facilities in the South offered the highest proportion of psychiatric walk-in and crisis services in comparison to the rest of the country

The authors note that in light of the COVID-19 pandemic, the U.S. emergency management system has been stretched beyond capacity and resources are scarce. There is a significant need for licensed mental health facilities in the United States to expand provisions of crisis services.

In regards to Kenosha, team members mentioned that at this time there is no walk-in clinic with a mental health provider available in Kenosha that is closest to the type of facility mentioned in the document. For people who need emergency mental health stabilization they can go to the Care Center and the provider is Dr. McCarthy.

OTHER DISCUSSIONS

- *Peer Support Specialist*
 - It was suggested that KCHC consider adding a Certified Peer Specialist to their behavioral health staff. The specialist is an individual with experience in the mental health and substance use services system trained to provide support to others struggling to find a path to recovery. The best person for the position is someone with lived experience because you can't make change to the system unless you hear the voices of those who rely or have relied on the system. It was noted that at this time KCHC does not have a Peer Specialist on staff.
- *Mental Health Staff Shortfall*
 - It was noted that there is a shortage of behavioral and mental health professionals. In Kenosha, KHDS is struggling to recruit and retain staff. A challenge is the agency finds it hard to compete financially with other agencies. For example, in Racine County, case managers are started at a higher rate. Other areas, such as Community Care, starting positions at \$50K with a bonus and KHDS starts a person with a master degree at \$40K. In addition, Kenosha County Human Services is experiencing similarities with finding and recruiting in the fields for this type of work. Wages are a factor but there are many other issues in regard to attracting and hiring qualified individuals. The staff shortage is happening all over Wisconsin. In Milwaukee, there are problems recruiting clinicians for the new mental health center and a new private hospital is having problems recruiting nurses. One contributing factor is COVID-19 launched the world into a virtual world. This is not conducive for behavioral health work. In addition, people are leaving public sector jobs to go to private sector jobs to work remotely. Kenosha County Aging, Disability & Behavioral Health Services and KHDS will begin discussions to consider alternatives in addressing the staff shortage.
 - It was noted that at this time KCHC isn't experiencing staff shortage because KCHC works in medically under-served areas, KCHC is eligible, through the national loan repayment program, health care professionals can get their education reimbursed.
- *Improving Crisis Intervention and Emergency Detention Services*
 - The team reviewed document "Toolkit for Improving Crisis Intervention and Emergency Detention Services" created by the Wisconsin Department of Health Services (*see SMHS – ATTACHMENT G*). The toolkit was developed as part of the Wisconsin Department of Health Services Learning Collaborative for Crisis Intervention and Emergency Detention managed by the Division of Care and Treatment Services.
 - Behavioral health agencies representing all regions of the state worked with staff from the Division of Care and Treatment Services from February through June 2018 to discuss strategies and approaches on how to support people experiencing a mental health crisis in the community rather than sending them to a state mental health institute for care and treatment.
 - Team members found the document beneficial and relevant to points the team has discussed and areas where best practices are being addressed and implemented in Kenosha.

LESSONS LEARNED

- Not one person can do the outreach and the team and behavioral health staff need to make connections with people who can reach the different demographics throughout the community.
- Customized outreach to each neighborhood of the County. Based on current data, trends and focused on the totality of health.
- Outreach efforts need to be targeted based on the needs of community, neighborhood and ethnic background.
- There is a need to build trust among the demographic and that takes time.
- Behavioral health staff have found that throughout the community there is a sense of distrust of mental health systems and government in general.
- The SMHS team needs to think about – what is needed to build better relationships with the community, are mental health system staff spending the necessary time dealing with the distrust of mental health resources among the various community members, and what about the sense of centralization building – is it something that works for Kenosha?

CONCLUSIONS

The SMHS team is well aware and acknowledges that the responsibility for community mental/behavioral health is under the purview of Kenosha County Government Kenosha County Human Services with respect to organization and budget and not the City of Kenosha.

In Phase II, the SMHS Team members felt it was most important to learn and gain knowledge of available behavioral/mental health resources in Kenosha and possible ways the team can help heighten the awareness of the public about the resources, programs, facilities, etc. The team spent several meetings learning and discussing the resources and how the information was currently shared with the public and ways to improve upon outreach and sharing of behavioral/mental health resources.

Several documents created by local agencies have been updated, such as Kenosha County Division of Aging, Disability & Behavioral Health Services document entitled “Kenosha County Behavioral Health Resources” and Kenosha Human Development Services (KHDS) list of counseling Services in Kenosha County. These documents along with other will be readily available to the general public, health and mental health providers, schools, community organization, businesses and government.

In addition, Kenosha County Behavioral Services has contracted with Kane Communications, to develop a county-wide marketing plan focused on behavioral/mental health – to heighten awareness of services, programs and resources, key messages, media venues – social media, apps, Facebook, , billboards, etc. Marketing plans include use bilingual text/

Members are looking for ways to help communities of color, young and older generations and families deal with the stamina of having mental illness themselves, a love one or someone they know.

The SMHS Team felt it was equally important to explore and learn about the expanding role of the Kenosha Community Health Center (KCHC) as a critical participant and partner addressing mental health with the initiation of the new Pillar Health Center, which provides an integrated medical, dental and behavioral health services in one location.

It was also emphasized that there is an urgent need for out-patient therapists.

Finally, but most importantly, the Team is very supportive of the critical need for an in-patient mental health facility in Kenosha. There are a number of efforts under way to address bringing in-patient beds to Kenosha or establishing partnerships with mental health providers with in-patient beds that are much closer to Kenosha than the major current facility located in Winnebago. The benefits are: 1)reduce time transporting patients; 2)cost reduction for law enforcement transport; and 3)most importantly, less of a burden for families and individuals dealing with behavioral/mental health issues.

RECOMMENDATIONS

The SMHS Team recommends the following:

- Local agencies continues to update behavioral/mental health resources document and share with the public a minimum of twice a year.
- Kenosha County Division of Aging, Disability & Behavioral Health Services, in partnership with Kane Communication, implements the marketing plan focused on heightening the awareness of mental illness and available behavioral/mental health resources in and around Kenosha.
- Kenosha Community Health Center (KCHC), Kenosha County Human Services, Kenosha County Division of Aging, Disability & Behavioral Health Services, and KHDS should develop a long lasting partnership addressing the need to strengthening the mental health system in Kenosha by providing quality behavioral/mental services, programs and resources to those in need.
- Kenosha County Division of Aging, Disability & Behavioral Health Services, NAMI - Kenosha (National Alliance for Mental Health) – Froedtert South – Kenosha Campus, and out-of-the-area partners will continue to work towards getting in-patient beds in Kenosha or to a facility that has in-patient beds for behavioral/mental health patients that is much closer than the facility in Winnebago.
- Kenosha County government and the City of Kenosha work together, when possible, on ways to strengthen the mental health system in Kenosha.
- Reconvene as a team in the second quarter of 2023 no later than June and check on the status of recommendations and progress in strengthening the mental health system in Kenosha.
- Request to the City to provide a link on their website under the “Kenosha Action Roadmap” icon to the Kenosha County Government website section on behavioral health resources.

TEAM INFORMATION

MEMBERS

Jack Rose, NAMI – Kenosha President and 15th District Alderman (Team Lead)

Rebecca Dutter, Director, Kenosha County Division of Aging, Disability & Behavioral Health Services

Jeannine Field, Director, Kenosha Human Development Services

Kari Foss, Behavioral Health Manager, Kenosha County Division of Aging, Disability & Behavioral Health Services

John Jansen, Director, Kenosha County Human Services

Mary Ouimet, CEO, Kenosha Community Health Center

Patrick Patton, Captain, Kenosha Police Department

Juan Torres, Board Member, ELCA Outreach Center

Brenda Wesley, Independent Consultant, Mental Health Advocate

PLEASE NOTE: The team had eight (8) persons with behavioral/mental health background and/or training and one (1) community member had no behavioral/mental health background or training.

MEETINGS

The SCPR Team held monthly meetings between January and June 2022.



WHAT'S NEXT - MAYOR ANTARAMIAN

It is time to re-imagine what kind of Kenosha we want to build – a community where all citizens can live equally, safely and freely.

The Kenosha Action Roadmap to Inclusion, Equality & Equity provides a great opportunity to bring together diverse individuals, organizations, businesses, faith-based community and government to chart a better course for the city of Kenosha where there is inclusion, equality and equity.

THE WORK OF THE TEAM

The Strengthening the Mental Health System Team will continue the work in this focus area as determined by the members of the team.

ROLL OUT NEXT FOCUS AREA

In 2023, we'll enter into the next phase of the Roadmap with an emphasis on developing our future leaders. Including the voices of our young people is vital and must be a part the work of the Roadmap.

Work is being done in the community, such as the redevelopment of the former Chrysler site in to the Kenosha Innovation Neighborhood (KIN), focused on preparing Kenosha's youth, young adults and young professionals for workforce demands in Kenosha.

TEAM MAKEUP

Based on lessons learned in phase I and II, a strong emphasis is on recruiting individuals to lead or be a member of the Team that has content or subject matter expertise. While not all the members have to be a content or subject-matter experts the teams will be comprised of a majority of members that have experience with the subject matter.



SPECIAL THANK YOU TO ALL THE INDIVIDUALS WHO SERVED ON THE TEAM

Pastor Roy Peeples, Turning Point Life Church, KARIEE Chair *(Note: By the time this summary was released in March 2023, Pastor Roy Peeples had passed away in January 2023.)*

Strengthening the Mental Health System Team Members

Jack Rose, Team Lead, NAMI – Kenosha President, and 15th District Alderman

“It takes a village.”

Rebecca Dutter, Director, Kenosha County Division of Aging, Disability & Behavioral Health Services

“Coming together is a beginning.”

Jeannine Field, Director, Kenosha Human Development Services (KHDS)

Kari Foss, Behavioral Health Manager, Kenosha County Division of Aging, Disability & Behavioral Health Services

“Keeping together is progress.”

John Jansen, Director, Kenosha County Human Services

Mary Ouimet, CEO, Kenosha Community Health Center (KCHC)

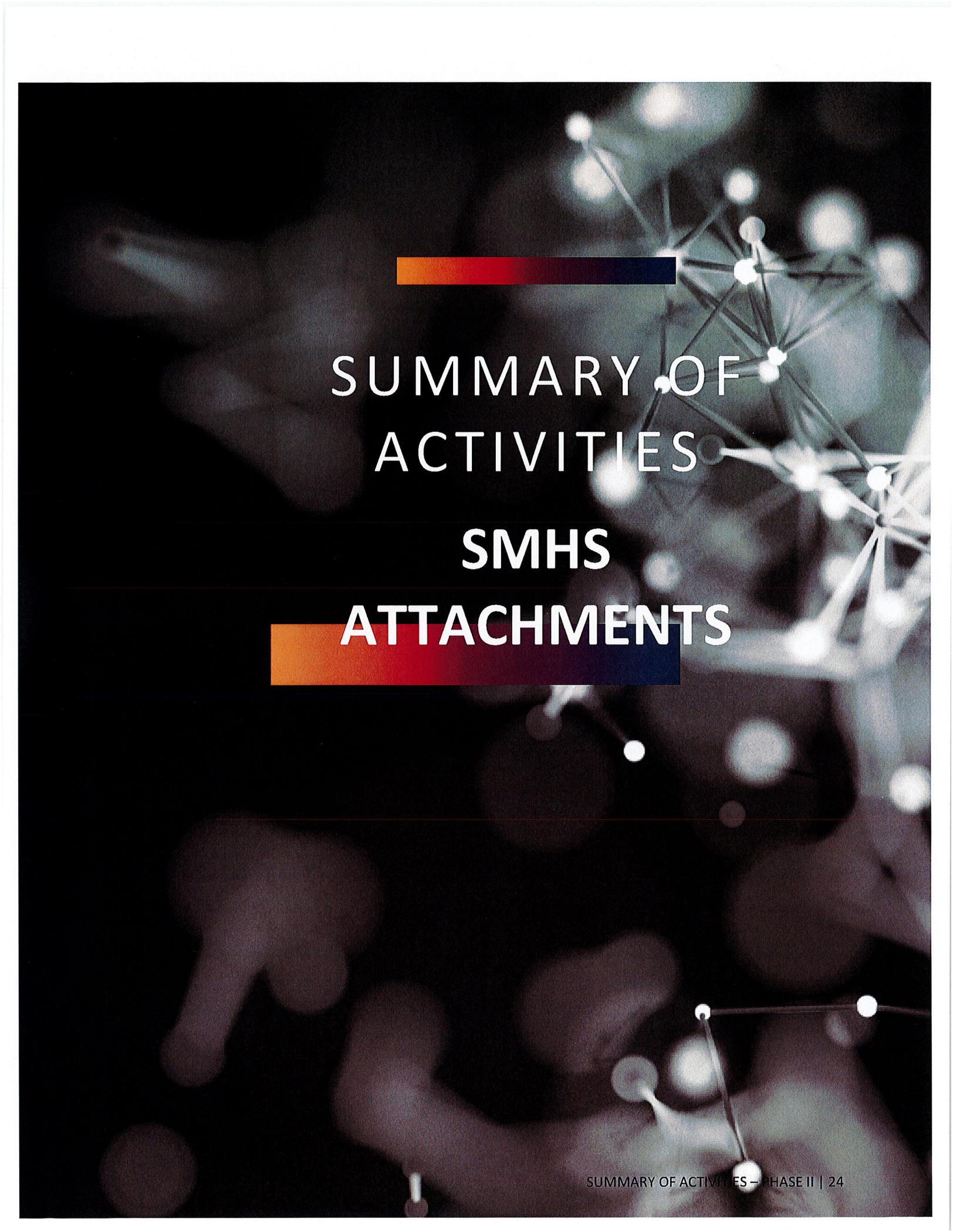
“Working together is SUCCESS!”

Patrick Patton, Captain, Kenosha Police Department

Juan Torres, Board Member, ELCA Outreach Center

Brenda Wesley, Independent Consultant, Mental Health Advocate

An expression of appreciation to Katherine Marks for her help and technical assistance with facilitating, assisting and supporting the Kenosha Action Roadmap to Inclusion, Equality and Equity Teams.



SUMMARY OF
ACTIVITIES

SMHS

ATTACHMENTS

KENOSHA COUNTY BEHAVIORAL HEALTH RESOURCES

KENOSHA COUNTY DIVISION OF AGING, DISABILITY
& BEHAVIORAL HEALTH SERVICES



RESOURCES AND PROGRAMS

- Crisis-10,440 contacts- 2021
- Behavioral Health Resource Center- 2898 contacts with 203 intake for LTC programs-2021
- Emergency Mental Health Detentions (Chapter 51)- 250 Detentions-2021
- Crisis Case Management- 98 clients served-2021
- Medication Management-4 clients served-2021
- Residential- 41clients in 2021
- KARE Center- 572 clients-2021



RESOURCES AND PROGRAMS

- Sunrise Clinic- Dr. McCarthy
- Bridges- 302 groups held with 799 participants- 2021
- Diversion Programs- 36 participants in 2021
- Long Term Care Programs- CCS and CSP
 - CCS (Comprehensive Community Services) - 222 enrolled as of 12/31/21
 - CSP (Community Support Program) - 85 enrolled as of 12/21/21
- CADTP (Comprehensive Alcohol and Drug Treatment Program)- 105 Admissions into the program



GRANTS

- Emergency Crisis COVID grant- Provides the TAPS Program (Therapy Addressing Pandemic Stress) and Recovery Housing
- Medication Assisted Treatment- MAT program is funded by a variety of grants. Grant funds treatment and therapy for those seeking to recover from an addiction.
- TAD Grant-(Treatment Alternatives and Diversion Program)- Provides Coordination for those in this diversion treatment program. It is a multi-stage program for those with behavioral health needs who are in the criminal justice system.

FUTURE PLANS

- Move towards pro-active system.
- Marketing Plan- Kane Communications Group has been hired to market the resources we have and identify the needs of communities and the way they want to receive information.
- Resource Center vs. Crisis - The focus of the system has been reactive, by focusing on providing resources, support and options to the community, we hope to reduce the need for crisis, hospitalization and recidivism.
- Residential Resources- We have been focusing on developing local, residential options for those who need continued support after a hospitalization.
- In patient beds- We have been in the process of a contract with Lake Behavioral Hospital in Waukegan, Ill. This is a closer option which benefits the client, the community and law enforcements time.



FUTURE PLANS

- Diversion Options- Expanding access to criminal justice diversion programs for those who qualify. This focuses on treatment for those with behavioral health needs who are in the criminal justice system.
- Community Outreach- We will be hiring a Behavioral Health Outreach Coordinator. This person will focus on keeping the community updated on resources and services.
- Human Services On The Go! – There are many events planned for 2022, with a kick off with National Drug Take Back Day in April.
- Substance Abuse Coalition/Opioid Task Force- Continued collaboration to focus on the substance use within our community.



COUNSELING SERVICES IN KENOSHA COUNTY



SMHS – ATTACHMENT B

This information provided by the Mental Health and Substance Abuse Resource Center at 3536 52nd St. Kenosha, WI 53144.
 This is provided for informational purposes only. Information is subject to change. Inclusion of an agency on the list does not constitute an endorsement or recommendation.
 Key: † Denotes Faith-Based Counselor on Staff

	AALTO	ADVANCE CLINICAL SERVICES	AMRI COUNSELING	ASAP- ADDICTION SERVICES and PHARMACOTHERAPY	AURORA BEHAVIORAL HEALTH SERVICES	BE INSIGHTFUL COUNSELING	CATHOLIC CHARITIES	CHILDREN'S HOSPITAL OF WI COMMUNITY SERVICES	COMPASSIONATE CARE COUNSELING
PHONE NUMBER	262-654-9370	262-864-1141	262-671-1625	262-946-5752	1-877-666-7223 Central Scheduling	262-764-2459	262-637-8888	414-266-3339 New Patients	262-652-6311
ADDRESS	8503 75th St Suite A Kenosha, WI 53142	6121 Green Bay Rd Ste 200 Kenosha, WI 53142	6321 23rd Avenue Kenosha, WI 53143	3825 39th Avenue Ste 120 Kenosha, WI 53144	12225 71st Street Kenosha, WI 53142	2901 35th St Lower Suite B Kenosha, WI 53140	800 Wisconsin Avenue Racine, WI 53403 (Kenosha on M/T/W/F)	6809 122nd Avenue Kenosha, WI 53142	3624 17th Avenue Kenosha, WI 53143 Moving To Racine
PHONES ANSWERED	Mon-Fri 9am-7pm Sat 9am-2:30pm	Mon-Fri 9am-6pm	Mon-Fri 9am-5pm	Mon-Fri 5am-1pm Sat-Sun 6am-9am	Mon-Fri 7:30am-5pm	Mon-Thur 9am-5pm Fri 9am-12pm	Mon-Fri 8:30am-5pm	Mon-Fri 8:30am-5pm	Appointment Only
TIME TO FIRST APPT.	2 weeks	Within 2 Weeks	2 Months	Within A Week	Only Taking Referrals From Aurora Primary Care Providers 6-9 Month Wait	1 Week	2 Weeks	Varies 6/22/22 (4-6 Months)	1 Week
URGENT SLOTS AVAILABLE	No	Yes	Yes	No	No	Based On Availability	Yes, Racine	Based On Availability	No
MENTAL HEALTH	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
SUBSTANCE USE	Yes	Yes	Yes	Yes	No	Yes	No	No	Yes
CHILDREN	5-17 yrs old	6 yrs & up	2 yrs & up	18 and up	7-17 yrs old	6 yrs & up	10 yrs & up	Infant To Toddler & up 6/22/22, 6 yrs & up Until New Provider Is Found	No
MEDICAL ASSISTANCE AND HMOs	All Except ICARE and MHS	Children's Community, United Healthcare, Anthem, MHS, UMR	Yes	All	Yes w/ Dr. Referral	Anthem, CCHP, UBH, MHS, Molina	All	Yes	No
MEDICARE	Yes	Yes	Yes	yes	Yes	No	Yes	No	No
SLIDING SCALE	No	No	Yes	no	No	No	Yes	Financial Counseling Available	No
SELF-PAY REDUCED FEE	Yes	Yes	Yes	\$18 visit/dose	Yes, On Set Scale	Yes	Yes	Financial Counseling Available	No
IN-HOME SERVICES	Virtual	No	No	No	Virtual	Virtual	Virtual	Virtual	No
MEDICATION MGMT ON SITE	No	No	No	Yes	Yes	No	No	No	No
BILINGUAL	No	Yes	Yes, Spanish and Arabian	spanish	Interpreter Service	No	Spanish-speaking Therapist (2)	Translators Available	No
GROUP OR INDIVIDUAL THERAPY	Individual and Group	Individual, Family, and Group	Individual, Family, and Group	Addiction-MAT and Counseling	Individual, Family, and Cognitive BT	Individual, Couples, Family, and EMDR	Individual, EMDR, Autism, and Disability	Individual and Family	Driver's License Issues, CDL
WEBSITE	https://altolife.com	www.advanceclinicalservices.com	http://amricounseling.com/	www.clinicofhope.com	advocateaurorahealth.org	www.beinsightfulcounseling.com	ccmke.org	www.chw.org/ communityservices	None

COUNSELING SERVICES IN KENOSHA COUNTY



This information provided by the Mental Health and Substance Abuse Resource Center at 3536 52nd St. Kenosha, WI 53144.
 This is provided for informational purposes only. Information is subject to change. Inclusion of an agency on the list does not constitute an endorsement or recommendation.
 Key: † Denotes Faith-Based Counselor on Staff

	FLEMING PSYCHOLOGICAL SERVICES	GUIDED WELLNESS	HARBORSIDE THERAPY	JOHN HAWLEY	HORIZON BEHAVIORAL HEALTH SOLUTIONS	INTER-CONNECTIONS	KENOSHA COMMUNITY HEALTH CENTER	OAKWOOD CLINICAL ASSOCIATES	PATHWAYS CONSULTING
PHONE NUMBER	262-654-8366	262-287-1999	262-564-5305	262-945-1526	262-948-1000	262-654-5333	262-656-0044	262-652-9830	262-652-7222
ADDRESS	6127 Green Bay Rd Ste 200 Kenosha, WI 53142	1112 56th Street Kenosha, WI 53140	6123 Green Bay Rd Ste 240 Kenosha, WI 53142	6501 3rd Avenue Suite 7 Kenosha, WI 53143	7201 Green Bay Rd Suite C2 Kenosha, WI 53142	920 60th Street Kenosha, WI 53140	4536 22nd Avenue Kenosha, WI 53140	24804 75th St Salem, WI and 4109 67th St Kenosha, WI	4633 Washington Road Kenosha, WI 53144
PHONES ANSWERED	Mon-Thu 8am -5pm Fri 8am-12pm	Mon-Thu 9am -4pm Fri 9am-12pm	Voicemail	Voicemail	Voicemail	Mon/Tue/Thu 9am-6:30pm Wed 9am-5pm Fri/Sat 9am-3pm	Mon-Thu 6:30am-7pm Fri 6:30am-5pm Sat 6:30am-3pm	Mon/Tue 9am-5pm Wed/Thu 9am-6:30pm Fri 9am-4pm	Mon-Thu 8am-5pm Fri 8am-2pm
TIME TO FIRST APPT.	5-6 Weeks	2-4 Weeks	1-3 Weeks	Not Accepting New Clients 5/27/2022	1 Week	2-3 Weeks	3 Weeks - 1 Month	1 Week	1-2 Weeks
URGENT SLOTS AVAILABLE	Based On Availability	No	Yes, For Current Clients	Based On Availability	No	Within A Few Days	Based On Availability	Yes	Based On Availability
MENTAL HEALTH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
SUBSTANCE USE	No	No	Yes	Yes	No	Yes (No New Clients At This Time)	No	Yes	No
CHILDREN	5 yrs & up	14 yrs & up	7 yrs & up	No	No	14 yrs & up	5 yrs & up Medical Only No Therapy Unless 18 yrs	4-17 yrs old	8 yrs & up
MEDICAL ASSISTANCE AND HMOs	UHC, Children's, and Blue Cross Blue Shield	Yes	All but Molina	Children's, Anthem, and UBH	No	Yes	Yes	Yes	Children's Community Health Plan, Blue Cross Blue Shield
MEDICARE	Based On Availability	Yes	Based On Availability	No	Yes	Yes	Yes	No	Yes
SLIDING SCALE	No	No	Yes	No	No	No	Yes	No	No
SELF-PAY REDUCED FEE	Yes	Yes	Limited	No	Yes	20% Self-Pay Discount	Yes	Upon Request	No
IN-HOME SERVICES	No	CCS Only	No	No	No	No	Virtual	No	No
MEDICATION MGMT ON SITE	No	No	No	No	No	No	Yes	No	No
BILINGUAL	No	No	No	No	Yes, Asian/Indian	No	Yes	Yes, Spanish	Yes, Spanish
GROUP OR INDIVIDUAL THERAPY	Individual, Couples and, Children's Groups	Individual, Marriage & Couples, Family, and Other Specialities	Individual and Couples, Austim	Individual, PTSD, Trauma, and EDMR	Individual	Individual, Family, and Marriage No In-Person Visits	Individual and Family (No Children)	Individual, Family, and Recovery Coaches	Individual, Marital and Family Counseling, Sexual Abuse, and EMDR
WEBSITE	https://www.flemingpsychological.com	http://www.guidedwellness.com	www.harborsidetherapy.com	None	None	https://www.interconnectionssc.com	https://www.kenoshahc.org	https://www.oakwoodclinical.com/	https://www.pathwaysconsultingllc.com

COUNSELING SERVICES IN KENOSHA COUNTY



This information provided by the Mental Health and Substance Abuse Resource Center at 3536 52nd St. Kenosha, WI 53144.
 This is provided for informational purposes only. Information is subject to change. Inclusion of an agency on the list does not constitute an endorsement or recommendation.
 Key: † Denotes Faith-Based Counselor on Staff

	PERSONAL INSIGHT COUNSELING SERVICES	PROFESSIONAL SERVICES GROUP	PSYCHIATRIC & PSYCHOTHERAPY CLINIC	ROGERS BEHAVIORAL HEALTH	SUNRISE CLINICAL SERVICES	THRIVE THERAPY SERVICES	WEST GROVE CLINIC	MENTAL HEALTH AND SUBSTANCE ABUSE RESOURCE CENTER
PHONE NUMBER	262-857-8707	262-652-2406	262-654-0487	1-888-927-2203	262-842-0538	262-997-9411	262-909-6008	262-764-8555
ADDRESS	6530 Sheridan Road Suite 7 Kenosha, WI 53143	2108 63rd Street Kenosha, WI 53143	6125 Green Bay Rd Ste 700 Kenosha, WI 53142	9916 75th Street Suite 205 Kenosha, WI 53142	3536 52nd Street Kenosha, WI 53144	310 Lance Dr Ste 100 Twin Lakes & 3200 Sheridan Rd #104 Kenosha, WI	1400 75th Street Kenosha, WI 53143	3536 52nd Street Kenosha, WI 53144
PHONES ANSWERED	Answering Machine 24 Hours	Mon-Thu 9am-6pm Fri 9am-5pm	Mon-Fri 9am-5pm	Mon-Fri 8am-6pm	Mon-Fri 9am-5pm	Mon-Fri 8:30am-5pm Sat 9am-3pm	Mon-Thu 8am-5pm or Leave A Message	Mon-Fri 9am-5pm
TIME TO FIRST APPT.	1 Day to 1 Week	1-2 Weeks	1 Month	Phone Assessment To Determine Level/Type of Services Needed	2 Weeks	Urgent 1 Week Other 4-12 Weeks	1-2 Days	No Wait For Information. Call Whenever You Need More Information
URGENT SLOTS AVAILABLE	Yes	Not Generally the Same Day	Yes	Call For Information	Yes	Yes	Yes	Assistance to Access These or Other Mental Health or Substance Use Services
MENTAL HEALTH	Yes	Yes	Yes	Call For Information	Yes	Yes	Yes	
SUBSTANCE USE	Yes	Yes	Yes	Yes	No	Yes	Yes	
CHILDREN	Late Teens	Yes	No	10-18 yrs old	13 yrs & up	5 yrs & up	Yes	
MEDICAL ASSISTANCE AND HMOs	No	Yes	No	Most, if HMO (No Molina)	Anthem MA, Centpatco, CCHP, UHC, Icare, Molina, and UHC Comm	Anthem, United Health, MHS, iCare, Network Health, Molina, MyChoice	CCHP, Anthem, UBH, and Molina	No Cost for Any of The Services Provided by the Resource Center
MEDICARE	No	Yes	Yes	No	Yes	Yes	Based On Availability	
SLIDING SCALE	Yes	Yes	No	No	No	No	No	
SELF-PAY REDUCED FEE	Yes	No	Self-Pay - No Sliding Scale	Yes	Yes	No	Yes	
IN-HOME SERVICES	No	No	Virtual	No	Virtual	Virtual	Virtual	
MEDICATION MGMT ON SITE	No	No	Yes	Telepsychiatrist & On-Site Nurse Practitioner	Yes	No	Yes	
BILINGUAL	No	No, will provide interpreter	No	Teletranslator	Yes	No	No	Yes, Spanish
GROUP OR INDIVIDUAL THERAPY	Individual, Veterans, Trauma, Anxiety, and Depression	Individual and Group	Individual, Family, and Marriage	Individual & Group, Adolescent & Adult, Dual Diagnosis, DBT, Anxiety & Depression, Adult & Child Skills Groups, and High-Functioning Disabilities	Individual, Group, Victim of Crime, and Pandemic Stress	Individual, Adult & Child EMDR, Brain Spotting, Play Therapy, CBT, Psych Evals	Individual, Group, Intensive Outpatient, and Medication Assisted Treatment	
WEBSITE	http:// www.personalinsightscounselingservices.com	https://www.psgcip.com	http:// www.ppckenosha.com/ index.html	www.rogersbh.org	www.KHDS.org	https://thrivetherapyservices.net	www.westgroveclinic.com	www.KHDS.org

Reasons for Program Termination

- Non-compliance with treatment agreement.
- Violation of the Hold Open Agreement.

Possible Results of Program Termination:

- Revocation of ATR.
- Incarceration.
- Sentencing on original charges.
- Extension of Jail Diversion Program participation time.



For more information regarding these programs, please contact:

Laura Williams
*Behavioral Health
Jail Diversion Coordinator*
262-657-7188



KHDS, Inc.
5407 8th Avenue
Kenosha, WI 53140
Phone: 262-657-7188
Fax: 262-653-2080
Email: lwilliams@khds.org

Behavioral Health Jail Diversion Program



Provided by:

Kenosha Human Development
Services, Inc.

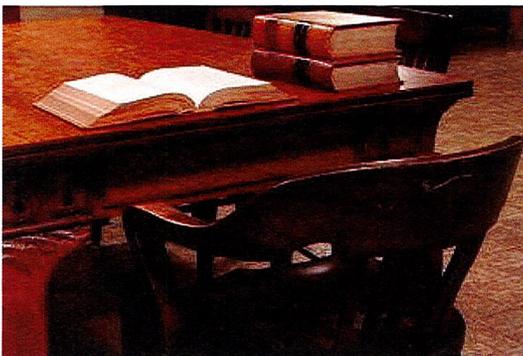
Under contract with:

Kenosha County Department of
Human Services

What is Behavioral Health Jail Diversion Program?

The Jail Diversion Program is designed to provide treatment for adults with a mental health diagnosis who have been charged with misdemeanor non-violent crimes. This pretrial program arranges for the participant's criminal charges to be placed on a court hold open status for up to 12 months. While enrolled, the participant will participate in psychiatric services and experience ongoing community support assisting them every step of the way toward their recovery.

Goal: To ensure participants receive the mental health treatment needed to enhance recovery and reduce the rate of recidivism in the criminal justice system.



Program Eligibility Requirements?

- Mental health diagnosis.
- Kenosha resident age 18 years and over.
- No pending cases/probation in other jurisdictions.
- Charged with *misdemeanor **non-violent crime(s).
- Voluntarily participate in the program for a period of six to twelve months.

** Felony charges accepted if stated in the Hold Open Agreement that the felony will be reduced to a misdemeanor upon successful program completion.*

*** Violent offenses considered on a case-by-case basis.*

Program Benefits?

- Access to mental health treatment.
- Assistance obtaining community services.
- Deferred prosecution agreement vs. incarceration.
- Reduced or dismissed criminal charge(s).
- Available as an Alternative to Revocation (ATR) or in conjunction with probation.

Program Participant Requirements?

Do:

- Keep all scheduled appointments with treating psychiatrist.
- Cooperate with psychological and/or psychiatric testing.
- Participant in a medication monitoring program and take all medications as prescribed.
- Keep all weekly check-in appointments with the Program Coordinator.
- Participate in counseling/group/community support programs recommended by the Program Coordinator.
- Attend all court hearings.

Refrain from:

- Refrain from ingesting any controlled substances not prescribed.
- Refrain from consuming alcohol.
- Refrain from committing any additional offenses.
- Refrain from attempts or threats to harm self or others.

Sharing Hope:

An African American Guide to Mental Health



3803 N. Fairfax Drive
Arlington, VA 22203

NAMI.org

HelpLine 800-950-NAMI

 @NAMICommunicate

 [Facebook.com/officialNAMI](https://www.facebook.com/officialNAMI)

 NAMICommunicate





NAMI is the National Alliance on Mental Illness, the nation's largest grassroots mental health organization. NAMI provides advocacy, education, support and public awareness so that all individuals and families affected by mental health conditions can build better lives.

Stock photos used in this publication are for illustrative purposes only and any person depicted in the stock photo images is a model.

Copyright 2014 NAMI
NAMI, 3803 N. Fairfax Drive
Arlington, VA 22203

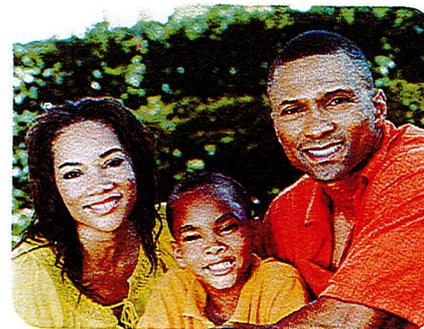
NAMI.org

HelpLine 800-950-NAMI

 @NAMICommunicate

 Facebook.com/officialNAMI

 NAMICommunicate



Wellness means being healthy physically, mentally and spiritually. Mental health conditions in particular can affect all of us. One in every four individuals has a mental health condition of some kind, according to the National Institute of Mental Health. African Americans are no exception.

Any part of the body—including the brain—can get sick. We all experience emotional ups and downs caused by specific events in our lives, such as a death in the family or a new job. Mental health conditions don't follow the rules of these typical reactions, however. They are medical conditions that cause changes in a person's thoughts, feelings and mood. These changes can make it hard to relate to others and carry out daily functions.

The good news is that there is help, and that these conditions can be treated. If you or someone you love has a mental health condition, it is important to know that recovery is possible.

This guide will help you learn how to recognize mental health conditions, the types of treatments and supports available and where to go for help. The stories in this guide illustrate what it is like to live with a mental health condition. They are meant to illustrate common issues only. For these examples, we will assume that an evaluation has been completed, since the only way to get an accurate diagnosis is to get a full evaluation from a mental health professional (see page 12 for more on getting an evaluation).

Mental health conditions:

- can make it hard to live day-to-day life.
- take a toll on personal and professional relationships.
- can occur at any age (50% begin by age 14).
- are treatable.
- are not divine punishment.
- are not anybody's fault.
- are not the result of bad parenting.
- are not caused by weakness or lack of willpower.



“Last week, for the first time in a long time, I was able to sit and have a decent conversation with Tony, my husband. It makes me nervous not knowing what to expect from him.”

Tony was sharp, hardworking and very popular. He had one of those personalities that you could not help but notice when he entered a room. Then, a few years ago, he started to change. His days got packed to the brim: he worked two jobs, went to the gym, played ball and just didn’t need to sleep. He looked and acted invincible. All of a sudden, he felt we needed lots of things we didn’t need before. I remember him saying, ‘I’ll work three jobs and a part-time gig to have the things we need.’

Then there were times when he would get angry over nothing and everything got on his nerves. He started missing work and wanted to stay in bed all day. I thought he had been working too hard and just needed a break. I tried to help by fixing his favorite meals and taking him out to a movie or dancing. Nothing worked.

We had begun to fight more and more, but then all of a sudden, he seemed to be his old self again. A month later, he started apologizing over and over for being a disappointment and a good for nothing. He has begun drinking and God knows what else he is doing. I know that Tony loves me, but I just can’t handle anymore not knowing which of his many moods I will be dealing with.”

—Aliyah

Tony Is Experiencing Symptoms of *Bipolar Disorder*

Bipolar disorder is a condition that causes an irregular pattern of changes in mood, energy and thinking. People with bipolar disorder have high and low moods, known as mania and depression, which differ from the typical ups and downs most people experience.

Symptoms of *Mania*:

- Increased energy, not wanting or not being able to sleep
- Euphoria, feeling invincible
- Splurging money or excess in other areas
- Agitation, irritability, nervousness, impatience, anger
- Thinking and/or speaking very fast
- Exaggerated self-esteem
- Poor judgment
- Disproportionate or unrealistic ideas or plans

Symptoms of *Depression*:

- Sadness and feelings of hopelessness
- Loss of self-esteem
- Excessive feelings of guilt or worthlessness
- Difficulty focusing and making decisions
- Drug and/or alcohol abuse
- Suicidal thoughts or plans

Facts You Should Know

- Some individuals with bipolar disorder do not realize that they need help.
- Bipolar disorder is highly treatable.
- African Americans with bipolar disorder tend to be underdiagnosed.
- Researchers have found high rates of attempted suicide among African Americans with bipolar disorder.
- Alcohol or other drug use is common with this condition; it often decreases when the disorder is treated.
- Treatment options include therapy, education, medication and other supports.



“I’m taking off school for a few days to go help my sister Jasmine. I’m really worried about her.

Jaz was a happy teen with good grades and good friends in school. Yes, sometimes she misbehaved, but it was nothing out of normal teen behavior. But in the past year, she has started acting increasingly weird. One day, for no apparent reason, she went into the school’s gym and completely trashed it. She is failing most of her classes. She doesn’t have any friends left.

The other day, Mom told me that Jaz has been refusing to come out of her room for days at a time. When I called to ask her what was going on, she said she was ‘hiding from the people who are trying to get her.’ I could not convince her that nobody is trying to get her. She sounded so afraid. I tried to tell her a joke to get her to relax. But instead of laughing, she cried. We know she is alone in her room, but Mom hears her talking to someone else. Other times she paces the floor all night, peeping through the blinds, as if looking for someone.

I am beginning to think that my sister is losing her mind. I hope things will be okay when I get there and that Jaz will be all right.”

—Jason

Jasmine Is Experiencing Symptoms of *Schizophrenia*

Schizophrenia is a condition that interferes with the ability to think clearly, manage emotions, make decisions and relate to other people.

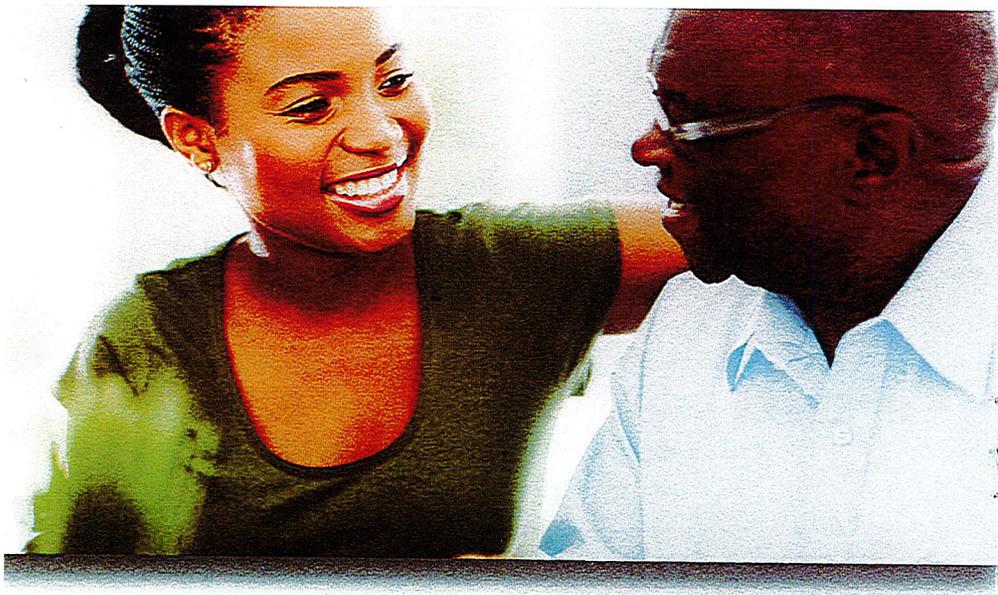
The first signs of schizophrenia may only be a change of friends, a drop in grades or an increase in irritability.

Other symptoms include:

- Inability to keep a job or to maintain healthy relationships
- Fears of being persecuted (mistreated, victimized, wronged)
- Inappropriate emotional reactions (such as weeping when someone tells a joke)
- Hearing, seeing or smelling things that do not exist (hallucinations)
- Difficulty thinking clearly or making rational decisions
- Difficulty distinguishing between reality and fantasy, usually called psychosis. Psychotic hallucinations and delusions people experience can cause them to behave in unusual or unpredictable ways
- Disorganized thoughts and language, such as leaping from topic to topic without any connection, making up words or uttering noises instead of words

Facts You Should Know

- While the occurrence of schizophrenia is the same across all racial communities, research has shown that African Americans tend to be overdiagnosed with schizophrenia due to provider bias and lack of cultural competence.
- The first signs of schizophrenia usually emerge in the teenage years or early 20s.
- People with this condition are not usually violent, but co-occurring substance abuse can increase this risk.
- Schizophrenia can be treated with therapy, education, medication and other supports.



Tammie's Father Experienced Symptoms of *Depression*

Depression is more than just feeling sad or blue once in a while—it's a condition that affects how a person thinks, feels and acts. It takes away a person's energy, interests and pleasure interfering with all aspects of life. The symptoms of depression are:

- Changes in sleep
- Changes in appetite
- Lack of concentration
- Loss of energy
- Lack of interest
- Low self-esteem
- Feelings of hopelessness
- Changes in movement
- Physical aches and pains
- Wishing to die and thoughts of taking one's life

These symptoms have to last for at least two weeks to be considered depression.

"I still can't believe Dad is gone. Worse, I can't believe he took his own life. That's just not something he would do. I know he had not been himself since he was diagnosed with diabetes. The doctors did say that he would go through bouts of the blues from time to time, but we never expected this.

Things started to change little by little. He started complaining of feeling weak and about his head hurting all the time. I thought he felt weak because he wasn't eating much. He used to be so outgoing and all—one of those strong, committed deacons of the church. He stopped helping at church because he said he was more of a burden than helpful. He loved to get together with friends for weekly board games. I don't even remember when he stopped doing that. Actually, now that I think about it, gradually, he stopped doing most of the things he used to enjoy doing. I thought he was just getting old and starting to slow down. Now I am thinking it was more than that.

Weeks before he passed, he gave away his home improvement tools. He really loved those tools, but I just thought he had no further use for them. A couple of days ago, he began cleaning out his closet. I thought this was a good sign and that he was starting to break through the slump, an 'out with the old, in with the new' situation. All of a sudden he seemed busy and in a better mood. Next week is his birthday. I miss him already."

—Tammie

Facts You Should Know

- Depression is the leading cause of disability in America.
- Depression can occur at any age, including childhood, teenage years and adulthood.
- Untreated depression is a risk factor for suicide.
- African Americans are less likely to receive appropriate diagnoses and treatment for depression and are more likely to have depression for long periods of time.
- Depression can be treated with therapy, education, medication and other types of support.

“Recovery is a personal journey. Once you get your diagnosis, explore what works to help you recover. You just have to find what works for you and work on it.”
—Mary

Recovery is Possible!

While the conditions we just covered can seem scary and overwhelming, the good news is that people who face them can and do get well. While people can recover, they need professional help to do it. They can't just snap out it, and praying is not enough.

Steps to Finding Help

If you are dealing with a mental health condition, you should:

1. Speak honestly about these matters with people you trust.
2. Seek help from a health care professional.
3. Contact NAMI.
4. Become your greatest advocate.

1. Speak honestly about these matters with people you trust.

If you think you or someone you love may have one of these conditions, talk with a person you trust about the changes you have noticed that concern you; perhaps he has noticed them as well. Introduce the subject matter with great respect and love, since the person who has the problem might not be aware of these changes or could feel scared or ashamed about them. If you think you have a mental health condition, tell someone you trust and ask for support in seeking help.

Mental Health Professionals

Clinical social workers are trained to help with individual and family problems, including mental health conditions.

Psychologists are trained in mental health issues. They provide counseling (therapy).

Psychiatrists are medical doctors, so they can prescribe medications. They specialize in mental health conditions.

2. Seek professional help.

It is very important to seek professional help as soon as possible. Your primary care doctor is a great place to start. Your doctor may be able to start the assessment process or assist you in getting a referral to a mental health professional.



Unfortunately, while many African Americans would prefer finding an African American mental health professional, this is not often possible. Thankfully, professionals are increasingly required to learn how to effectively treat people from diverse backgrounds.

Your mental health provider will play an important role in your treatment, so make sure you can work with this person, that you communicate well together and that she respects and integrates your culture, beliefs and values into your treatment plan.

- Ask questions to make sure the provider is a good fit for you.
- Speak clearly and honestly with your provider. A good provider should take the time to explain things in terms that you can understand. Remember, they are there to help you. Ask as many questions as you need in order to understand the situation and accept the suggested treatment.
- Mention your beliefs, values and cultural characteristics. Make sure that he understands them so that they can be considered in the course of your treatment. For example, mention whether it is important for you that your family be part of your treatment.

If finances are preventing you from finding help, get in contact with a local health or mental health clinic or your local government to see what services you qualify for. You can find contact information online at findtreatment.samhsa.gov, or by calling the National Treatment Referral Helpline at 800-662-HELP (4357).

Questions you can ask to get a sense of your provider's level of cultural sensitivity:

- Have you ever treated African Americans with my diagnosis?
- Have you received training in cultural competence or multicultural mental health?
- How do you see our cultural backgrounds influencing our relationship and my treatment?
- How do you plan to integrate my beliefs and practices in my treatment?

During Your First Doctor's Appointments:

- Make a list of the changes and behaviors you have observed that worry you.
- Be honest and explain to the doctor everything you have noticed so he can make the right diagnosis. To make a diagnosis, the doctor looks at a group of symptoms. Your doctor will want to know the following:
 - Frequency: how often the feeling or behavior occurs.
 - Intensity: how much it interferes with a person's daily life.
 - Duration: how long it lasts.
- Be aware that African Americans are more likely to mention physical symptoms related to mental health problems, and that culturally insensitive providers might not recognize the connection of these symptoms to a mental health problem.
- Be patient. It could take time and multiple visits before you get the right diagnosis.

3. Contact NAMI.

You and your family are not alone. NAMI, an organization of individuals and family members who live with mental health conditions, offers free support, information, education, hope and assistance. NAMI members get what you are going through since they have gone through similar experiences.

To find a NAMI near you, visit www.nami.org or call 800-950-NAMI (6264).

"NAMI gave me the love and support I needed, right when I needed it. I no longer feel alone. In NAMI, I have a family that supports me and helps me deal with my illness."

—Debbie

4. Become your greatest advocate.

African Americans generally experience disparities in mental health care. Some of these disparities are due to bias and lack of cultural sensitivity from the mental health system, which manifest as misdiagnoses and inadequate treatment, among others. Furthermore, the mental health system can be challenging to navigate. For these reasons, learning as much as possible about the illness, treatments, your rights, resources, etc. will help you navigate the system so that you can get appropriate care. Your local NAMI can show you how to find the information you need. The more you know, the more you can make educated decisions about your care.

Treatments and Supports

Thankfully, there are different treatment options available. Often, a combination of them works best. Research shows that people get better when they embrace a treatment plan of their choosing that includes a variety of treatments and supports. You can choose what works best for you in partnership with your health care provider.

Family and Peer Support

"Intimate relationships with family members and friends are so wonderful to experience. Feeling connected is the most wonderful feeling of all."

—Clarence

Whether it's from the family you were born into or the family you have chosen, support from loved ones can play a big role in your treatment plan. They can keep you accountable, help you recognize the early signs of a possible relapse, help you with other treatment components (for example, exercise with you or take you to appointments), and provide moral support, among other things.

Peer-support groups have proven to be very helpful as well. They consist of supports provided by people who have lived experience dealing with mental health conditions. Organizations such as NAMI offer free education classes and support groups for people living with mental health conditions and family members. To find a NAMI in your community, visit www.nami.org or call 800-950-NAMI (6264).

Spirituality and Faith

Faith and spirituality can greatly help in the recovery process. If spirituality is an important part of your life, your spiritual practices can be a strong part of your treatment plan. Talk to your doctors about how important your faith is to you,

and spend time in prayer and worship focused on healing (finding a good doctor, receiving the right treatment, dealing with the symptoms, etc.). Your spiritual leaders and faith community can provide great help and support during the difficult times caused by mental health conditions. At the same time, unfortunately, sometimes faith communities can be a source of additional distress if they are not well informed and do not know how to support families dealing with these conditions.



Psychotherapy

Psychotherapy consists of talking to a trained professional about the situations you are going through. The professional will listen without judgment and support you through your life's challenges by helping you see them in a different light, offering insight and helping you explore them. Don't worry about your privacy; everything you share with your therapist is confidential.

Medications

Let's face it: We don't always like to take medications for fear of becoming addicted to them or not being exactly sure of what you are taking. However, medications need to be considered since they have proven to work well for mental health conditions. You and your doctor can seek the medication(s) most effective for you. Talk with your doctor about different options and their side effects. Some things to remember:



- It usually takes time and various tries before finding the right medication(s).
- Be patient, and don't give up if the medications don't seem to work at first. It takes time for them to start working in your system, and experiencing a period of medication adjustment is common.
- You may experience side effects from the medication; monitor them and report them to your mental health provider.
- Don't discontinue the medications once you start feeling better. Feeling better means that the medications—and the other treatments you are using—are working.

Other Healing Practices

The arts (dance, music, visual arts, etc.), journaling, meditation, yoga and other relaxation techniques are helpful recovery practices. In addition, it is important to live a healthy and active lifestyle that includes eating well and exercising.

NAMI Resources

Sharing Hope

Sharing Hope is an hour-long program that increases mental health awareness in African American communities by sharing the presenters' journeys toward recovery and exploring the signs and symptoms of some illnesses. www.nami.org/sharinghope.



www.nami.org

On NAMI's website, you can find the latest information on mental health, as well as treatment and support resources. You can also read inspirational stories of recovery from real people—and even share your own.

NAMI HelpLine

Our free phone line is open Monday-Friday from 9 a.m. to 5 p.m. EST. The HelpLine can assist you in connecting with your local NAMI, community services and supports, and also send you information on specific topics. 800-950-NAMI (6264)

Education and Support Programs

NAMI offers a variety of free programs for people with mental health conditions and their family members. These programs are taught by trained volunteers who have had similar experiences. For more information, visit www.nami.org/programs.

Other Resources

American Psychiatric Association www.healthyminds.org

Black Psychiatrists of America www.bpainc.org

Substance Abuse and Mental Health Services Administration www.samhsa.gov/index.aspx

National Association of Black Social Workers www.nabsw.org/mserver

National Institute of Mental Health www.nimh.nih.gov/health/topics/index.shtml

National Suicide Prevention Lifeline www.suicidepreventionlifeline.org

The Association of Black Psychologists www.abpsi.org



KCHC

Kenosha Community Health Center, Inc.

Overview of Services

March 2022

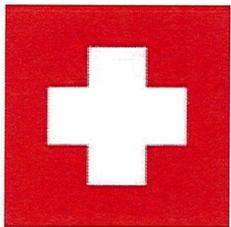


Who is KCHC KCHC?

Who is KCHC?



“We are a nonprofit organization offering to the underserved citizens of Kenosha County, Racine County, and Walworth County comprehensive healthcare which enables our patients to maintain their well-being by addressing health disparities and providing access to all”



Medical Services



Dental Services



Behavioral Health
Services



Pharmaceutical
Services

What is a *community health center*?

A community health center is an organization that:

- * Provides **primary health care services** that are comprehensive, high-quality, and culturally competent **AND support services** such as transportation, translation, and health education
- * Has a **sliding fee scale** for these services, and does not discriminate services provided based on patients' ability to pay
- * Responds to the unique needs of diverse, medically underserved populations through the development of **integrated, patient-centered care systems**
- * Reduces health disparities through prioritizing **coordinated care** and engaging in **quality improvement practices**

What does “federally qualified” mean?

A community health center that is federally qualified:

- * Receives funding from the **Health Resources & Services Administration (HRSA) Health Center Program** to provide their sliding fee-scale services
- * Is a **stand-alone organization** that is **held to a high standard of federal regulatory requirements** in order to receive funding
- * Includes **patient representation** in their board of governors
- * Receives reimbursement for services provided to **Medicare/Medicaid patients**
- * **Providers credentialed; Malpractice Insurance through FTCA**
- * Able to provide **340B Drug Pricing Program discounts** for patients needing pharmaceutical services

What a federally qualified health center (FQHC) is *not*

A FQHC is **NOT**:

- * A federal agency
- * A free clinic
- * A health center owned or operated by any city, county, state, or federal governmental agency.
- * “The Health Department” or part of the County
- * Owned or operated by any local or regional private healthcare system

How Does A Community Maximize the FQHC Federal Dollars?

- * Federally Qualified Health Centers (FQHCs) provide preventive medical, dental, and behavioral health care medically underserved and vulnerable populations, including the uninsured and those living below the poverty level.
- * Because FQHCs receive a special designation from the Bureau of Primary Health Care and the Centers for Medicare and Medicaid Services that allows them to get reimbursed for care provided to medically underserved populations (MUPs) or in medically underserved areas (MUAs), such as rural areas and inner cities. FQHCs are primarily funded by the Health Resources and Services Administration (HRSA) under Section 330 of the Public Health Service (PHS).
- * **Better performing FQHCs have demonstrated the more they do, the more self-sustaining they become, and the more services they can provide.**
- * **Collaborations and partnerships are the key to strategically positioning growing FQHC services and resources in the community.**

Kenosha Community Health Center, Inc.

26 Years of Service

Services located within multiple locations:

- * Administrative Offices; 625 57th Street, Ste. 700,
- * Clinic at 4536 22nd Ave.
- * Clinic at 6226 14th Ave.
- * Clinic at the Boys & Girls Club; 1330 52nd Street, #205
- * Clinic at Silver Lake; 903 S. 2nd Street, Silver Lake
- * Mobile Care

2020-2021 marks a change in leadership and direction of the health center.

- * Experienced Board of Directors
- * New executive and mid-level leadership
- * Improved service model and focus to patient and family experience
- * Expansion of services, provider recruitment, organizational partnerships

Board of Directors

Tamarra Coleman (President)

Anita Johnson (Vice President)

Joseph Clark, CPA (Treasurer)

Dana Berry (Secretary)

LaVetta Arrington

Shannon Brehmer

Sue Gerber

Erin Ginn

John L. Rocha II, LCSW

Terry Rose, J.D.

Paul Spottswood, MD

Venkata Thota, MD

Kathleen Woeste, RN

Jeffery Zeller, DDS

KCHC Executive Leadership Team



MARY OUIMET DNP, RN
CHIEF EXECUTIVE OFFICER



GARY MOSS
CHIEF FINANCIAL OFFICER



NICOLE MUBANGA, MD
CHIEF MEDICAL OFFICER



JOHN VASELANEY, DDS
CHIEF DENTAL OFFICER



RAYMOND GARAY
EXECUTIVE DIRECTOR
OF MEDICAL SERVICES



JODI ALLEN
EXECUTIVE DIRECTOR
OF DENTAL SERVICE

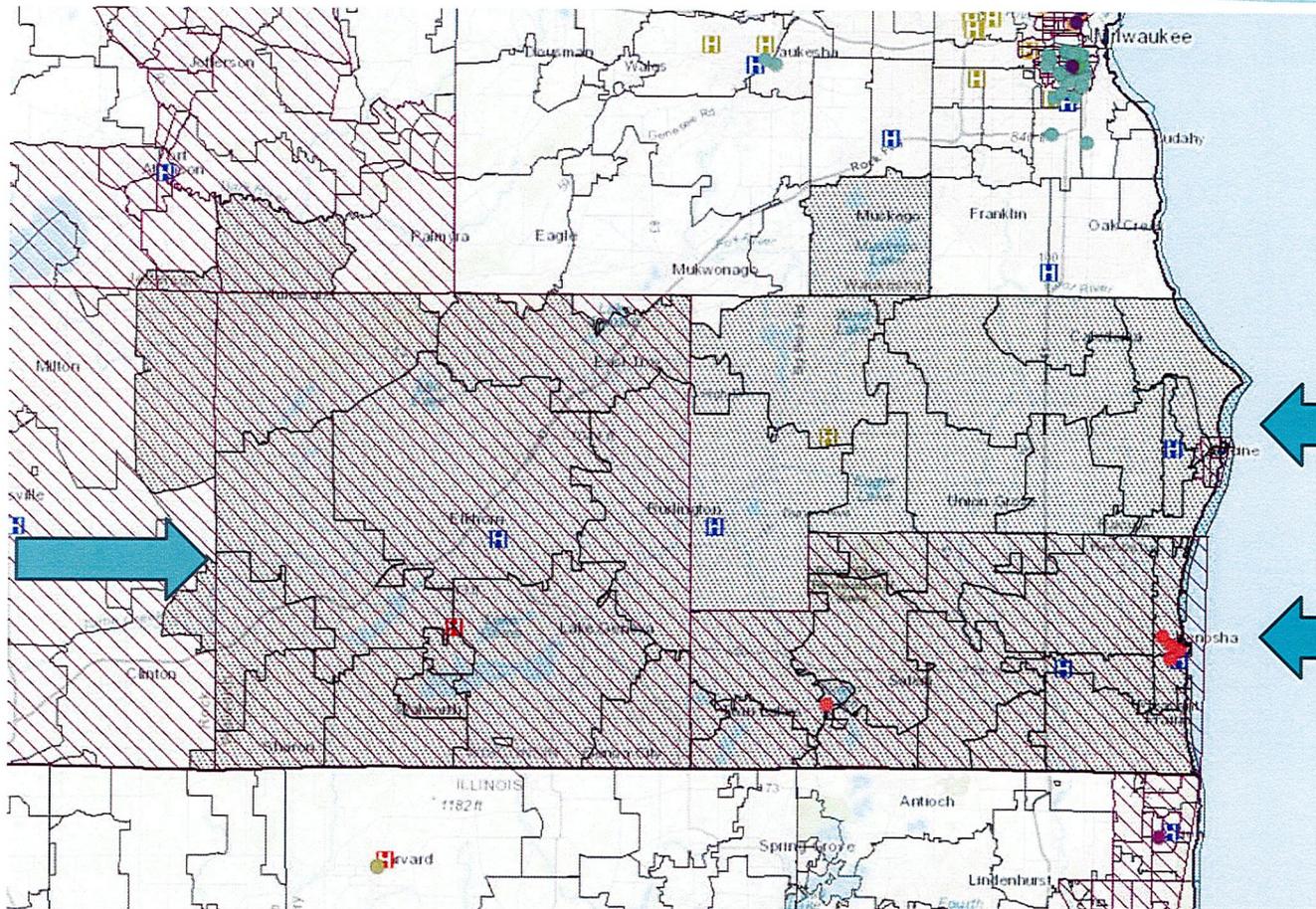


JOLIE HELGESEN
DIRECTOR OF HUMAN RESOURCES



KENNETH MORRIS
DIRECTOR OF COMPLIANCE,
RISK & SAFETY

Service Areas



Walworth Co.

Racine Co.

Kenosha Co.

Community Needs Assessment: Significant Gaps to Care Access

* **Unmet Medical Care**

- * 21% respondents delayed or did not seek medical care due to costs.
- * The percentage of adults who received primary health services through a Medical Doctor or Nurse Practitioner's office decreased steadily from 74% in 2008 to 61% in 2019.
- * Those most likely to report unmet needs were in the 40% household income bracket.

* **Unmet Dental Care**

- * 18% reported someone in their household did not get the dental care they needed sometime in the last 2 months. This is an increase from 16% in 2016.

* **Unmet Prescription Medications**

- * 11% reported someone in their household had not taken prescribed medication in the past 12 months due to prescription costs

* **Unmet Mental Health Services**

- * 4% reported someone in their household had an unmet mental health care need

Although the extent of our reach to the high-risk, vulnerable population has been broad, there remains a significant gap in those not routinely accessing care. KCHC has set out to address this gap by adapting services to better meet identified needs.

Services Strategically Located

Sites Located Within Most Challenged Areas

- * Dental access in city and county
 - * 14th Avenue; 38 dental operatories
 - * Silver Lake; 3 operatories
- * Medical access at all locations
- * Behavioral access at all locations
- * Enabling services at all locations

Mobile Care Services Expanding our Reach

New Location Planned in 2022

Enabling Services

KCHC “Patient Support Services” Program

- Health Literacy (case management)
- Translation/Interpretation
- Health Education
- Case Management
- Patient Care Advocates
- Insurance Eligibility Assistance

2020-2021

Rebuilding the Foundation

Expanded Access Through Service Growth

- * Over 50 mobile Covid-19 testing and vaccination missions
- * Added dual certified Psychiatric Nurse Practitioner
- * Added Transition of Care Nurse to work with hospitals and external agencies
- * Re-opened Silver Lake Clinic with expanded dental hours
- * Seal-A-Smile re-started with additional reach to the schools
- * Hired a Pharmacist and expanded 340B Services

Set a New Bar for Comprehensive Quality

- * Implemented new Quality Management Plan, Integrated Structure, and Balanced Scorecard Approach
- * Completed first Culture of Safety Survey
- * Implemented Patient Advisory Group
- * Improved quality measurement (Azara DVRS, MTC)

Stabilized Workforce and Improved Employee Engagement

- * Market adjusted all positions
- * Implemented Town Hall meetings

2020-2021

Rebuilding the Foundation (cont.)

Improved Operations

- * Implemented new phone system
- * Multiple revenue cycle projects (pricing project, A/R clean up, etc)
- * Dexis Implementation (Dental)
- * Updated 5 Dental Operatories
- * New Risk Management and Document Management System (Compliatric)
- * New IT partnership
- * New Revenue Cycle Partnership

Established New Academic Partnerships

- * Medical College of Wisconsin; Outcomes Research
- * UWM College of Nursing advance practice preceptorships/ research support
- * Marquette University College of Nursing research partnership
- * Gateway Technical College Advisory Board Participation

But Now It is Time to Grow Into A Sustainable Model for the Future

- * KCHC is planning to strategically grow all services within all service areas within the HRSA scope
- * Plan to work with community partners to move appropriate patients into the FQHC care model
- * New service design is underway and continuously shaped by community feedback

Key Learnings to Shape New Service Design

- * Brand confusion and lack of knowledge regarding services.
- * Traditional services are not enough.
- * Traditional healthcare model is inconvenient.
- * Many uninsured individuals who lacked education and knowledge about self-care and accessing healthcare services. Given work obligations, this was not a priority.
- * There is a growing mental health demand (especially in schools).
- * Not an efficient pathway for referrals into the center from hospitals and other healthcare agencies
- * Many individuals were not getting the benefit of 340-B pharmacy program
- * Need to make better connection to those moving in and out of homelessness as well as the detention centers

Plans Underway to Reset the Current KCHC Model in 2022

- * *A new site under a new brand name with a new way of delivering integrated medical, dental, and behavioral health care will be opened in June 2022*
- * *Mid-size businesses with a large workforce of low-income workers and their families will be targeted as a population of focus as well as those in shelter.*
- * *Plan to design deliver culturally competent care with a focus on assessment of Social Determinants of Health.*
- * *Population outcomes will be tracked over time*
- * *Plan to formalize the mobile care model for those who will not come into traditional healthcare settings*
- * **Initial Goal:** Reach a minimum of 30% of those not currently accessing care through new programming

New KCHC Site

4006 Washington Road, Kenosha, WI



Additional Strategies Underway to Address Gaps in Unmet Needs

- * **Building awareness and expanding services in Kenosha County at Silver Lake Location:**
 - * Dedicated medical and dental providers; expanding hours
 - * Increased outreach through vaccine missions and introductions to area dental practices
 - * Pursuing addition of psychiatric onsite and telehealth services
 - * Increasing marketing to area
- * **Expanding services to children and adolescents**
 - * Seal-A-Smile program expanding reach
 - * Pursuing before and after school partnership to provide medical, dental, and behavioral services
 - * Implementing sports physical program with KUSD
- * **Partnering with area hospitals**

KCHC Behavioral Health Program

KCHC Starting to Turn Around Volume Decline Pre-Covid 19

	<u>2017</u>	<u>2018</u>	<u>2019</u>	<u>2020</u>	<u>2021F</u>
Total unduplicated patients	15,888	14,607	14,026	16,613	15,400
<u>Encounters:</u>					
Medical	19,647	16,345	14,517	18,192	19,059
Dental	24,149	24,533	24,219	16,014	20,749
Behavioral Health	2,671	1,011	1,347	1,212	1,734
Enabling Services	2,152	401	1,200	446	601
Total Encounters	48,619	42,290	41,283	35,864	42,143
Average encounters per patient	3.1	2.9	2.9	2.2	2.7
COVID tests included in above				11,675	4,571
COVID vaccines not included above					5,550

Behavioral Health Team Poised for Growth



Clare Lewandowski,
PhD, LP



Heidi Eckelberg,
NP



Anna Amari,
MSW, APSW



Reed Stanek,
MSW, APSW



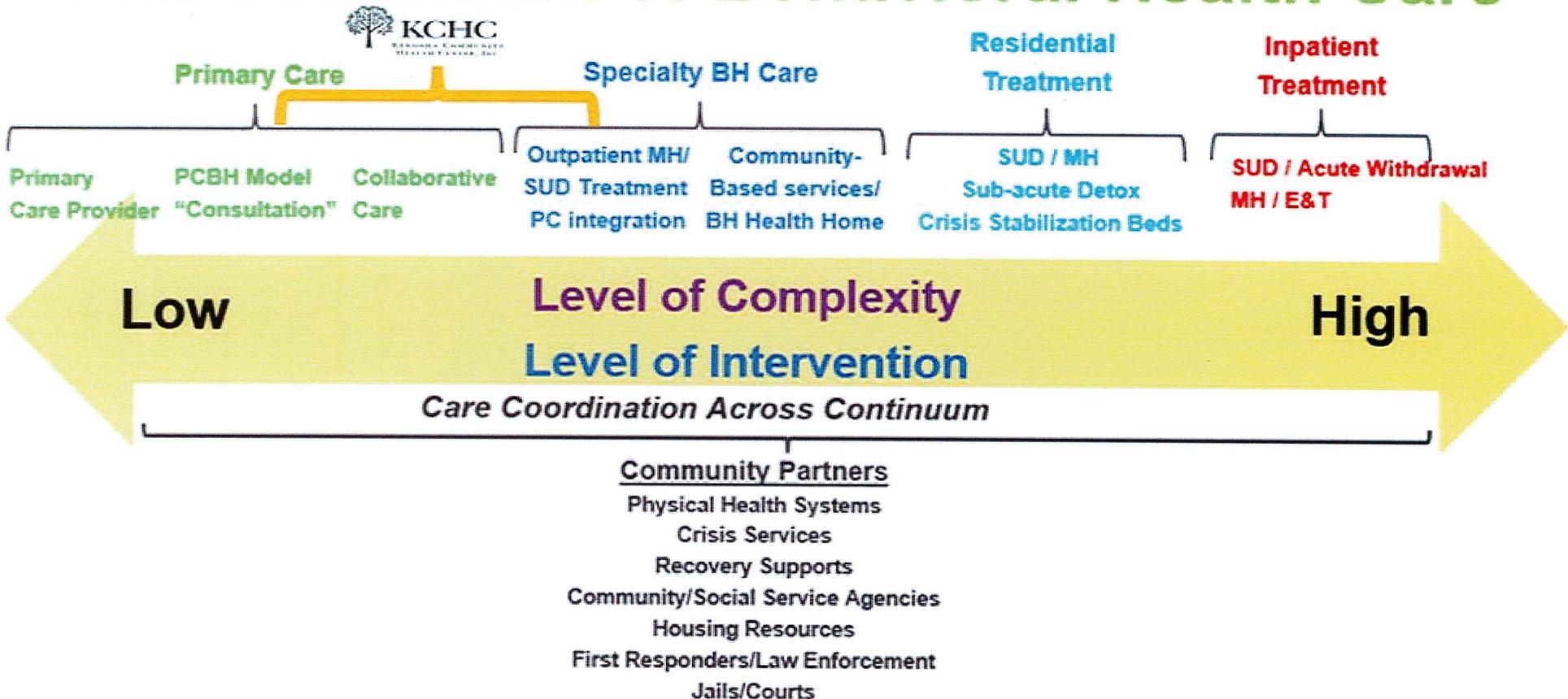
Erica Moreno,
Case Manager

Behavioral Health Program: Today's Baseline

- * DHS certified outpatient clinic
- * Improved access and shifted to evidence-based treatment with targeted therapies
- * Counseling services are patient directed, and goal driven to return to natural supports and community.
- * Recently added Psychiatric NP Prescriber- will expand psychiatry as referrals grow
- * Many areas for potential growth based on need (child and adolescent; substance abuse; CHP, etc.,)

Finding Our Niche in BH

Full Continuum of Behavioral Health Care



So Where Can KCHC Add Most Value To
Address the Behavioral Health Needs of the
Kenosha Community At this Time?

RESEARCH WEEKLY: Availability of Walk-in and Crisis Outpatient Treatment Services in the United States

By Nina Robertson

The U.S. health care system is failing those with serious mental illness due, in part, to the lack of outpatient mental health crisis services available around the country, according to a study recently published in *Psychiatric Services*. Hospital emergency departments are considered the frontline services when triaging a mental health crisis. These settings are unable to provide adequate resources in a timely manner, which highlights the necessity for outpatient mental health crisis services to manage acute and subacute psychiatric events.

Outpatient mental health services offer various, specialized methods for individuals experiencing a mental health crisis such as verbal de-escalation, psychotherapeutic strategies, outpatient and inpatient referrals and treatment planning. This novel study published in *Psychiatric Services* examines the lack of these outpatient services in the form of walk-in services and crisis services around the country. The authors look into expansive policy options to remedy this national issue.

Study details

The authors examined temporal trends, geographic variation and characteristics of psychiatric facilities that provide emergency psychiatric walk-in and crisis services across the United States. They used cross-sectional, annually collected data that covered the 2014-2018 period from the National Mental Health Services Survey (N-MHSS) that is sponsored by SAMHSA. This representative survey accounted for all public and private mental health treatment facilities in the United States. It serves as the annual census of all U.S. mental health facilities curated in the National Directory of Mental Health Treatment Facilities and the Behavior Health Treatment Services Locator. U.S. Census Bureau data was utilized to calculate population-based rates of services per 100,000 adults in the United States. Both sets of data were merged to calculate state level trends of service availability.

Results

Analysis indicated that nearly half (42.6%) of all U.S. mental health facilities did not offer any mental health crisis services between 2014 and 2018. A third of all facilities offered emergency psychiatric walk-in services and just under one-half provided crisis services. Only 25% of all facilities in the United States provided both emergency psychiatric walk-in services and crisis services.

Between 2014 and 2018, walk-in and crisis services availabilities declined by 15.8% and 7.5%, respectively. N-MHSS data showed that facilities in the South offered the highest proportion of psychiatric walk-in and crisis services in comparison to the rest of the country.

Implications

The authors note that in light of the COVID-19 pandemic, the U.S. emergency management system has

been stretched beyond capacity and resources are scarce. There is a significant need for licensed mental health facilities in the United States to expand provisions of crisis services. The sparse geographic availability of psychiatric care in many states such as Massachusetts, New Jersey, Texas, Florida and Delaware raises concerns about underdeveloped psychiatric emergency infrastructure in these regions. These disparities around the U.S. borders and coasts indicate necessary policy efforts to increase equitable access to services, according to the authors.

Outpatient settings are the largest component of the U.S. mental health system. Crisis care is often unavailable for those who cannot access adequate outpatient services. Results indicate a significant need for more mental health facilities that expand the availability of crisis services. The authors state that funding and policy must intersect to solve this national issue. They cite multiple, practical interventions such as an “increase in authorization and appropriation of funds, a 5% Mental Health Block Grant, increased funding for research and evaluation, additional payment mechanisms, and a central coordinating role for Congress.” The authors conclude by arguing that the mental health care system must take into account the effects of the ongoing COVID-19 pandemic. This should be done alongside physical health care to allow those with serious mental illness to access the care they deserve.

References

Kalb, L., Holingue, C., Stapp, E., et al. (June 2021). Trends and Geographic Availability of Emergency Psychiatric Walk-In and Crisis Services in the United States. *Psychiatric Services*.

Nina Robertson is a research intern at the Treatment Advocacy Center.

[View as Webpage](#)

To receive *Research Weekly* directly in your email inbox on a weekly basis, click [here](#).

Questions? Contact us at orpa@treatmentadvocacycenter.org

Research Weekly is a summary published as a public service of the Treatment Advocacy Center and does not necessarily reflect the findings or positions of the organization or its staff. Full access to research summarized may require a fee or paid subscription to the publications.

The Treatment Advocacy Center does not solicit or accept funds from pharmaceutical companies.

Toolkit for Improving Crisis Intervention and Emergency Detention Services



WISCONSIN DEPARTMENT
of **HEALTH SERVICES**

P-02224 (08/2018)

Table of Contents

Introduction.....	3
Ten Essential Values for Crisis Response.....	4
Providing Value to Consumers	5
Obstacles to Improvement.....	6
Resources	6
Knowledge.....	6
Services.....	6
Coordination.....	7
Timing.....	7
Data	7
Client	7
A Quick Guide to Positive Change	8
Best Practices.....	9
Assure a comprehensive understanding of the crisis	10
Assure adequate time with the individual in crisis	11
Collaborate with community partners.....	12
Collaborate with law enforcement	13
Commitment to Zero Suicide and suicide safe care.....	14
Develop and utilize regional or statewide crisis call centers	15
Develop residential crisis stabilization programs.....	15
Ensure crisis providers have appropriate training and competence	16
Ensure timely access to supports and services.....	16
Focus on strengths-based and recovery-oriented service provision	17
Make a strong commitment to safety.....	17
Make it a priority to help the individual to regain a sense of control	18
Make peer support available	18
Provide culturally and linguistically appropriate services.....	19
Provide referrals and follow-up	19
Provide services in the least restrictive manner.....	20
Provide trauma-informed care.....	21
Respect client rights	21
Respond to self-defined crisis without dismissing as not meeting criteria	22
Skillfully serve people with dementia	23
Support recovery from substance use disorder.....	24
Take meaningful measures to reduce likelihood of future crisis.....	25
Use 24/7/365 centrally deployed mobile crisis.....	26
Use data driven processes.....	26
Model for Improvement.....	27
Science of Improvement	29
References.....	29

Introduction

This toolkit was developed as part of the Wisconsin Department of Health Services Learning Collaborative for Crisis Intervention and Emergency Detention managed by the Division of Care and Treatment Services.

Behavioral health agencies representing all regions of the state worked with staff from the Division of Care and Treatment Services from February through June 2018 to discuss strategies and approaches on how to support people experiencing a mental health crisis in the community rather than sending them to a state mental health institute for care and treatment.

Agencies involved with crisis response services and the emergency detention process are encouraged to use the strategies and approaches included in this toolkit to improve local practices.

The Wisconsin County Human Services Association was a partner in the development of this toolkit.

Ten Essential Values for Crisis Response

The following are the 10 essential values from the Substance Abuse and Mental Health Services Administration that are fundamental in responding to any crisis situation.

1. **AVOIDING HARM:** Allowing a period of watchful waiting to minimize the duration and negative impact of interventions used.
2. **INTERVENING IN PERSON-CENTERED WAYS:** Seeking to understand the individual, their unique circumstances, and how their personal preferences can be incorporated in crisis response.
3. **SHARED RESPONSIBILITY:** The individual in crisis becomes an active partner in regaining control rather than a passive recipient in the time of crisis.
4. **ADDRESSING TRAUMA:** The importance of understanding the individual's trauma history and vulnerabilities associated with the crisis interventions used.
5. **ESTABLISHING FEELINGS OF PERSONAL SAFETY:** The importance of understanding for that person to experience a sense of security and personal safety.
6. **BASED ON STRENGTHS:** Identifying and reinforcing the resources on which an individual can draw on to recover from and protect from future crisis events.
7. **THE WHOLE PERSON:** Understanding that an individual with a serious mental illness in crisis is a whole person and though their illness is relevant it is not paramount to recovery.
8. **THE PERSON AS CREDIBLE SOURCE:** Never dismiss the person as a credible source of information—factual or emotional—in terms of understanding the person's strengths or needs.
9. **RECOVERY, RESILIENCE, AND NATURAL SUPPORTS:** The crisis response should contribute to the individual's larger journey towards recovery and resilience; fostering dignity and hope.
10. **PREVENTION:** The crisis response requires measures that address the person's unmet needs through individualized planning and promoting systemic improvements.

Providing Value to Consumers

There are eight types of process obstacles that get in the way of providing value to consumers. These obstacles should be reduced or eliminated.

TIM WOODS is a prompt to help clarify the value-depleting activities that take place during the delivery of a service or the production of a good.

Transportation—Moving things from one location to another unnecessarily.

Inventory—Making too much or too little.

Motion—Moving people unnecessarily.

Waiting—Delaying operations because pieces necessary for the work are missing.

Overproduction—Completing a task before it is needed.

Over processing—Performing unnecessary steps to get the desired result.

Defects—Failing to deliver the product or service right the first time.

Skills—Failing to use the skills and capabilities of the workforce.

What value-depleting activities impact crisis response services?

Participants in the DHS Learning Collaborative for Crisis Intervention and Emergency Detention identified the following value-depleting activities for crisis response services.

- Rework. Services were not done right the first time.
- Whitespace. Consumers experiencing delays and waiting while nothing is happening.
- Process time. It may take too long to execute a particular step in the crisis response.
- Process variation. There may be inconsistencies in crisis response that make it difficult to intervene and effect a change to the process.

Obstacles to Improvement

Partners in the DCTS Learning Collaborative for Crisis Intervention and Emergency Detention identified many issues that impact the quality of a crisis response. View these obstacles as a source of improvement and consider how to eliminate or minimize their effect.

Resources

- Lack of staff to fill key positions and all shifts.
- Lack of funding for social workers.
- Lack of prescribers.
- Lack of on-call therapists in jails.
- Lack of transport options.
- Lack of reimbursement for services from insurance and managed care organizations.

Knowledge

- Lack of consistent definitions across stakeholders for incapacitated and unconscious, emotional outburst and mental health disorder, behavioral crisis and mental health crisis, imminent risk and dangerous.
- Lack of clear understanding of who qualifies as a consumer under Wis. Stat. § 51.15.
- Lack of understanding what is required for an individual under a court order.
- Lack of understanding of crisis by health care providers, family, etc.
- Limited assessment training for providers, resulting in a low comfort level to perform assessments.
- Limited ability of providers to handle a client's risk of suicide.

Services

- Limited access to services and supports for people without a diagnosis.
- Limited availability of services and supports for voluntary consumers.
- Limited availability of services and supports for youth and young adults.
- Limited availability of services and supports for individuals with memory issues.
- Limited availability of services and supports for people with co-occurring disabilities (substance use disorder, physical disabilities, cognitive limitations, and aging).
- Limited stabilization options, especially for youth and young adults.
- Limited crisis beds.
- Limited public and private psychiatric hospital beds.
- Limited willingness of many private hospitals to admit children and high-risk individuals.
- Limited willingness to serve individuals requiring long-acting medication injections.

Coordination

- Limited sharing of private information due to state and federal regulations.
- Lack of communication between behavioral health agencies, family, hospitals, law enforcement.
- Lack of willingness among agencies to train all staff in key crisis competencies.
- Lack of clear lines of authority in mental health crisis.
- Lack of harmonization with county corporation counsel.
- Lack of interest among community services working as a system.
- Lack of consistent procedures and policies among agencies—behavioral health, law enforcement, etc.
- Lack of involvement of the crisis team by emergency departments.
- Lack of management for transports.
- Lack of options under insurance contracts for most suitable placements, limiting treatment.
- Lack of organization among agencies in discharge planning.

Timing

- Delays in talking with people due to high crisis line call volume.
- Delays in crisis team response due to size of the county or coverage area.
- Delays in emergency departments locating private, involuntary psychiatric beds.
- Delays in psychiatric hospital admission due to the need to obtain medical clearance.
- Delays in psychiatric hospitals receiving and admitting individuals.
- Delays in managed care organizations to address or treat decompensating clients, leading to longer inpatient stays.
- Delays in obtaining hospital-to-hospital consultation necessary for information exchange and transfer.
- Delays in scheduling follow-up appointments.

Data

- Lack of statistics to understand current state.
- Lack of information on needed services and opportunities for improvement.

Client

- Lack of understanding of mental health, leading to feelings of shame and delaying care.
- Lack of dedication to services and ongoing care from high-need individuals and/or voluntary clients.
- Lack of stable housing, creating difficulties in tracking and locating the individual for services and ongoing care.
- Lack of social supports, leading to more crises.

A Quick Guide to Positive Change

Consider implementing one or more of the following strategies to make quick, meaningful improvements to crisis response services.

- Collaborate with partners—emergency departments, schools, etc.
- Develop strong relationships with law enforcement and promote crisis intervention teams.
- Collaborate with adult and child protective services.
- Align services with and adequately respond to self-defined crisis.
- Identify individuals who are high system users and develop collaborative crisis plans that provide proactive crisis management.
- Use in-place and residential stabilization options.
- Add peer support specialist services to crisis team.
- Promote face-to-face assessment and intervention, making mobile crisis contact a priority.
- Use crisis to bridge to other services such as supports for sustaining prescriptions, overseeing medication self-administration, and maintaining abstinence and sobriety, etc.
- Ensure the crisis team is skillfully trained and regularly engaged in practice of crisis and risk assessment as well as crisis management.
- Use clinical supervision to enhance clinical decision-making on each case before allowing an emergency detention or a dismissal from detention.
- Provide thorough and universal follow-up after each hospitalization or situation involving suicidal ideation or intent.

Best Practices

There are many best practices for managing mental health crises in the community. This section identifies 24 of these strategies. Essential features of each strategy are identified along with examples drawn from participants in the DHS Learning Collaborative for Crisis Intervention and Emergency Detention.

- Assure a comprehensive understanding of the crisis.
- Assure adequate time with the individual in crisis.
- Collaborate with community partners.
- Collaborate with law enforcement.
- Commit to zero suicide and suicide safe care.
- Develop and utilize regional or statewide crisis call centers.
- Develop residential crisis stabilization programs.
- Ensure crisis providers have appropriate training and competence.
- Ensure timely access to supports and services.
- Focus on strengths-based and recovery-oriented service provision.
- Make a strong commitment to safety.
- Make it a priority to help the individual regain a sense of control.
- Make peer support available.
- Provide culturally and linguistically appropriate services.
- Provide referrals and assure follow-up.
- Provide services in the least restrictive manner.
- Provide trauma-informed care.
- Respect client rights.
- Respond to self-defined crisis without dismissing as not meeting criteria.
- Skillfully serve people with dementia.
- Support recovery from substance use disorder.
- Take meaningful measures to reduce the likelihood of future crisis.
- Use 24/7/365 centrally deployed crisis.
- Use data driven processes.

Assure a comprehensive understanding of the crisis

Concepts	Examples
<ul style="list-style-type: none">• Create an approach where interventionists derive a comprehensive understanding of the crisis—not only what, why, and how the crisis developed, but the context of the situation—including when and when not the situation occurs.• Be mindful that crisis—especially recurring events—signals a failure to address an underlying issue.• Escape a restricted facility view of a crisis by using mobile crisis resources that develop a much more comprehensive situational picture in the natural environment.	<ul style="list-style-type: none">• Establish a practice of meeting with family or having consultative calls with significant others.• Conduct a daily debriefing on all crisis cases and include multiple program partners as appropriate.• Offer remote access to crisis records, treatment history, and current plans on clients.• Develop avenues to access to primary treatment records.

Assure adequate time with the individual in crisis

Concepts	Examples
<ul style="list-style-type: none">• Strive to fully understand the individual's situation both objectively and as experienced by the individual.• Avoid pressures to quickly resolve a crisis at the expense of not fully understanding what the individual is experiencing.• Assure face-to-face time with the individual is a core element of service.• Anticipate the individual will not be in a position to describe their situation clearly and concisely, particularly after being involuntarily transported for an evaluation.	<ul style="list-style-type: none">• Communicate and collaborate with jail and youth services center, clarifying roles to assist with or mitigate the risk of crisis for the individual.• Provide consultative contacts with family and friends at outset and throughout the crisis.• Make information readily available and coordinated within the agency.• Create access between internal and external agencies to exchange current client information.• Facilitate outpatient provider collaboration.• Create multiple follow-ups and attempt follow-up action.• Provide in-home crisis stabilization.• Utilize collaborative anticipatory crisis planning (proactive) to avert crises in the first place.• Provide crisis planning for all individuals with settlement agreements or commitments.

Collaborate with community partners

Concepts	Examples
<ul style="list-style-type: none"> • Take purposeful actions to collaborate with partners to produce synergies. • Eliminate redundancy and waste in services to minimize frustration and bolster efficiency and effectiveness. 	<ul style="list-style-type: none"> • Form a change team with the director and all mental health as well child and family supervisors and managers. • Partner with other service providers, such as adult protective services, child protective services, private sector, hospitals, stabilization facilities, homeless providers, and schools. • Become a mental health first aid trainer and provide training. • Facilitate partner or citizen review panels that include people with lived experience. • Establish a permanency roundtable and crisis dementia response steering committee. • Encourage medical director to reach out to doctors at inpatient facilities. • Include crisis-related training at monthly business meetings and during clinical supervision. • Encourage outpatient mental health providers to provide school-based consultation (ForwardHealth Update 2018-25). • Develop reciprocal and collaborative working relationships with Family Care managed care organizations, hold regular meetings.

Collaborate with law enforcement

Concepts	Examples
<ul style="list-style-type: none">• Establish strong partnerships with law enforcement that promote mutual understanding, reduce frustration, and lead to better coordination.• Promote crisis intervention team training to improve police response and situational awareness.• Establish and use crisis drop-off centers to reduce unnecessary delays and unwarranted use of emergency medical care.• Become a Stepping Up county.• Promote excellence and professionalism in policing through the Wisconsin Law Enforcement Accreditation Group.• Do sequential intercept mapping.	<ul style="list-style-type: none">• Support law enforcement use of mental health awareness flags in dispatch database.• Equip law enforcement with partial crisis plans.• Facilitate an evidence-based decision-making initiative, a model policy for law enforcement response to mental health crises.• Pair or embed crisis response staff with law enforcement.• Connect police with crisis staff at the scene.• Conduct staffing and system review with criminal justice partners.• Work with law enforcement to transport to the crisis center instead of an emergency department.• Provide transportation to hospital apart from police through crisis staff or paid or off-duty law enforcement.

Commitment to Zero Suicide and suicide safe care

Concepts	Examples
<ul style="list-style-type: none"> • Assess the level of suicide risk. • Use a universal screening tool to identify who is at risk for suicide. • Use collaborative safety planning that includes reduced access to lethal means and includes asking for assistance from family or significant others. • Engage individual in follow-up treatment with a provider adept in suicide care. • Provide follow-up caring contacts by phone, email, or text within 24 or 48 hours. 	<ul style="list-style-type: none"> • Use the Columbia Suicide Severity Rating Scale. • Become a Zero Suicide organization. • Use the safety planning intervention. • Engage family and significant others in support. • Promote the gun shop project. • Make gun locks available through the crisis program. • Coordinate referrals and warm handoffs to capable, ongoing care and treatment that directly focuses on suicide. • Train staff on QPR, SAFE-T, cognitive behavior therapy for suicide prevention, and Collaborative Assessment and Management of Suicidality. • Utilize lock boxes for medications.

Develop and utilize regional or statewide crisis call centers

Concepts	Examples
<ul style="list-style-type: none"> • Establish a regional 24/7 clinically staffed hub/crisis call center that provides real-time, coordinated crisis intervention capabilities (phone, text, chat). • Use technology for real-time coordination across the system of care. • Utilize data for identifying service needs, performance improvement, and accountability across systems. • Train call staff to provide high-touch support to individuals and families. • Tap into available outpatient and inpatient services in the area. 	<ul style="list-style-type: none"> • Affiliate with National Suicide Prevention Lifeline and access the stipend for doing so. • Partner with HOPELINE. • Use back-up resources when existing crisis lines or staff are occupied.

Develop residential crisis stabilization programs

Concepts	Examples
<ul style="list-style-type: none"> • Develop low-cost, short-term, sub-acute programs for individuals who need support and observation to avoid high-cost, hospital-based acute care. • Create stabilization services that operate in a home-like environment, using peer staff, offering 24/7 access to psychiatric and mental health clinicians. • Utilize 23-hour living room models with welcoming and accepting environment, conveying hope, empowerment, choice, and higher purpose. • Utilize peer-operated respite, providing restful, voluntary sanctuary for consumer guests. 	<ul style="list-style-type: none"> • Use crisis beds in-lieu of, before, or after an inpatient hospitalization. • Offer centralized crisis center where all crisis functions are consolidated, allowing for receiving individuals from law enforcement. • Create youth foster homes for stabilization.

Ensure crisis providers have appropriate training and competence

Concepts	Examples
<ul style="list-style-type: none"> • Develop and deliver evidence-based and role-specific crisis training appropriate to the high-risk, high-demand role. • Train a variety of personnel who will be called upon in a crisis—crisis staff, peer support, and police. • Implement specialized training for law enforcement, such as crisis intervention team training. • Create and train on standardized screening and assessment tools and procedures to be used by all crisis providers. 	<ul style="list-style-type: none"> • Enable crisis staff to write the emergency detention apart from law enforcement using staff qualified under Wis. Stat. ch. 48 or 938. • Adopt strategies from the crisis dementia innovation grants and dementia support teams. • Link specialized staff with crisis: opioid overdose outreach worker, peer support specialist, dementia specialist. • Train all staff in the use of naloxone. • Utilize Collaborative Assessment and Management of Suicidality, motivational interviewing, dialectical behavior therapy, trauma-focused cognitive behavioral therapy, cognitive behavior therapy for suicide prevention, etc.

Ensure timely access to supports and services

Concepts	Examples
<ul style="list-style-type: none"> • Take actions to reduce intensity and duration of distress. • Take actions to de-escalate the crisis, avoid narrowing options. • Make crisis services available 24/7/365. • Provide outreach or mobile services when individuals are unable or unwilling to come to traditional services on site. • Create access to a supervisor 24/7 to help solve problems quickly. 	<ul style="list-style-type: none"> • Notify crisis services prior to involvement of the emergency department. • Use telehealth technology to extend capacity and range of services. • Establish same-day-appointment system or just-in-time scheduling with clinician or psychiatrist. • Arrange to have prescriber time at crisis center. • Encourage family mobile team to interface with child welfare to de-escalate and coach parents through crisis. • Provide transportation to services. • Streamline phone system.

Focus on strengths-based and recovery-oriented service provision

Concepts	Examples
<ul style="list-style-type: none"> ● Assess the individual’s assets and strengths at least as much as their clinical signs, symptoms, and deficits. ● Utilize strengths-based planning to affirm an individual’s sense of confidence and efficacy in resolving the crisis. ● Emphasize strengths toward building resiliency and capability for self-management of the current situation and in the future. 	<ul style="list-style-type: none"> ● Determine service satisfaction through a survey. ● Provide services that meet the individual on their terms. ● Assess strengths and assets in equal proportion to symptom or problem identification. ● Collaborate on crisis stabilization and safety planning. ● Emphasize self-efficacy. ● Complete crisis stabilization plan at discharge from hospital or other treatment service. ● Use community resources—volunteer drivers, gas cards, etc. ● Work actively with schools.

Make a strong commitment to safety

Concepts	Examples
<ul style="list-style-type: none"> ● Ensure actual safety and perceptions of safety for clients and staff. ● Establish safe policies and procedures, such as not requiring staff to visit homes alone, providing communication devices, and having ready access to historical information on client dangerousness. ● Provide a ligature resistant, welcoming, non-institutional, and safe physical space. ● Use appropriate staffing ratios to number of individuals being served. ● Facilitate strong relationships with law enforcement and first responders. ● Establish policies that emphasize no force first. 	<ul style="list-style-type: none"> ● Use standardized risk assessment protocols and tools. ● Provide face-to-face assessment to the extent possible, using telehealth as a back-up. ● Provide safe rooms for people who may be at risk of imminent violence. ● Use Calm Harm app.

Make it a priority to help the individual regain a sense of control

Concepts	Examples
<ul style="list-style-type: none"> • Support the individual in regaining a sense of control as opposed to feeling as if he or she is spinning out of control. • Involve the individual in crisis to avoid the feeling that control is being wrested away, often provoking resistance that staff can inaccurately view as further evidence that the individual does not understand the crisis situation. • Provide informed decision-making, which is more than simply apprising the individual of risks and benefits associated with various interventions. • Reinforce personal responsibility, allowing the individual choice, even if it is suboptimal. 	<ul style="list-style-type: none"> • Use motivational interviewing to help the individual discover one’s own solutions and to reinforce self-efficacy. • Utilize collaborative crisis planning. • Use concurrent documentation by involving the individual in the writing of a response or crisis plan and related clinical documentation.

Make peer support available

Concepts	Examples
<ul style="list-style-type: none"> • Find ways to include peer-related experience in all services. • Connect individuals in crisis with others who have lived experience with mental illness and behavioral health crisis to reduce fear and isolation. • Share first-hand experiences of hopefulness. • Make peer-operated respite services available. • Promote diversity—language, racial, ethnic, LGBTQ, etc.—in peer supports. 	<ul style="list-style-type: none"> • Use peer drop-in center. • Attach recovery coaches to adult services. • Include peer support for follow-up. • Develop and use peer warmlines. • Encourage use of peer-run respites. • Extend peer services to hospital emergency departments, law enforcement, etc. • Involve peers in crisis planning. • Offer family peer support. • Connect with local affiliates of the National Alliance on Mental Illness.

Provide culturally and linguistically appropriate services

Concepts	Examples
<ul style="list-style-type: none"> • Establish services congruent with culture, gender, race, age, sexual orientation, health literacy, military background, and communication needs of the individual being served. • Identify and improve areas to better engage and connect with individuals in crisis despite cultural and linguistic differences. • Provide clients with choice among crisis staff, beyond linguistic proficiency and cultural capability alone. • Assure accessibility for differently abled individuals. 	<ul style="list-style-type: none"> • Hire for diversity in staff. • Provide ongoing diversity training for staff. • Employ an outpatient youth therapist.

Provide referrals and follow-up

Concepts	Examples
<ul style="list-style-type: none"> • Offer 24-hour, 48-hour, and one-week follow-up. • Provide outpatient scheduling 24/7. • Develop follow-up services that are linked, coordinated, and tracked for behavioral health, detoxification, homelessness, etc. • Coordinate with hospitals for follow-up care at discharge. 	<ul style="list-style-type: none"> • Utilize 100 percent follow-up: multiple follow-ups and attempts to follow-up. • Implement the Purple Tube Project with dementia care plan and resources. • Provide outreach on psychiatric care to inpatient physicians. • Refer to the HOPELINE. • Collaborate with emergency medical services providing mental health support services. • Collaborate with homeless providers and Projects for Assistance in Transition from Homelessness. • Develop and use a facility discharge checklist.

Provide services in the least restrictive manner

Concepts	Examples
<ul style="list-style-type: none">• Assure services follow legal requirements under Wis. Stat. ch. 51.• Help individuals stay connected to their daily world by providing services where the individual lives, works, and recreates.• Assure services are person-centered and avoid coercion.• Promote connection to resources in local environment.• Encourage natural supports.	<ul style="list-style-type: none">• Expand diversion resources and options for voluntary services.• Offer walk-in mental health services.• Promote easy access to outpatient appointments.• Provide crisis supports after hospitalization.• Incorporate medication observation by outreach workers.• Establish a policy for clinical consultation before an emergency detention.• Provide direct access to services for the homeless.• Bring client to crisis facility rather than a hospital.• Train schools, therapists, etc., in the definition of a crisis and ask them to assess the individual before calling for crisis services.

Provide trauma-informed care

Concepts	Examples
<ul style="list-style-type: none"> • Recognize that individuals often have a history of victimization, abuse, or neglect. • Train staff to understand how past trauma may impact the individual’s current status and their response to the current crisis or considered interventions. • Recognize that evaluating trauma is not asking blunt questions from a checklist but a sensitive and expert evaluation. • Apply the principles of trauma-informed care: safety; trustworthiness and transparency; peer support; collaboration and mutuality; and empowerment, voice, and choice. 	<ul style="list-style-type: none"> • Train staff on practices to support trauma-informed care. • Include an assessment of trauma in the crisis assessment. • Employ collaborative crisis and safety planning that, to the extent possible, confers empowerment, voice, and choice for the individual being served. • Develop and provide peer support resources. • Train staff to use Trauma Screening, Brief Intervention, and Referral to Treatment. • Use trauma-focused cognitive behavioral therapy.

Respect client rights

Concepts	Examples
<ul style="list-style-type: none"> • Recognize an individual in crisis is also in a heightened state of vulnerability. • Assure all responders are well versed in the broad rights of consumers (confidentiality, informed consent, unwarranted seclusion or restraint, right to speak with an ombudsman or advocate, etc.). • Enact processes to support the values of shared responsibility and recovery that include an individual having a clear understanding of one’s rights as well as access to an advocate. 	<ul style="list-style-type: none"> • Provide an informational packet to all individuals assessed by the crisis team. • Conduct collaborative crisis planning with a focus on strengths and recovery. • Use trauma-informed, person-first, and recovery-focused language.

Respond to self-defined crisis without dismissing as not meeting criteria

Concepts	Examples
<ul style="list-style-type: none">• Establish approaches that support open access, immediate action, and intervention for individuals identifying themselves in crisis, recognizing that crisis does not equate with need for hospitalization.• Create a culture that never puts an individual's concerns off—welcoming calls from any community member and avoiding a screen-out—that can tacitly encourage a crisis to escalate.• Establish practices to prevent minimizing concerns, recognizing that the overt presentation might mask deeper and bigger issues.	<ul style="list-style-type: none">• Provide meaningful guidance and assistance to securing needed resources and referral to services.• Triage and offer or refer to immediate appointments.• Promote the HOPELINE.• Check in with clients at regular intervals.• Work with other service providers and partner to provide service as a coordinated system.• Walk the individual to where they need to be for services, make introductions.• Ensure that there is no wrong door to services.

Skillfully serve people with dementia

Concepts	Examples
<ul style="list-style-type: none"> • Establish an involved, broad-based, collaborative coalition of individuals interested in improving the dementia capacity of crisis response. • Review capacity of current dementia resources and training needs; identify strengths and gaps in needed supports and implement a plan. • Review crisis response results and make adjustments accordingly. • Use data to measure need and effectiveness, including emergency protective placement. • Focus on prevention as a strategy to reduce the need for crisis response. • Create resources that will provide supports for in-place stabilization. • Explore availability of and expand the number of facilities willing to accept people who need urgent placement. 	<ul style="list-style-type: none"> • Provide in-home stabilization and transition services using specially trained dementia in-home health providers. • Develop collaborative relationships with dementia care specialists through the aging and disability resource centers. • Work in collaboration with in-home health providers. • Develop specialized training and adaptations for serving elders and individuals with dementia (Use the resources of the UW-Oshkosh Dementia Care Project Learning Center and UW-Green Bay Behavioral Health Training Partnership). • Develop skills in soothing strategies and music and memory. • Avoid attempts at reality orientation or debating when it is upsetting or counterproductive. • Utilize strategies attempted through the crisis dementia innovation initiatives. • Use crisis plans. • Include adult protective services staff in provision of crisis services. • Use Purple Tube Project with dementia care plan. • Use screening tools such as the St. Louis University Mental Status Exam, National Task Group Early Detection Screen for Dementia, or Mini-Cog.

Support recovery from substance use disorder

Concepts	Examples
<ul style="list-style-type: none">• Provide training on Screening, Brief Intervention, and Referral to Treatment (SBIRT) and American Society of Addiction Medicine (ASAM) criteria.• Train staff in motivational interviewing.• Develop detoxification resources through crisis, both medically managed and medically monitored (social detox).• Train and equip crisis staff with naloxone for opioid emergencies.• Assure that crisis staff are knowledgeable about substance use disorders and have current information on resources and treatment.• Develop policies and practices to assure that over time crisis can bridge clients to mainstream substance use disorder treatment providers.	<ul style="list-style-type: none">• Train on and make referrals for substance use disorder services covered under Medicaid, including Comprehensive Community Services.• Use warm handoffs, link substance-using individuals to treatment resources, including those that provide medication-assisted treatment.• Employ crisis planning, crisis management, and regular follow-up to support and sustain individuals referred to substance use disorder providers.• Provide assistance to clients navigating insurance barriers to treatment.• Train staff in tobacco cessation resources from the UW-Madison Center for Tobacco Research and Intervention.

Take meaningful measures to reduce likelihood of future crisis

Concepts	Examples
<ul style="list-style-type: none">• Establish measures across services to identify service gaps and promote improvement.• Share information, where able, across systems to address individual needs and support continuity of care.• Make linkages to address certain needs beyond the scope of the crisis program (ongoing behavioral health treatment, housing agencies, foster care, schools, etc.).	<ul style="list-style-type: none">• Employ active crisis management.• Assign staff to oversee and follow the case over time.• Provide a high-risk crisis or care manager.• Use crisis to oversee and follow up on all individuals under settlement agreement or commitment.• Provide in-person and phone follow-up and welfare checks.• Provide medication delivery and supervised self-administration and contract with prescribers.• Distribute resource lists.• Provide community education.• Attach supported apartment program to crisis.• Conduct regular staffings or reviews involving crisis staff and potentially other partners.

Use 24/7/365 centrally deployed mobile crisis

Concepts	Examples
<ul style="list-style-type: none"> • Establish a centrally deployed in-person 24/7 mobile outreach and support service that provides assessment and intervention within a normal, comfortable environment (home, workplace, etc.). • Assure medical backup is available. • Recognize hospitalization is not inevitable and alternatives exist: consumer-managed peer respite, in-home stabilization, residential stabilization, same-day or next-day appointments, etc. • Utilize GPS-enabled mobile dispatch. 	<ul style="list-style-type: none"> • Develop procedures that encourage crisis team to go to community residence and the individual's home. • Establish partnerships that support yet limit unnecessary law enforcement, emergency department, medical facility, or inpatient involvement. • Develop a database that allows remote access to previous crisis screens and plans. • Cultivate a range of voluntary care options for mobile crisis staff. • Develop an outreach philosophy of building relationships, including to homeless shelters. • Maintain 24/7 access to crisis team supervisors.

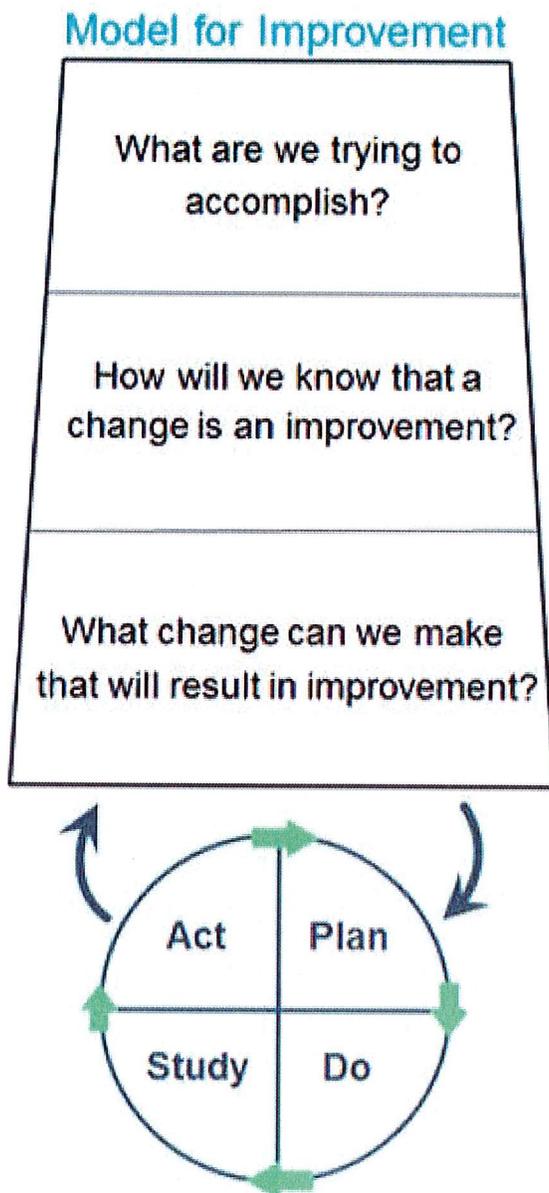
Use data driven processes

Concepts	Examples
<ul style="list-style-type: none"> • Maintain sound databases and use data to measure service needs and effectiveness. • Provide continuous and contemporary feedback to management and direct care staff on data measures. 	<ul style="list-style-type: none"> • Make suggestions to Department of Health Services for useful Program Participation System reports. • Use the standardized definition of diversion and measure diversions from inpatient psychiatric hospitalization. • Measure call volume across different time periods. • Measure times in the process of opening and closing a crisis call. • Use data to identify high-frequency, high-likelihood, or high-consequence issues to address in the context of a risk matrix or failure mode effects analysis.

Model for Improvement

The model of improvement described in this section was initially developed by Tom Nolan and colleagues at [Associates in Process Improvement](#) as a framework for accelerating improvement in the business world. It since has been used extensively by the [Institute for Health Care Improvement](#) and [NIATx](#).

The model has two parts. One part is three questions, which can be addressed in any order. The other part is the Plan-Do-Study-Act (PDSA) cycle to test changes in real work settings.



Testing Change

The model for improvement is based on a trial-and-learn approach to improvement. The PDSA cycle describes how to test change by trying it, observing the consequences, and acting on what is learned.

It is better to run small cycles of change sooner rather than large cycles later, after a long period of planning.

Each properly done PDSA cycle is informative and provides the basis for further improvement. Once you have something that works on a small scale you can start implementing on a larger scale.

Challenges to address at each step

Step 1: Plan: Plan the test or observation, including a plan for collecting data.

- State the objective of the test.
- Make predictions about what will happen and why.
- Develop a plan to test the change. (Who? What? When? Where? What data needs to be collected?)

Step 2: Do: Try out the test on a small scale.

- Carry out the test.
- Document problems and unexpected observations.
- Begin analysis of the data.

Step 3: Study: Set aside time to analyze the data and study the results.

- Complete the analysis of the data.
- Compare the data to your predictions.
- Summarize and reflect on what was learned.

Step 4: Act: Refine the change, based on what was learned from the test.

- Determine what modifications should be made.
- Prepare a plan for the next test.

Science of Improvement

Set an Aim

Improvement requires setting aims. An organization will not improve without a clear and firm intention to do so. The aim should be time-specific and measurable. It should also define the specific population of people that will be affected. Agreeing on the aim is crucial; so is allocating the people and resources necessary to accomplish the aim.

Establish a Measure

Measurement is a critical part of testing and implementing changes. Measures tell a team whether the changes they are making actually lead to improvement.

Select a Change

There are many kinds of changes that will lead to improvement, but having specific changes from a limited number of change concepts is a good start. Change concept identified as a larger group will be useful in developing specific ideas for changes that lead to improvement. Creatively combining these change concepts with knowledge about specific subjects can help generate ideas for tests of change.

Test the Change

Use the PDSA cycle to test change.

References

- Center for Mental Health Services, Substance Abuse and Mental Health Services Administration: [Practice Guidelines: Core Elements for Responding to Mental Health Crises](#)
- National Action Alliance for Suicide Prevention: [Crisis now: Transforming services is within our reach](#)
- National Action Alliance for Suicide Prevention: [Recommended standard care for people with suicide risk: Making health care suicide safe.](#)
- National Suicide Prevention Lifeline: [Crisis Center Follow Up to Save Resources and Save Lives](#)
- Wisconsin Department of Health Services: [Wisconsin's Journey with Dementia: Crafting New Priorities in 2018, P-02137](#)
- Wisconsin Department of Health Services: [Wisconsin Dementia Care Guiding Principles 2015, P-01022](#)

