City of Milwaukee

200 E. Wells Street
Milwaukee, Wisconsin
53202

Meeting Minutes

COMMUNITY INTERVENTION TASK FORCE

ARNITTA HOLLIMAN, CHAIR
Ald. Milele A. Coggs, Ald. Nik Kovac, Ald. Chantia Lewis, Nicholas DeSiato. Stephen Hargarten, Cassandra Libal, Aaron Lipski, David Muhammad, Mary Neubauer, Joshua Parish, Jamaal Smith, Leon Todd, Nicole Waldner, Amy C. Watson, and Brenda Wesley

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Monday, November 29, 2021 | **2:00 PM** | **Virtual Meeting**

This will be a virtual meeting conducted via GoToMeeting. Should you wish to join this meeting from your phone, tablet, or computer you may go to https://global.gotomeeting.com/join/958443429. You can also dial in using your phone United States: +1 (872) 240-3412 and Access Code: 958-443-429.

1. Call to order.

The meeting was called to order at 2:04 p.m.

2. Roll call.

Present 14 - Kovac, Coggs, Lewis, Muhammad, Parish, Smith, DeSiato, Hargarten, Holliman, Libal, Lipski, Neubauer, Waldner and Watson

Absent 1 - Wesley

Excused 1 - Todd

Also present:

Aaron Cadle, LRB
Jay Ehlers, MPD
Rob Henken, Wisconsin Policy Forum

3. Review and approval of the previous meeting minutes from November 8, 2021.

The meeting minutes from November 8, 2021 were approved without objection.

4. Presentation on the Crisis Assessment Response Team (CART) program.

Officer Ehlers said that he has been an officer for 14 years; with CART for 4 years; CART was a collaboration between the City and Milwaukee County Behavioral Health Division (BHD) with 1 officer and 1 clinician to respond to mental health crisis related calls from the community; and goals were to reduce the amount of emergency detentions, get voluntary treatment, and facilitate ongoing care for individuals.

Member Lewis inquired about the additional hiring of CART personnel and said that she wanted more exhaustive, overall CART data, including response types and outcomes, to get a better understanding of CART, its process, and any gaps.

Member Waldner replied that 3 officers have been chosen (2 with the County and 1 with MPD) and training would commence once the MPD officer was hired.

Member DeSiato said that the intent was to talk through the CART program to give a better understanding of the program, present situations and better understanding of when law enforcement would or would not be necessary, and respond to any specific questions.

Member Hargarten said that prior to CART or other programmatic response presentations, there should first be data presented on 911 call types, requests for services, and responses followed by an evaluation of the appropriateness of those call types and responses.

Member Muhammad proceeded to give a presentation on Crisis Response from Milwaukee County. DHHS and BHD have been committed to redesign Milwaukee's mental health delivery system by investing in community-based resources that were more accessible to those in need.

The following HRSI report recommendations were created: downsize and redistribute inpatient capacity, involve private health systems in a more active role, reorganize Crisis Services and expand alternatives, reorganize and expand community based services, reduce emergency detentions, promote a recovery oriented system through person-centered approaches and peer supports, enhance and emphasize housing supports, ensure cultural competency, ensure Trauma Informed Care, and enhance quality assessment and improvement programs.

The following Wisconsin DHS Report on Mental Health Service Delivery recommendations were created: consider statutory changes to align the emergency detention process in Milwaukee County with the process in other counties in the state, require community-based crisis services prior to emergency detention, strengthen community-based mental health services, and implement reforms and policies that reduce inpatient utilization in Milwaukee County and over time transition the Milwaukee County inpatient treatment model to deliver services in the most efficient and cost-effective setting.

The new Mental Health Emergency Center (MHEC) near 12th St. and Walnut Ave. on the near north side of the City of Milwaukee had recently opened and was situated in close proximity to where more than 70% of the patients were currently served by BHD. It would greatly improve access to care of a large percentage of people who have historically utilized the Psychiatric Crisis Service. MHEC staff would be able to support non-police initiatives that would require backup, clinical consultation, or someone to call for guidance. The center was an upstream investment in mental health services for adults, adolescents, and children. It would be operated as a joint

venture partnership between BHD and four local health systems (Advocate Aurora Health, Froedtert Health, Children's Hospital of Wisconsin, and Ascension Wisconsin). It would serve voluntary and involuntary patients by providing crisis stabilization and assessment, emergeny treatment, connections to inpatient, residential, community-based, peer support, and outpatient services. The facility would be a highly effective alternative to calling 9-1-1. People in crisis could show up at the facility and receive care, decreasing interactions with law enforcement.

On Crisis Response, BHD served 3,576 patients through CART, Crisis Mobile, and CCT. Individuals and family members facing a mental health crisis can speak with a mental health professional through the Milwaukee County Crisis Line (414-257-7222). Specially trained clinicians would provide over-the-phone assessment and de-escalation, link callers to community resources, and assist law enforcement and various other agencies in servicing those individuals in crisis. The line is available 24 hours 7 days a week.

In 2020, the Crisis Mobile Team (CMT) served 2,888 people. Through contact with the Crisis Line, a CMT may be dispatched anywhere in the community to provide in-person assessment, stabilization, linkage to services, and appropriate follow-up afterwards. CMT was a non-police mobile response providing services 24 hours a day 7 days a week. The adult CMT had 2-3 teams in service during the day and after 8 pm, one team until midnight. The children's CMT has 1-2 teams in service throughout the day with current staffing patterns until midnight. In the 2020 budget, BHD would be hiring 15 new staff to expand Mobile Crisis Services.

In 2020, 2,004 individuals were contacted through the Crisis Assessment Response Team (CART). CART consisted of a mental health clinician and a trained law enforcement officer who partner together to co-respond to mental health crisis calls in the community. When onsite, CART would provide assessment and stabilization services and work to assist the individual in obtaining voluntary treatment as an alternative to being involuntarily detained or arrested. When available, CART is dispatched by contacting 9-1-1 or the non-emergency numbers for the Milwaukee Police Department and West Allis Police Department. CART data showed consistently that CART resulted in something other than emergency detention or arrest more than 80% of the time. The City awarded BHD $300,000 to expand CART. Recruitment was underway to fill those positions. There were 3 MPD teams with clinicians being hired for 3 more MPD teams and 1 West Allis team. There was approval for 3 Sheriff's Department teams both with officers and clinicians with a goal to get up to 5 teams by the middle of next year. That team woul be a 24/7, 365 days a year, team that would serve adults and kids.

The Community Consultation Team (CCT) specialized in helping individuals with co-occuring intellectual/developmental and mental health needs. The mobile team would go into the community to provide crisis response. Through ongoing consultative services, CCT woudl hlep individuals continue to enjoy a stable life in the community. CCT would help individuals continue to enjoy a stable life in the community, offer ongoing education services for providers, and offer support to the family members who cared for them. CCT was available Monday through Friday from 8 am to 4:30 pm.

BHD client demographics, between 2016 through the end of 2020, showed 14,581 total clients served (4,475 in 2020) and the number served (in descending order) based on race black/African American at 6,760 (2,169 in 2020); white/Caucasian at 6,329 (1,893 in 2020); other at 1,051 (292 in 2020); Alaskan Native/American Indian at 257

(78 in 2020); Asian at 144 (32 in 2020); and Native Hawaiian/Pacific Islander at 40 (11 in 2020). Data was not available based on Hispanic or Latino origin.

Concerning FQHCs partnerships, early crisis intervention services were delivered by embedding BHD resources at two FQHC locations on north and south sides. Included were short-term high intensity services, same day walk-in urgent care, and navigation services. Fully integrated were medical and behavioral health services to county residents at locations closer to their homes.

In February, BHD and Sixteenth Street Community Health Centers opened Access Clinic South (ACS) offering behavioral health, substance abuse disorder services, and Comprehensive Community Services (CCS), an integrated behavioral health program for adults with severe mental illness and/or substance use disorders that would provide a coordinated, comprehensive, community-based array of recovery-focused services, treatment and psychosocial rehabilitation services. With a focus on prevention and early intervention, ACS would increase access to much needed services for families on the south side of Milwaukee. BHD Care Coordination team and Team Connect members were present at ACS. The partnership played a key role in the County's larger redesign, focusing on expanded and enhanced access to community-based services. The clinic allowed BHD to quickly connect people with culturally competent care that they needed within their own community. Services included psychiatric assessment, medication evaluation, peer support services, counseling and/or referrals to appropriate outpatient clinics, and access to additional community programs.

The opening of Access Clinic East (ACE), in partnership with Outreach Community Health Centers, helped BHD better serve County residents by bringing behavioral health and substance use disorder resources to the north and east side community. Dedicated BHD staff to the clinic has allowed the clinic to quickly connect people with the culturally competent care they need within their own community. The expansion of community health center resources was a part of DHHS/BHD's efforts to increase early intervention services and create a racially and culturally equitable system of care in the County serving all communities. BHD would continue to partner with other local community health centers, so the clinics would serve as significant "front door" for integrated health and other needs and create mutually beneficial partnerships that would allow for the integration of primary, specialty, dental, mental health and social support services for a more comprehensive continuum of care to meet the whole person's needs.

Members questioned Crisis Response coverage for early morning shifts, CART teams for the County and City, 9-1-1 call intake and triage process and decision making, training for dispatchers and telecommunicators, the use of force, Officer Ehler's role, a model without law enforcement or escort, CMT call intake and response, and MFD call intake and response.

Member Muhammad replied that there are times when CART and other Crisis Response teams were not available, there was a need to expand accessibility and coverage for all the Crisis Response teams, and CART was a collaboration between the City and County. The 257 number does the screening for CMT. There were 2 children and 3 adult CMT teams that would go out separately. The 257 number was connected to 9-1-1 via the 211 number. Further CMT data could be provided in the future.

Officer Ehlers replied. Call intake would come from CART line directly or be

dispatched from 9-1-1, the Crisis Line, or other non-emergency numbers as determined by those dispatchers. Telecommunicators take calls first then forwards them to dispatchers. Telecommunicators and dispatchers have the necessary training from CART. Presentations regarding that training could be provided to the task force in the future for better understanding by the task force. CART would look at the calls and prioritize a response based on the level of unsafe situations such as the presence or threat of violence, aggression, and unsanitary conditions. The goal was to obtain voluntary treatment for individuals. Chapter 51 commitment and the use of force (less than 1%) was rare. There was only two times where force was used in 2021 concerning a subject with a firearm and an attempted hanging. Appropriate referrals are made at the scene. CART would remain on standby at a scene or meet elsewhere as needed. Officers have some CIT training and experience, were aware of CART and CMT, have the ability to request CMT and CART to make assessments, and take calls off-duty like himself. He has various roles with taking calls, assisting others, accompanying visits, providing advice, and being a mentor to others. He has built rapport, familiarity, and trust with some subjects in the community. Experience with subjects was very dynamic and may be different each time with the same subject based on the subject's condition and state each time, which may alter or vary each time. Officers may have different skills, may make different analysis, and some are more familiar with him. A model without law enforcement would be CMT. CART was for unsafe situations that needed law enforcement. Law enforcement presence was a deterrent, could change behaviors, provide a sense of control, and was necessarily just for the use of force. For unsafe and tactical situations, clinicians would wait until the scenes were made or determined safe first by law enforcement for the clinicians' safety.

Member Libal added that the transition to the County's CART team was new, separate from the City, just started, and engagement of 9-1-1 calls for the County would have to be determined.

Member Hargarten said that the task force needed a more comprehensive understanding of all the tiered responses.

Member Parish commented. MFD's dispatch system was not connected to MPD's system currently. Calls with medical needs would be dispatched to MFD. MFD would categorized those calls with its emergency medical dispatch system. MFD has over a thousand different call types. MFD crews on a scene would make an assessment, diagnosis, and treatment. Treatment would vary, depend on the patient, and could include transport to ED.

Member Lipski commented. For situations where MFD is responding to scenes with a violent act, call dispatch may be made to MFD first, both MFD and MPD simultaneously, or to MPD first. MFD would remain cautious and wait for scenes to be cleared first, as required by State law, by MPD or better trained professionals for certain situations, such as a shooting or an individual contemplating suicide. The task force should obtain and review call types and responses and focus on those resulting in fatality or injury.

Member Kovac commented. There should be further data on CMT call intake and response. Safety is a priority, and the partnership between CART and law enforcement made sense. There should be a protocol established to better dispatch responders and reduce redundancy in personnel.

Member Neubauer added that data on CMT and CIT was provided before but can be

provided again.

Member Coggs said that FPC or MPD should have access to call intake and response data.

Member Lewis said that the Emergency Management and Communications Director should obtain the data but that the position was vacant, that a problem was when a call outcome did not match the call type, and for protocols to be put in place to log call types correctly.

Member Watson said that the task force could take a look at the Los Angeles County Alternative Crisis Response Preliminary Report and Recommendations , 9-1-1 data doesn't reflect mental health related calls very accurately, other call codes that might be likely mental health related calls should be added to the discussion, and the task force should look at calls more broadly including those resulting in the use of force that did not result in injury or fatality.

Member DeSiato added that MPD could provide data on pointed issues, MPD would invite members to ride along with a CART team to experience, get context, and understand firsthand the dynamics, reality, and appropriateness of situations, responses, and law enforcement.

Member Muhammad concurred with the importance of the air traffic module for triaging calls appropriately and said that he perhaps Lauren Hubbard, Director of Community Crisis Services, or others could come at the next meeting to share data points.

Chair Hollimon said for members or their offices to send to clerk staff their data requests, data, or contacts to invite. Clerk staff was to compile the data requests or data and extend those invitations. Invitations to include the Risk Managers in the City Attorney's Office (Kari Gipson) and in MPD (pending recruitment), and Director of Emergency Management and Communications (vacant currently).

5. Review of research on comparable cities and best practices.

a. HSRI Milwaukee Psychiatric Crisis Service Redesign Phase 1 Adult Planning Summary

Appearing:
Rob Henken, Wisconsin Policy Forum

Mr. Henken gave a presentation. The planning summary report was from 2018. It looked at the crisis response system, prevention, and provided recommendations. The redesign planning team consisted of the Wisconsin Policy Forum, Human Services Research Institute, Technical Assistance Collaborative, and Public-Private Advisory Committee. Member Muhammad had presented on progress made with crisis response, prevention, and BHD.

Phase 1 (Planning) of the report involved the convening of a Public-Private Advisory Committee, development of basic redesign assumptions, an environmental scan and report, and conceptual models for adults (planning summary report) and children (planning internal summary).

Phase 2 (Continuted Planning & Implementation) of the report involved assembling a

public/private work team and multiple subgroups with the focus on developing financial, operational, and structural details for each component and the delivery system as wells has having a phased implementation plan.

There were key planning assumptions. By statute, Milwaukee County BHD serves as Treatment Director and there are legal, fiscal, & clinical reasons for BHD to maintain exclusive operational responsibility for those duties. BHD can influence law enforcement and court policies and practices, but it will take time and resources to transform the practice philosophy and behaviors of the judiciary and the 20+ municipal law enforcement agencies in Milwaukee County. Milwaukee County will not invest additional property tax levy, above the amount currently expended, on the psychiatric crisis continuum of services. There is variation in the private health systems' clinical capabilities to effectively care for patients with behavioral health disorders in ER, outpatient, and inpatient settings; the health systems recognize the need to enhance their capabilities, and some are already actively working to address this. Private health systems benefit from having a dedicated psychiatric ED and would not be able to replicate these services in multiple ER settings cost-effectively, given the unique expertise and treatment setting required and significant workforce shortages. The county's 10 Medicaid MCOs are accountable for ensuring positive health outcomes and financially incentivized to reduce avoidable health care utilizations and costs.

Three models were considered: a centralized system organized around a single large psychiatric emergency facility; a decentralized system, with multiple sites providing a diverse array of crisis services (including some capacity for receiving individuals under emergency detention); and a dispersed system with vastly enhanced county investment to shift most crisis episodes out of ED into less intensive support services; private health system EDs care for individuals with more complex needs. The centralized system had existed with a single large psychiatric facility at BHD. A decentralized system would require multiple sites. A dispersed system was the current implementation and a hybrid model for a public-private partnership. A modified dispersed system would consist of 5 components to be enhanced: crisis prevention, early/subacute intervention, acute intervention, crisis treatment, and resolution/reintegration.

The care delivery philosophy should be embraced by all private providers, the justice system, and community stakeholders involved in the continuum. The philosophy consisted of continuing transition from a system focused on emergency detentions and disposition decisions to one informed by principles of prevention, diversion, person-centered care, dignity, recovery, and crisis resolution.

There should be cross-cutting functions with: air traffic control being a centralized call center, patient service tracking system, and treatment director disposition system; health information exchange/WISHIN to facilitate personal health information accessibility and access to crisis plans; telepsychiatry being accessible to all early intervention/subacute, acute crisis intervention programs and providers; enhanced, coordinated non-law enforcement transportation strategy; and justice system/law enforcement buy-in for new overriding philosophy, reformed policies and practices.

A dedicated psychiatric emergency department would be needed despite increased investment in all other continuum components. A dedicated psychiatric ED must include appropriate clinical expertise, physical environment/milieu, legal acumen, and be smaller in population with a narrower focus for mainly individuals under emergency detentions and those with highly complex needs. BHD should retain treatment

direction function.

Other key components included partnership with FQHCs, crisis resource centers, enhanced private hospital ER behavioral health capabilities, crisis stabilization houses, urgent care/triage clinic, and CMT and CART teams. Crisis resources centers have increased from 2 to 3. CMT and CART should be expanded, redefined, and play a greater role in warm hand-offs.

Utilization would be changed in two ways: 1) shifting from intensive, restrictive, and facility-based servics to those that are more person-centered, supportive, and community-based and 2) reduce volume overall. Reduction in volume would occur at three levels: individuals entering crisis service system, crisis episodes per individual, and admissions to different crisis services per episode. Strategies for reducing volume would be prevention at the individual level; diversion at the episode level; and early resolution in less intensive crisis services, increased coordination and communication at the admissions level. Potential admissions diverted from the crisis system and EDs were 750 (2%) in 2019, 2,250 (7%) in 2020, and 3,350 (10%) in 2021.

Members Parish commented. A positive from the redesign planning summary was the creation of Vision, a master health information and record exchange system. Several large healthcare systems have onboarded Vision to exchange information, and providers have been able to see patient care records. MFD has engaged the system. Also, treatment court has stepped up their role with high impact cases to look at compliance, deferred prosecution agreements, and options to remove people from the criminal justice space. Many recommendations from the planning summary have occurred, were in process, or were being planned. MFD continues to look at ways to reduce its call volumes. Getting and linking data as requested by members would be a very challenging and prolonged undertaking. It may take a dedicated academic or research entity to properly collect and decipher data from various agencies. There should be deliberateness in what data to collect.

Member Hargarten said that data would be a heavy lift, was critically important for the task force's decision making, and questioned a shift in EDs with psychologists and psychiatrists embedded.

Member Parish inquired about doing a pilot in the zip code areas with the highest utilization and about the Impact Connect air traffic control system.

Mr. Henken replied that there was a workforce challenge with not enough psychiatrists, asking each health system to ramp up their capabilities would be a daunting task, there was the prospect of telepsychiatry, the vision is to embed BHD more into the private health care systems, the new MHEC facility was a step towards the central city being a high utilization area, targeted initiatives in areas of highest utilization made sense, he was not privy to information on Impact Connect, and ARPA funds could help with upfront capital investment dollars towards air traffic control systems.

Member Lewis asked for Mr. Henken's presentation to be sent to clerk staff and then forwarded to members.

b. Police diversion programs in other cities

i. Policing Alternatives and Diversion Initiative in Atlanta, GA

This item was not discussed.

c. Other

This item was not discussed.

6. Review of CCFN 210785, Resolution amending Common Council File Number 201519 relating to the MPD Diversion Task Force.

a. Development of a mission statement
b. Additional membership
c. Other aspects

Members discussed moving forward with the resolution regarding the name change, additional membership, and other aspects of the resolution except the mission statement, which still needed to be reviewed further.

Ald. Lewis said that she would do so.

Chair Holliman said that the mission statement would be a main agenda item for the next meeting.

Chair Holliman said that all other items on the agenda would be tabled to the next meeting.

7. Review of task force structure, decision-making, and recommendations process.

a. Establishing work groups and work group participants.
b. Other

There was no discussion.

8. Review next steps.

a. Set next meeting date and time

To be determined.

b. Agenda items for the next meeting

Items to include review of the mission statement, task force structure, decision-making, and recommendations process. Other items to be determined.

9. Adjournment.

The meeting adjourned at 3:55 p.m.

Chris Lee, Staff Assistant
Council Records Section
City Clerk's Office

Meeting materials for past, present, and future meetings can be found within the following file:

210555 Communication relating to findings, recommendations and activities of the Community Intervention Task Force (formerly MPD Diversion Task Force).

Sponsors: THE CHAIR