Mental Health 2.0
Funding and Policy Recommendations for the Next Biennium
Wisconsin Council on Mental Health

The 2013-2014 legislative session saw unprecedented activity in support of the expansion of mental health services and supports in Wisconsin. Both the Governor's budget and the recommendations from the Speaker's Task Force on Mental Health provided new funding for community-based services and supports for adults and children with mental disorders; together about $34 million were allocated. The Wisconsin Council on Mental Health (WCMH) was pleased that many of these initiatives reflected policies that we had promoted, some for many years.

The 2015-2017 funding and policy recommendations reflect the need to address the following:

- Funding that is needed to support the investments made in the 2013-2015 budget and ensure that these new or expanded programs and services can be successfully implemented and evaluated.
- Expanding effective diversion and reintegration programs for people with mental illnesses.
- Targeted new initiatives, especially related to children's mental health.
- Additional areas for further discussion

A. Funding that is needed to support the investments made in the 2013-2015 budget and ensure that these new or expanded programs and services can be successfully implemented and evaluated.

1. <u>Strengthen peer support in Wisconsin</u>

Peer support refers to a variety of approaches to providing support to individuals and families dealing with mental health disorders by utilizing the experience of those who have been there. This might include adults with lived experience of mental illness working with other such individuals to develop recovery plans or parents of children with serious emotional disturbances supporting other parents and helping them navigate the complicated systems they must deal with. What is unique about peer support is that it is not based on the medical model, but rather is grounded in that lived experience that is perceived by consumers and families as credible and meaningful. A number of the programs being expanded or developed as a result of the 2013-2015 budget and Speaker's Task Force recommendations are built on the services of certified peer specialists (CPS) and parent peer specialists (PPS). Clearly peer-run respite requires a well-trained peer workforce. But Comprehensive Community Services (CCS) uses both CPSs and PPSs and Coordinated Service Teams (CST) also rely on PPSs. Additionally the certification of forensic peer specialists will enhance the reintegration efforts discussed in section B. The Division of Vocational Rehabilitation (DVR) has supported individuals with mental illnesses who are part of their system in obtaining peer specialist certification. But a number of things can be done to invest in the development of a pipeline for new CPSs and PPSs and strengthen other venues for peer support.

Some costs for all of these initiatives may be able to be met through the Mental Health Block Grant (MHBG) funds. The Governor's Office should consult with the Department of Health Services (DHS) on this.

The annual Consumer Conference has long served as a place for consumers to develop connections with other consumers, develop their voice and learn about the opportunities available as CPSs. It also provides training opportunities for those further along in their recovery. However, changes in funding have meant that the funds to support this conference are no longer available. $40,000 in funding will serve to ensure that we continue to stimulate the interests of those who will be the future of the peer workforce.

Recovery Centers take a variety of forms but provide opportunities for peers to develop their work-related skills and to become familiar with peer support roles. Wisconsin currently has 11 Recovery Centers which have been supported by the MHBG. However the $25,000/yr. allocated for these centers is not adequate to hire staff that have or can develop the skills for grant-writing and management and program administration. We recommend adding $1.5m annually to ensure each program has the financial resources to succeed and develop sustainability.

Training programs for CPSs and PPSs are a critical investment in the mental health workforce. Currently there is a certification process for CPSs who work only with individuals with mental illnesses. However, the DHS has done significant work to create a certification process for PPSs and to explore development of integrated CPS training and certification to work with individuals dually diagnosed with mental illness and substance use disorders. There is further interest in developing specialization for forensic peer specialists and youth peer specialists. There are both one-time costs for developing these certifications (such as defining the competencies, developing training and developing the certification exam) as well as ongoing costs for training and exams. While counties and agencies employing individuals seeking to become certified can be involved in funding the training and exams for some individuals there is a need for an on-going role for the DHS. The DHS has identified estimates of total costs and funds currently available through the MHBG which can be used to identify funds needed from the budget to support this.

Because CPSs and PPSs have very different roles than the traditional workforce, training for employers is needed to help employers understand how to best utilize these providers within the scope of their practice. While such a training has been developed for CPSs corresponding training needs to be developed for PPSs and potentially for other types of peer providers as certification is developed.

2. Provide additional funding to DHS to support effective implementation and oversight of new and expanded programs.

While some of the larger initiatives in the Governor's budget included staff positions for the DHS, there are a variety of new programs, especially those created through the Speaker's Task Force on Mental Health, for which no new staffs were provided. Many of these programs require contracting by the DHS, training in the program models and oversight to ensure their success. Additionally, no funds were provided to enhance the DHS' ability to monitor and report outcomes. We believe that it is critical for

the Legislature, consumers, family members and advocates to have better data to ensure that the new investment in funds is achieving the desired outcomes. While significant work has been done at DHS to improve their data collecting, monitoring and reporting capabilities, additional resources are required to create meaningful and valid measures and benchmarks.

Estimated cost: The Governor's Office and DHS should consult on developing a benchmark for staffing increases that should be associated with new grant programs (e.g., .2 or .25 FTE per program). The WCMH and the DHS have been starting to work on identification of data needs; the Governor's Office should consult with DHS on the level of funding that may be needed to enhance their efforts.

3. Provide additional funding to the Office of Children's Mental Health to initiate needed activities.

The 2013-2015 biennial budget created the Office of Children's Mental Health (OCMH). However the funding only covers the costs of the Director and three staffs, plus basic costs of running the office. This means there are no funds for priority activities that may be needed in order for the OCMH to achieve its objectives. Funds should support their ability to collect and analyze data and to administer their Collective Impact process.

Estimated Cost: The Governor's Office should consult with the OCMH on their funding needs.

4. Continued Funding for Individualized Placement and Support

IPS is an evidence based practice that promotes the recovery of people who have experienced serious mental illness through competitive work related to their employment preferences. The Speaker's Task Force invested in IPS for the current biennium only. However, IPS requires up to three years for programs to reach fidelity. Additionally, the single year of funding is not conducive to procurement. An ongoing appropriation is consistent with Governor Walker's Better Bottom Line initiative and critical to maintaining his commitment to expanding employment supports for Wisconsinites who have experienced mental illness. IPS also supports the Governor's investment in Comprehensive Community Services, which includes the programmatic components to implement IPS.

Estimated Cost: $594,000 per year to support 3 regional trainers and incentive funds to 20 sites statewide.

B. Expand Effective Diversion and Reintegration Programs for Inmates with Mental Illnesses

Individuals with mental illnesses are overrepresented in the criminal justice system. This is usually because of the symptoms of the mental illness when it is not being adequately treated. When individuals receive appropriate treatment and supports in the correctional institutions and are then able to seamlessly receive these upon their release it significantly reduces the likelihood of re-offense and recidivism. Individuals can be supported at a lower costs in the community than within the correctional

institution and with an improved quality of life. Additionally, diversion programs can respond more appropriately to individuals with mental illnesses who come into contact with the criminal justice system by ensuring they are linked to and follow up with treatment. The following three programs have been priorities for the WCMH in prior years.

1. Expand Opening Avenues to Reentry Success (OARS)

OARS has been successful in supporting inmates with mental illnesses in reintegrating into the community and has significantly reduced recidivism rates for this population. The program also allows earlier release for some inmates. However, OARS continues to be available only for inmates returning to certain regions of the state, although DHS and DOC could expand the program if funds to contract to serve more individuals were available. Additionally, OARS could benefit from specialization of probation and parole officers working with this population in order to improve engagement with the offender.

Estimated Cost: The Governor's Office should consult with DHS and DOC to explore options for continuing to expand this to inmates from additional areas of the state.

2. Ensure that Inmates with Mental Health Needs Obtain Prompt Access to Health Services

The Disabled Offender Economic Support (DOES) program has been successful in facilitating the receipt of disability benefits for eligible individuals leaving the correctional institutions. More individuals can receive timely receipt of such benefits with additional funding for disability/benefits consultation if the program were expanded to additional institutions. Additionally, many individuals in the corrections system will now be eligible for health care coverage either under the Medicaid option for childless adults under 100% FPL or the health care Marketplace. DOC should be supported in making resources available to facilitate enrollment in order to ensure individuals receive timely access to health care, including mental health care and medications, upon release. These efforts will support the success of OARS and potentially reduce the costs associated with that program.

Estimated Cost: The Governor's Office should consult with DHS and DOC to explore options for continuing to expand this to inmates from additional areas of the state.

3. Expand the Treatment Alternatives and Diversion Program (TAD)

Legislation to expand the TAD program to serve individuals with a mental illness only died in committee in the 2013-2015 legislative session. While most individuals served by treatment courts have a substance use disorder or co-occurring mental health and substance use disorder, those with a mental illness only can be successfully served through this model, as witnessed by such courts in Eau Claire and Outagamie counties. The Legislature should change the criteria so that someone with a mental illness only is eligible for the program.

Estimated Cost: There is no costs to make this policy change. However the Legislative Council Study Committee on Problem Solving Courts has made additional recommendations for enhancing these

programs, some of which have a fiscal impact. The WCMH has been supportive of expansion of the TAD.

C. Targeted new initiatives.

1. Children and Youth Priorities

A child's earliest years provide the foundation for future success in life. The growth of the architecture of the brain is more rapid between birth and age five than any other developmental periods. Early experiences shape the neuro-pathways of the brain. A strong foundation increases the probability of positive mental health outcomes. Although a critical element of development, infant and early childhood mental health is often overlooked as an important element of child development.

Expand Trauma Informed –CBT to additional counties and tribes

This initiative would provide training and technical assistance to support implementation of trauma informed cognitive behavioral therapy, an evidence-based practice. This approach is comprehensive, training providers and parents together and providing learning collaborative calls. The Department of Children and Families (DCF) has provided financial support for this initiative to date, which has trained individuals in 16 counties and one tribe.

Estimated costs: About $45K per site for a year (additional funds come from the local community). We understand that DCF has budgeted $180,000 for the next biennium – taking it to scale requires $1.7mil to fund training and TA for the rest of the 55 counties and 10 tribes

Expand Implementation of the Pyramid Model (PM)

PM is an evidence-based framework (not a curriculum) that is applicable in all systems serving young children and has a parent component. It is a quality improvement, relationship-based initiative that is in line with science and supports healthy brain development. PM is related to positive outcomes for children. Currently PM is mainly funded through Race to the Top dollars (which will end in December of 2016).

Estimated costs: The projected biennial costs for taking this to scale are $5.8m. The Governor's Office should discuss this with state agencies and with the Wisconsin Alliance for Infant Mental Health to determine a plan for continuing and growing this initiative.

Identify options to fund psychosocial interventions, crisis respite and preventative/proactive respite that don't require removing children from the home at great expense

Studies show when caregivers have respite they are better able to handle the day to day challenges that come with caring for a child with Severe Emotional Disturbance (SED). Recently, despite wraparound services, no respite could be found for a child with SED for 4 months. Now, because the situation

continues to escalate at home, the county is pushing out of home care at cost of $9,000-$12,000 per month when a few hundred dollars of respite every month could have prevented this. The DHS reports many emergency detentions of youth at Winnebago MHI for 5 days or less that may also represent an inappropriate or unnecessary use of this resource. Medicaid limitations on reimbursement for respite are a challenge, but the State should explore the possibility of focusing on the psycho-social aspects of rehabilitation for the child, that address the child's real needs while also providing respite for the family.

Estimated Cost: This is part of what needs to be explored.

Eliminate aversive interventions like seclusion and restraint (S/R) in all child serving agencies.

Given the catastrophic injury to a boy at Wyalusing Academy (WA) last year (and subsequent closing of WA) and the State's continued promotion of trauma informed care (TIC), we think it's incumbent on the State to work to eliminate aversive interventions like S/R in all child serving services/agencies. Funding is requested to provide training and technical assistance to providers of services to children on alternatives to seclusion and restraint to include but not be limited to TIC and Therapeutic crisis intervention (TCI).

Estimated Costs: Unknown at this time. At the federal level, the proposed Keeping All Students Safe Act includes funding to train schools on how to effectively address and change challenging behavior that students experience. What we do know is that aversive interventions cause more trauma and mental health issues for children and youth, and there is no therapeutic benefit. Providers and child serving agencies have long said that they have no other tools or training so the State should provide funding for robust training that teaches child serving agencies how to avoid the use of aversive interventions.

Expand Trauma Informed System with At Risk Preschool Children to additional counties and tribes

This program, which has been operational in Waukesha County for a number of years, serves children birth-5 years old that enter the Child Protective Services system. The Birth to 3 and Early Childhood programs have stepped up to address the needs of these kids, who wouldn't otherwise qualify for Birth to 3/Early Childhood services.

Estimated Costs: $1.4m. to take this to scale.

2. Stipends for Consumers and Family Members

Rationale: Many councils are comprised of individuals who are in paid status for the time they serve on the council or its committees. Often this is because the individual is working for an agency that has a proprietary interest in the work of the council. Some persons with disabilities or family members of persons with disabilities serving on disability councils may also be working for agencies who reimburse them for the time they serve on the council or its committees. However, in seeking to achieve geographically, ethnically and culturally diverse representation on the council, some councils will seek to recruit individuals with disabilities or family members of individuals with disabilities who are not part of

agencies or organizations that will reimburse them for the time they spend at council or committee meetings. In those cases where the council has statutory requirements for a certain number or percentage of members who are persons with disabilities or family members of persons with disabilities the inability to provide compensation can compromise the council's ability to meet the representation requirements for these groups.

Additionally, some departments or agencies under whose authority the councils operate have funds that are not state general purpose revenues that they can use to cover the cost of compensation for these individuals. Thus, this statutory change does not create a fiscal liability with respect to state GPR nor does it create a mandate upon those agencies or departments under whose authority the disability councils operate. What it does do is create the ability of those departments or agencies to utilize existing non-GPR funds to ensure that the disability councils can effectively meet the statutory requirements for participation of persons with disabilities and family members of persons with disabilities.

Statutory Revision: 15.09 Councils

15.09 Councils
(6) REIMBURSEMENT FOR EXPENSES. Except as noted in sub (a), Mmembers of a council shall not be compensated for their services, but, except as otherwise provided….

(a) Members of disability councils who are persons with disabilities or family members of persons with disabilities may be compensated for time involved in meetings of the council and committees of the council if:
    1) The member does not otherwise receive compensation for the time they participate in meetings of the council or its committees; and
    2) If the agency or department under whose authority the council operates identifies non-general purpose revenues to cover the cost of such compensation.
(b) The agency or department under whose authority the council operates will set the compensation at a level that it deems will be sufficient to support the required level of participation of persons with disabilities and family members of persons with disabilities on the council.

Estimated cost: No GPR, there is already $25K designated in MHBG to cover consumer/family involvement.

D. Additional Areas for Further Discussion

1. Expand Child Psychiatry Consultation Program to Additional Regions.

Act 127 created the Child Psychiatry Consultation Program for the entire state. It directs DHS to select among proposals for regional hubs based on a competitive process. At this point it is unclear whether the funds allocated will be adequate to support regional hubs that will serve the entire state. Should it

be determined that the funds allocated are not sufficient additional per year funding would be needed starting in 2016.

2. Modifications to the Medical Assistance Purchase Plan

We understand the Governor's will again propose a number of changes to the Medical Assistance Purchase Plan (MAPP) similar to those proposed last budget. Some of these were embraced by advocates because they would reduce excessively high premiums that some MAPP members experience and which can create a disincentive to work. However, the Governor also proposed changing the definitions of the sort of work which would qualify individuals for MAPP, essentially eliminating situations where in-kind arrangements have been developed. While the WCMH supports integrated, competitively paid work as a the goal for individuals with mental illnesses, movement to this goal requires appropriate job training and supports. Ongoing funding of Individualized Placement and Support would be critical to support movement of people to competitive work. Individuals associated with the WCMH are working with representatives from the Governor's Council on People with Disabilities and others on an alternative proposal. Advocates and DHS should work together to explore the feasibility of this compromise language.

Estimated Cost: Our goal is to keep this as close to cost neutral as possible.

3. Suicide Prevention

Suicide Prevention is a new priority area for the mental health block grant. Wisconsin has consistently ranked above the national average suicide rate and this was identified as a high need in the needs assessment process last year. The DHS has provided some MHBG funds for suicide prevention since 2004. That amount was increased to about $125,000/year in 2011 after Wisconsin lost federal funding through the Garrett Lee Smith (GLS) Youth Suicide Prevention grant. Wisconsin was again awarded GLS funding, of about $480,000/year, in 2012. Together these grants have allowed for development of a robust menu of suicide prevention activities. However, the GLS grant ends in 2015 (although a no-cost extension can be granted if funds remain at the end of that period). Wisconsin may have an opportunity to apply for another grant at that time. Should there not be another procurement or if Wisconsin is not successful in its application the ability to continue the significant level of suicide prevention now occurring in the State will be jeopardized. The State should consider a plan for allocating additional funds for suicide prevention should this scenario come to pass.

Estimated Cost: In the absence of federal funding, the state will have $125,000 allocated through the MHBG for suicide prevention. An additional $125,000 would allow continuation of some basic suicide prevention activities in support of the Wisconsin Suicide Prevention Strategy. $200,000-300,000 additional funds would be ideal.

4. Reduce Discrimination Against Individuals Living with Mental Disorders.

One of the few recommendations of the Speaker's Task Force on Mental Health not enacted by the legislature was a bill to reduce stigma. The Assembly Republicans have indicated this will be a priority

for them. The WCMH supports "stigma" reduction efforts that can be shown to result in behavior change, that is, reduction in discrimination against people with mental illnesses. For example, stigma in the health care field results in health care providers minimizing or discounting valid health care concerns when the fact of a person's mental illness is revealed, which has led to suffering and even death. Any initiative should empower individuals with mental illness and be grounded in the lived experience of such individuals.

5. Transportation

Lack of transportation options, especially in rural areas, can be a barrier to people participating in non-Medicaid funded programs (such as peer support) and is a barrier to employment. Legislation to increase funding for transit and for the 85.21 fund can help to address these barriers.

6. Medicaid Reimbursement Issues

Medicaid reimbursement rates are a perennial concern for providers. Rates are rarely increased and often are significantly less than other payers. This has the potential to lead providers to reduce or cease services to the Medicaid population. At the same time the State has an interest in supporting the use of evidenced-based interventions. One potential solution is to develop a system that can reimburse providers at a higher rate when they document the use of evidence-based treatments and therapies with their clients (but only through an increase in current rates, not further penalizing providers by reducing rates). Such treatments may include cognitive behavioral therapy or dialectical behavior therapy in outpatient settings or fidelity to the Assertive Community Treatment standards for community support programs. Such an approach can reward those providers using these interventions and encourage their continued participation in the Medicaid program while at the same time ensuring better outcomes for clients, which will likely lead to cost savings.

The Division of Mental Health and Substance Abuse Services should work with the Division of Health Care Access and Accountability to explore other reimbursement models that could improve access to services. For instance, school-based providers can facilitate access to treatment in rural areas by eliminating additional travel time and costs for families but the current reimbursement structures do not always support this model.

And, finally, prior authorization in the Medicaid program has been very burdensome to providers. While it is necessary to ensure the appropriateness of services delivered and paid for by Medicaid, the DHS should look at ways this can be accomplished with the least amount of information collected at the most reasonable intervals.