LEGISLATIVE & POLICY COMMITTEE
of the
Wisconsin Council on Mental Health

Minutes of the May 8, 2014 Meeting

Members in attendance:

Shel Gross, Wisconsin Council on Mental Health	Paula Buege, Children & Youth Committee of the Wisconsin Council on Mental Health
Mary Neubauer, Wisconsin Council on Mental Health	Matt Strittmater, La Crosse Co. DHS/Wisconsin County Human Services Association
Mike Bachhuber, Independent Living Council of Wisconsin	William Parke-Sutherland, Grassroots Empowerment Project
Stacy Paul	Kit Kerschensteiner, Disability Rights Wisconsin
Annabelle Potvin, NAMI – Wisconsin	Joanne Juhnke, Wisconsin Family Ties
Carol Keen, Astar/Cardinal Capital Management	

Alternates in attendance:

Barbara Beckert, Disability Rights Wisconsin	

DHS Staff: Dan Zimmerman (Bureau of Prevention Treatment and Recovery/BPTR), Kay Cram (BPTR), Ryan Stachoviak (BPTR), Kate McCoy (BPTR), Karen Bittner (BPTR), Joanette Robertson (BPTR)

Guests: Dr. Rick Immler (Wisconsin Council on Mental Health), Jackie Baldwin (Children and Youth Committee), Kim Eithun (Office of Children's Mental Health), Carla Shedivy (Wisconsin Association of Family and Children's Agencies)

Introductions; review and approval of the April 3, 2014 minutes.

Mr. Strittmater moved to approve the minutes "as is." Mr. Parke-Sutherland seconded the motion. The motion passed unanimously.

Ms. Bittner and Ms. Robertson introduced themselves to the committee. They are newly hired staff members in the Bureau of Prevention Treatment and Recovery and are coordinated service team coordinators.

Announcements/follow-up from last meeting (please remember that announcements should be limited to items that can't be communicated via e-mail, meeting minutes, the agenda, etc.)

None.

DHS meetings, legislation and policy updates (Shel Gross)

- On May 6th, the Joint Committee on Finance voted to have Comprehensive Community Services become a state-matched Medicaid benefit (it has been a county-matched benefit).
- Mental health advocates will meet with DHS Deputy Secretary Kevin Moore tomorrow. During the meeting with Mr. Moore in June, the funding/policy recommendations will be presented to him for possible incorporation into the DHS budget request.
- U.S. Rep. Barber's proposed bill, H.R. 4574 (http://beta.congress.gov/bill/113th-congress/house-bill/4574), which has not yet been introduced, and U.S. Rep. Murphy's bill, H.R. 3717

(http://beta.congress.gov/bill/113th-congress/house-bill/3717) were discussed and comparisons made. Summaries of the two bills may be found at http://barber.house.gov/sites/barber.house.gov/files/2014.05.06%20Summary_StrengtheningMentalHealthinOurCommunitiesAct.pdf and at http://murphy.house.gov/uploads/Summary.pdf, respectively. Mr. Gross indicated that Barber's bill retains the positive aspects of Murphy's bill, but does not include the negative aspects of Murphy's bill (e.g., cuts to the protection and advocacy system). Mr. Gross also said that mental health advocates, such as Mental Health America no longer will try to improve/revise Murphy's bill, but will support Barber's bill.

- The Milwaukee County Board of Supervisors released their recommendations for appointments to the new Milwaukee County Mental Health Board (see the document at http://www.thewheelerreport.com/wheeler_docs/files/0507west.pdf). The County Board had a very open process to arrive at the four nominated persons per category. Ms. Neubauer recounted the discussions with the Milwaukee County Mental Health Task Force and the County Board on this issue.

2015 - 2017 budget priorities (Shel Gross)

Committee members discussed the four documents related to the budget and policy priorities (see Attachments 1 – 4). It was recommended that everyone refer to the listing of items as "funding and policy recommendations," as this phrase more accurately states the Council's intent. Mr. Gross will compile the suggested edits and reorganization, rework the paper, and send it out again for review and comment.

Meaningful Consumer/Family Involvement (Shel Gross)

The committee discussed ideas for increasing meaningful consumer involvement. Among the suggestions were increasing funding/support for a consumer conference, which is included in the 2015 – 2017 Mental Health Budget Priorities, and obtaining input from consumers on various issues or to establish priorities using SurveyMonkey or similar tool. Ms. Paul, Mr. Parke-Sutherland, Ms. Potvin, and Ms. Buege will participate in an ad hoc workgroup to develop specific proposals.

Other business/agenda items for the March meeting (Shel Gross)

Mr. Odulana suggested the addition of item #30 below for discussion in a future committee meeting.

Public comments

None.

The meeting was adjourned at 3:37 p.m.

Possible agenda ideas for the June 21, 2014 meeting or subsequent meetings:

1. Progress towards the committee's strategic plan.
2. Current legislative action(s) (e.g., state budget, etc.).
3. Discussion of updating s. 51.61 (1) (i), Stats., related to use of restraint and isolation/seclusion.
4. Update on federal and State mental health parity regulation.
5. Mental health services in Family Care and SSI Managed Care.
6. Have a joint meeting with the Children and Youth Committee, as well as the Criminal Justice Committee and the Adult Quality Committee periodically.

7. Have a department representative provide a description of Community Options Program (COP) funds for persons who have a mental illness and the impact of Family Care on these funds.
8. Update from DHS staff regarding Community Recovery Services (CRS).
9. Update on the Department's pilot projects related to the MH/AODA Infrastructure Study.
10. Presentation from DHS staff on increasing mental health benefits for childless adults enrolled in BadgerCare Plus Core.
11. Presentation from DOA's Division of Housing on funding and options for supported housing for persons who have a mental illness.
12. Issues related to Medicaid prior authorization requirements.
13. Health Care Exchanges.
14. Health Information Network.
15. Olmstead and active treatment issues; brainstorming regarding these issues.
16. Models of self-determination.
17. Mental health advance directives.
18. The Drug Advisory Committee should address medication therapy and alternative functional medicine, as well (medical homes).
19. An update from staff at the Office of the Commissioner of Insurance of complaints and issues related to the implementation of the mental health/substance abuse parity requirements and implementation of the Patient Protection and Affordable Care Act.
20. Quality improvement for mental health programs.
21. Update on best practices for the use of antipsychotics for children.
22. Discussion with Division of Quality Assurance staff regarding Immediate Jeopardy citations in hospitals and nursing homes (particularly Milwaukee Co. Behavioral Health).
23. Discussion with Division of Health Care Access and Accountability staff regarding the Request for Bid to select a new transportation management agency (i.e., replace LogistiCare).
24. Update from Vince Maro regarding the crisis intervention/stabilization project for Family Care enrollees.
25. Discussion of the Affordable Care Act and enrollment;
26. Discussion of the impact of the expansion of Comprehensive Community Services and other Medicaid changes may have on community support programs
27. Discussion of HMO responsibilities related to child protective services
28. Discussion regarding administrative rules related to marriage and family therapists, professional counselors, and social workers (MPSW 1 – 20), as well as substance abuse counselors (SPS 160 – 168)
29. Have department staff and staff from North Central Health Care (Langlade, Lincoln, and Marathon counties) discuss North Central's efforts to provide integrated care (medical/health home).
30. Setting up a task group to make recommendations on streamlining the diverse mental health activities/programs, and responsible agencies (both government and non-government) that could lead to the establishment of few major bodies as overseers and/or coordinators, similar to the coordinating activities of the Office of Children's Mental Health.

Attachment 1

Survival Coalition Mental Health Budget Priorities – DRAFT – April 30, 2014

A. Allocate targeted funding to support the significant investments made in the last budget.

The 2013-2015 legislative session saw unprecedented activity in support of the expansion of mental health services and supports in Wisconsin. Recognizing that Wisconsin had very limited access to community mental health services, both the Governor's budget and the recommendations from the Speaker's Task Force on Mental Health provided new funding to begin to expand access for community-based services and supports for adults and children with mental disorders; together about $22 million were allocated. We propose strategic investments for the 2015 – 2017 budget to ensure the success of these initiatives, recognizing that investments in the community will reduce the need for costly and traumatizing institutional and crisis services.

1. Support the development of the peer and parent specialist workforce.

   A number of the new initiatives are built on the services of certified peer specialists (CPS) and parent peer specialists (PPS): peer-run respite, Comprehensive Community Services (CCS) and Coordinated Service Teams (CST). The Division of Vocational Rehabilitation (DVS)has supported individuals with mental illnesses who are part of their system in obtaining CPS certification. Enhanced DVR funding made possible in the 2013-2015 biennium may expand the number of mental health consumers who can be supported in this way. Similarly, the expansion of the Individualized Placement and Support (IPS) model made possible by funds from the Speaker's Task Force on Mental Health will provide job opportunities for those who have obtained their certification. But a number of things can be done to ensure that the pipeline for CPS and PPS is working well (see Appendix A for details about these initiatives):

   a. Support the annual Consumer Conference
   b. Support Recovery Centers
   c. Parent and Peer Specialist Training
   d. Facilitated Employer Training on Benefits for CPS and PPS
   e. Continued Funding for IPS Employment Supports

2. Provide additional funds to the Department of Health Services (DHS, and other state agencies, as appropriate) 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 program, 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.

3. Provide additional funds to the Office of Children's Mental Health for 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, such as data collection and analysis or training/consultation. The director should identify and the budget should provide needed funds.

B. Improve the criminal justice system's response to individuals with mental illnesses.

Individuals with mental illnesses are overrepresented in the criminal justice system. This is usually due to the symptoms of the mental illness when it is not being adequately treated. A number of successful existing programs can be expanded in order to ensure that individuals with mental illnesses coming into contact with the criminal justice system are receiving treatment rather than incarceration, when it does not compromise public safety, and are reintegrated more successfully back into the community.

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. This saves money for the Department of Corrections (DOC) by leading to early release for some inmates and by reducing those returning. However, OARS continues to be available only in certain regions of the state, although it could be expand 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.

2. Ensure the 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.

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 and provide additional funding.

C. Reduce the stigma associated with mental illness and reduce discrimination against individuals living with mental disorders and their families

1. Fund efforts in support of evidence-based stigma reduction.

   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 bill would have provided funds to support local efforts around individuals disclosing stories about their mental illness and recovery. Work by Patrick Corrigan and his colleagues has demonstrated that such disclosure is the only evidence-based approach to changing negative attitudes about individuals living with mental illnesses.

2. Reduce discrimination against people with mental illnesses in health care settings

   Research demonstrates that individuals with mental illnesses are more likely than other individuals to have certain health-related complaints discounted by health care professionals. The consequence is a failure to diagnosis and treat existing health care conditions, with resulting poorer health outcomes including death. Wisconsin United for Mental Health has initiated efforts to work with emergency departments around this issue. Funding should be provided to support efforts to educate these and other providers and change practices to reduce discrimination.

3. Reduce discrimination against parents of children with serious emotional disorders related to child support payment for out of home treatment.

   It is not uncommon for parents to have to file a CHIPS (child in need of protection or services) petition with the courts to access the type of care their child needs. This is most often for care that requires the child to temporarily live away from home. When a court orders the placement of a child outside the home in a nonmedical residential facility, such as a foster home, group home, or residential care center, the court must also order either or both parents to pay child support to help cover the costs for such services. Currently, the child support payment for one child is 17% of the parents' gross wages. This is not consistent with how parents would be required to cover the costs of for other types of medical care. This payment should be handled in the same manner as payment for other types of treatment.

D. Increase access to paid respite care for families of children with SED

Parenting a child with behavioral challenges can be an exhausting, isolating, 24x7 experience. However, Respite care is rarely funded by public mental health programs. It cannot be funded by Medicaid as it is viewed as being for the benefit of the parent, not the child. It is allowed only through the children's long-term support waiver, which is currently an option for a small number of children and only if you can find providers. And yet staffs at Winnebago Mental Health Institute indicate that many children are being placed inappropriately, potentially as a form of respite, at a very high cost. If hospitals are used for "respite" it can costs $900-2500 night. We need to identify and fund options for respite care that don't require removing children from the home at great expense.

Appendix A: Supporting the Development of the Parent and Peer Specialist Workforce

Support the annual Consumer Conference

The Consumer Conference has long served as a place for consumers who may be making their initial steps in recovery to learn about the opportunities available as certified peer specialists and to learn about how to move forward on this particular life path. However, changes in funding have meant that the funds to support this conference are no longer available. This modest funding will serve to ensure that we continue to stimulate the interests of those who will be the future of the peer workforce.

Support Recovery Centers

Wisconsin currently has 11 Recovery Centers, which have been supported by the Mental Health Block Grant. Funding for these centers has always been minimal and this undercapitalization has made it problematic to develop sustainable programs. 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. This environment has often been the critical next step for those who have an interest in the peer specialist training but who may not yet be prepared for the formal training and certification process.

Parent and Peer Specialist Training

While there are a number of peer specialist training programs that consumers can access in order to prepare for their certification, DVR continues to send people to Chicago for training. Funds can be allocated to allow for this training to occur in Wisconsin, which will be more convenient for those participating in the course and less costly to DVR. Additionally, work still needs to be done to finalize training and certification for parent peer specialists; funds are needed to support the development of the certification process.

Facilitated Employer Training on Benefits for CPS and PPS

While we are creating a peer and parent workforce we also need to work with the potential employers to make sure they understand the benefits of using these employees and the ability to be reimbursed for their services. We also know from current experience that certified peer specialists and parent peer specialists find themselves being asked to do things that are not appropriate to their role and training. Funds are needed to support training for these potential employers to facilitate hiring and appropriate use of this workforce.

Continued Funding for IPS Supports

The Speaker's Task Force on Mental Health provided funding to create a regional infrastructure for training programs in the IPS model of employment for people with serious mental illnesses. However, this funding was only for the 2013-2015 biennium. This will allow for only minimal training, not adequate to create a strong infrastructure to support implementation of IPS. Additionally, as the expansion of CCS will continue in the 2015-2017 biennium, and CCS being a significant "hub" for IPS, these training resources will continue to be needed. Work is a vital therapeutic tool and it is also cost effective. IPS has shown a reduction in costs for day treatment services and is linked to reductions in the use of both crisis and inpatient services.

Attachment 2

Mental Health Budget Priorities
Preliminary Ideas – DRAFT – April 18, 2014

The 2013-2015 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 2015-2017 budget priorities 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.
- Items that did not make it through the 2013-2104 legislative process or may need some modifications.
- Targeted new investments.

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. Support the development of the peer and parent specialist workforce.

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 and parent peer specialists. Clearly, peer-run respite requires a well-trained peer workforce. But Comprehensive Community Services (CCS) uses both peer and parent specialists and Coordinated Service Teams (CST) also rely on parent peer specialists. The Division of Vocational Rehabilitation (DVR) has supported individuals with mental illnesses who are part of their system in obtaining peer specialist certification. Enhanced funding made possible in the 2013-2015 biennium may expand the number of mental health consumers who can be supported in this way. Similarly, the expansion of the Individualized Placement and Support (IPS) model made possible by funds from the Speaker's Task Force on Mental Health will provide job opportunities for those who have obtained their certification. But a number of things can be done to ensure that the pipeline for new parent and peer specialists is working well.

a. Support the annual Consumer Conference

The Consumer Conference has long served as a place for consumers who may be making their initial steps in recovery to learn about the opportunities available as certified peer specialists and to learn about how to move forward on this particular life path. However, changes in funding have meant that the funds to support this conference are no longer available. This modest funding will serve to ensure that we continue to stimulate the interests of those who will be the future of the peer workforce.

b. Support Recovery Centers

Wisconsin currently has 11 Recovery Centers, which have been supported by the Mental Health Block Grant. Funding for these centers has always been minimal and this undercapitalization has made it problematic to develop sustainable programs. 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. This environment has often been the critical next step for those who have an interest in the peer specialist training but who may not yet be prepared for the formal training and certification process.

c. Parent and Peer Specialist Training

While there are a number of peer specialist training programs that consumers can access in order to prepare for their certification, DVR continues to send people to Chicago for training. Funds can be allocated to allow for this training to occur in Wisconsin, which will be more convenient for those participating in the course and less costly to DVR. Additionally, work still needs to be done to finalize training and certification for parent peer specialists. BPTR has a process for this and one of the new CST staff will be working on this, but funds may be needed to support the development of the certification process.

d. Facilitated Employer Training on Benefits for CPS and PPS

While we are creating a peer and parent workforce we also need to work with the potential employers to make sure they understand the benefits of using these employees and the ability to be reimbursed for their services. We also know from current experience that certified peer specialists and parent peer specialists find themselves being asked to do things that are not appropriate to their role and training. Funds are needed to support training for these potential employers to facilitate hiring and appropriate use of this workforce.

e. Continued Funding for IPS Supports

The Speaker's Task Force on Mental Health provided funding to create a regional infrastructure for training programs in the IPS model of employment for people with serious mental illnesses. However, this funding was only for the 2013-2015 biennium. This will allow for only minimal training, not adequate to create a strong infrastructure to support implementation of IPS. Additionally, as the expansion of CCS will continue in the 2015-2017 biennium, and CCS being a significant "hub" for IPS, these training resources will continue to be needed.

2. Provide additional funding to DHS (and other state agencies, as appropriate) 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 program, 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.

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, such as data collection and analysis or training/consultation. The director should identify and the budget should provide needed funds.

B. Items that did not make it through the 2013-2104 legislative process or may need some modifications.

1. **Expand Programs that Support Effective Reintegration of 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. This both saves DOC money and improves the quality of life for these individuals.

a. 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. This saves money for the DOC both by leading to early release for some inmates but mainly by reducing those returning. However, OARS continues to be available only in certain regions of the state, although DHS 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.

b. Ensure the Inmates with Mental Health Needs Obtain Prompt Access to Health Services

The 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.

2. **Other legislation**

a. Treatment Alternatives and Diversion Program. Change the criteria so that someone with a mental illness only is eligible for the program and provide additional funding.
b. Stigma. Funding to support efforts to reduce stigma and discrimination against persons with mental illness.
c. IPS. As noted above, funding was for the 2013-2015 biennium only but the need will be ongoing.

d. Milwaukee County Mental Health Board. Monitor status and advocate for changes that may need to be made.
e. MAPP. Work with Governor's Council on People with Disabilities and DHS to develop alternative so that premiums can be lowered and people with non-traditional work can be served.

C. Targeted new investments.

1. Children and Youth Priorities

a. Address infant and early childhood mental health. Support efforts to enhance social and emotional development. The MHBG provides a small amount of funds to support the Wisconsin Alliance of Infant Mental Health.
b. Respite Care. Respite care is rarely funded by public mental health programs. It cannot be funded by Medicaid as it is viewed as being for the benefit of the parent, not the child. It is allowed only through the children's long-term support waiver, which is currently an option for a small number of children and only if you can find providers. And yet staffs at Winnebago Mental Health Institute indicate that many children are being placed inappropriately, potentially as a form of respite, at a very high cost. If hospitals are used for "respite" it can costs $900-2500 night. We need to identify and fund options for respite care that don't require removing children from the home at great expense.
c. Eliminate charges for child support for kids removed to group home. Parents don't pay support if children need to go to the hospital for cancer treatment.
d. Address inequity in use of Children's Long-Term Support waiver for children with SED. Currently a relatively small percentage of kids served in the CLTS waiver program are kids with SED. There is a concern that the functional screen inappropriately screens out these children. Discussion are occurring with children's MH advocates and the DLTS.
e. Expand psychiatric telehealth. While there is statutory authority for psychiatric telehealth the infrastructure costs are significant. Special equipment is needed to encrypt transmission to meet HIPAA standards. Grants to counties/providers will facilitate uptake of this technology.
f. Eliminate aversive interventions like seclusion and restraints in all child serving services/agencies. An information request found that there were 3000 instances of use of seclusion and restraints in only 12 school districts subsequent to Act 125 (note: please indicate time frame). [Add DRW information here]. Statewide, required reporting by districts would facilitate tracking this data to ascertain how well schools may be complying with the legislation. Success requires not just training, but culture change. Funding needs to recognize the cost of providing adequate staffing to support a trauma informed environment.
g. Eliminate psychiatrist sign-off as a requirement for Medicaid reimbursement when sign-off by another qualified provider is acceptable and adequate. The shortage of psychiatrists makes this requirement a burden and unnecessarily delays treatment. This would include sign-offs on treatment plans when such can be approved by another licensed provider.

2. Transportation

The WCMH has not traditionally been active on transportation issues, and yet transportation can be a barrier for people participating in non-Medicaid programs (such as peer support) and is also a barrier to employment. The Medicaid non-emergency transportation broker has been on area where the WCMH has had some involved in the past few years and needs to be monitored. Legislation supporting development of regional transit systems can be important for people with mental illnesses.

Attachment 3

Mental Health Budget Priorities
Preliminary Ideas
Updated draft; L & P section =C & Y inserted under **A.** on 54.7~~29~~.14

The 2013-2015 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 2015-2017 budget priorities 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.
- Items that did not make it through the 2013-~~2104~~-2014 legislative process or may need some modifications.
- Targeted new investments.

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. Support the development of the peer and parent peer specialist workforce.

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 and parent peer specialists. Clearly, peer-run respite requires a well-trained peer workforce. But Comprehensive Community Services (CCS) uses both peer and parent peer specialists and Coordinated Service Teams (CST) also rely on parent peer specialists. The Division of Vocational Rehabilitation (DVR) has supported individuals with mental illnesses who are part of their system in obtaining peer specialist certification. Enhanced funding made possible in the 2013-2015 biennium may expand the number of mental health consumers who can be supported in this way. Similarly, the expansion of the Individualized Placement and Support (IPS) model made possible by funds from the Speaker's Task Force on Mental Health will provide job opportunities for those who have obtained their certification. But a number of things can be done to ensure that the pipeline for new parent peer and peer specialists is working well.

a. Support the annual Consumer Conference

The Consumer Conference has long served as a place for consumers who may be making their initial steps in recovery to learn about the opportunities available as certified peer specialists and to learn about how to move forward on this particular life path. However, changes in funding have meant that the funds to support this conference are no longer available. This modest funding will serve to ensure that we continue to stimulate the interests of those who will be the future of the peer workforce.

b. Support Recovery Centers

Wisconsin currently has 11 Recovery Centers, which have been supported by the Mental Health Block Grant. Funding for these centers has always been minimal and this

undercapitalization has made it problematic to develop sustainable programs. 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. This environment has often been the critical next step for those who have an interest in the peer specialist training but who may not yet be prepared for the formal training and certification process.

c. Parent Peer and Peer Specialist Training

While there are a number of peer specialist training programs that consumers can access in order to prepare for their certification, DVR continues to send people to Chicago for training. Funds can be allocated to allow for this training to occur in Wisconsin, which will be more convenient for those participating in the course and less costly to DVR. Additionally, work still needs to be done to finalize training and certification for parent peer specialists.

d. Facilitated Employer Training on Benefits for CPS and PPS

While we are creating a peer and parent peer workforce we also need to work with the potential employers to make sure they understand the benefits of using these employees and the ability to be reimbursed for their services. We also know from current experience that certified peer specialists and parent peer specialists find themselves being asked to do things that are not appropriate to their role and training. Funds are needed to support training for these potential employers to facilitate hiring and appropriate use of this workforce.

e. Continued Funding for IPS Supports

The Speaker's Task Force on Mental Health provided funding to create a regional infrastructure for training programs in the IPS model of employment for people with serious mental illnesses. However, this funding was only for the 2013-2015 biennium. This will allow for only minimal training, not adequate to create a strong infrastructure to support implementation of IPS. Additionally, as the expansion of CCS will continue in the 2015-2017 biennium, and CCS being a significant "hub" for IPS, these training resources will continue to be needed.

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 program, 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.

3. **<u>Provide additional funding to the Office of Children's Mental Health to initiate needed activities.</u>**

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. The director should identify and the budget should provide needed funds.

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- **Collaborative System of Care**: Sufficient funding to support a statewide Collective Impact initiative and technical assistance to support effort.
- **Travel**: Sufficient funding to support national and statewide travel for 4 staff. **Access accommodations** such as sign language interpreters, plain language and health literate print materials in alternate formats (including Braille, large print, etc.); and cultural/linguistic competence modifications.
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- **Web and logo development. Office space, equipment and supplies**.
- **Infrastructure support**

4. **<u>Child Psychiatry Consultation Program for the entire state</u>**.

If the Child Psychiatry Consultation Program for the entire state is implemented and plans that the program would be divided into five regions, an additional per year of funding would be needed starting in 2016.

B. Items that did not make it through the 2013-2104 legislative process or may need some modifications.

1. **<u>Expand Programs that Support Effective Reintegration of Inmates with Mental Illnesses</u>**

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. This both saves DOC money and improves the quality of life for these individuals.

a. 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. This saves money for the DOC both by leading to early release for some inmates but mainly by reducing those returning. However, OARS continues to be available only in certain regions of the state, although DHS could expand the program if funds to contract to serve more individuals were available.

b. Ensure the Inmates with Mental Health Needs Obtain Prompt Access to Health Services

The 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. 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.

2. <u>Other legislation</u>

a. <u>Treatment Alternatives and Diversion Program</u>. Change the criteria so that someone with a mental illness only is eligible for the program and provide additional funding.
b. <u>Stigma</u>. Funding to support efforts to reduce stigma and discrimination against persons with mental illness.
c. <u>IPS</u>. As noted above, funding was for the 2013-2015 biennium only but the need will be ongoing.
d. <u>Milwaukee County Mental Health Board</u>. Monitor status and advocate for changes that may need to be made.
e. <u>MAPP.</u> Work with Governor's Council on People with Disabilities and DHS to develop alternative so that premiums can be lowered and people with non-traditional work can be served.

C. Targeted new investments.

Attachment 4

Mental Health Budget Priorities
Preliminary Ideas
Updated draft; L & P section =C & Y inserted under **A.** on 5.7.14 JJ/WFT edits 5.7.14

The 2013-2015 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 2015-2017 budget priorities 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.
- Items that did not make it through the 2013-2014 legislative process or may need some modifications.
- Targeted new investments.

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>Support the development of the peer and parent peer specialist workforce.</u>

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 and parent peer specialists. Clearly, peer-run respite requires a well-trained peer workforce. But Comprehensive Community Services (CCS) uses both peer and parent peer specialists and Coordinated Service Teams (CST) also rely on parent peer specialists. The Division of Vocational Rehabilitation (DVR) has supported individuals with mental illnesses who are part of their system in obtaining peer specialist certification. Enhanced funding made possible in the 2013-2015 biennium may expand the number of mental health consumers who can be supported in this way. Similarly, the expansion of the Individualized Placement and Support (IPS) model made possible by funds from the Speaker's Task Force on Mental Health will provide job opportunities for those who have obtained their certification. But a number of things can be done to ensure that the pipeline for new parent peer and peer specialists is working well.

a. <u>Support the annual Consumer Conference</u>

The Consumer Conference has long served as a place for consumers who may be making their initial steps in recovery to learn about the opportunities available as certified peer specialists and to learn about how to move forward on this particular life path. However, changes in funding have meant that the funds to support this conference are no longer available. This modest funding will serve to ensure that we continue to stimulate the interests of those who will be the future of the peer workforce.

b. <u>Support Recovery Centers</u>

Wisconsin currently has 11 Recovery Centers, which have been supported by the Mental Health Block Grant. Funding for these centers has always been minimal and this

undercapitalization has made it problematic to develop sustainable programs. 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. This environment has often been the critical next step for those who have an interest in the peer specialist training but who may not yet be prepared for the formal training and certification process.

c. Peer Specialist Training and Parent Peer Specialist Certification

While there are a number of peer specialist training programs that consumers can access in order to prepare for their certification, DVR continues to send people to Chicago for training. Funds can be allocated to allow for this training to occur in Wisconsin, which will be more convenient for those participating in the course and less costly to DVR. Additionally, work still needs to be done to finalize certification for parent peer specialists.

d. Facilitated Employer Training on Benefits for CPS

While we are creating a peer workforce we also need to work with the potential employers to make sure they understand the benefits of using these employees and the ability to be reimbursed for their services. We also know from current experience that certified peer specialists find themselves being asked to do things that are not appropriate to their role and training. Funds are needed to support training for these potential employers to facilitate hiring and appropriate use of this workforce.

e. Continued Funding for IPS Supports

The Speaker's Task Force on Mental Health provided funding to create a regional infrastructure for training programs in the IPS model of employment for people with serious mental illnesses. However, this funding was only for the 2013-2015 biennium. This will allow for only minimal training, not adequate to create a strong infrastructure to support implementation of IPS. Additionally, as the expansion of CCS will continue in the 2015-2017 biennium, and CCS being a significant "hub" for IPS, these training resources will continue to be needed.

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 program, 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.

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