

**LEGISLATIVE & POLICY COMMITTEE**

of the

Wisconsin Council on Mental Health

Minutes of the June 12, 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	Mike Lappen, Ozaukee County DHS, Wisconsin County Human Services Association
William Parke-Sutherland, Grassroots Empowerment Project	Joanne Juhnke, Wisconsin Family Ties
Stacy Paul	Kit Kerschensteiner, Disability Rights Wisconsin
Annabelle Potvin, NAMI – Wisconsin	

**Alternates in attendance:**

Barbara Beckert, Disability Rights Wisconsin	
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**DHS Staff:** Dan Zimmerman (Bureau of Prevention Treatment and Recovery/BPTR), Kay Cram (BPTR), Ryan Stachowiak (BPTR), Joyce Allen (BPTR), Rebecca Wigg-Ninham (BPTR)

**Guests:** Dr. Rick Immler (Wisconsin Council on Mental Health), Matthew Stanford (Wisconsin Hospital Association), Charlie Morgan (Legislative Fiscal Bureau)

Introductions; review and approval of the May 8, 2014 minutes.

Mr. Parke-Sutherland moved to approve the minutes with the following changes (strikeout font used for deletions and italicized font for additions):

- On page 2, the paragraph under the header “Meaningful Consumer/Family ...” should read: 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, *Ms. Juhnke*, and Ms. Buege will participate in an ad hoc workgroup to develop specific proposals.
- On page 2, the paragraph under the header “Other business ...” should read: Mr. Odulana suggested *via e-mail* the addition of item #30 below for discussion in a future committee meeting.

Ms. Neubauer seconded the motion. The motion passed unanimously with one abstention.

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.)

Ms. Buege noted the following upcoming events:

- Wisconsin Family Ties Fun Day on July 8<sup>th</sup> at Mt. Olympus in Wisconsin Dells ([http://www.wifamilyties.org/year2014/2014\\_Family\\_Fun\\_Day\\_flyer.pdf](http://www.wifamilyties.org/year2014/2014_Family_Fun_Day_flyer.pdf)).
- Wisconsin Family Ties Annual Children Come First Conference will be held on November 10<sup>th</sup> and 11<sup>th</sup> in Wisconsin Dells.

- Ms. Buege and her son will testify before Congress on the proposed “Keeping All Students Safe Act” (<https://beta.congress.gov/bill/113th-congress/house-bill/1893>).

#### Meaningful consumer and family involvement (Paula Buege)

Ms. Buege and other committee members discussed barriers to meaningful consumer and family involvement, such as transportation, time, and lack of compensation, as well as ideas/efforts to improve involvement, such as teaching consumer how to effectively tell their stories, having a pre-meeting and a post-meeting for consumers to provide necessary background/context to the agenda items, etc. Grassroots Empowerment Project is developing a training for consumers in participation and decision-making processes. The workgroup will next meet on July 10<sup>th</sup> at 10:00 at Wisconsin Family Ties.

#### Improvement of the adult mental health system delivery processes (Justin Odulana)

Prior to the May meeting, Dr. Odulana suggested via e-mail 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. Dr. Odulana provided further details (see Attachment 1). The committee discussed Dr. Odulana's suggestion and will continue to review this concept.

#### MH 2.0; DHS updates; updates on implementation of budget items and bills (Shel Gross)

Attachment 2 provides the June 6<sup>th</sup> draft of the Mental Health 2.0 – Funding and Policy Recommendations for the Next Biennium paper; this version incorporates comments from the Wisconsin Council on Mental Health and subsequent comments from this committee and Department of Health Services staff. Mr. Parke-Sutherland provided a suggested edit to item #2a dealing with reducing stigma (see Attachment 3).

The next meeting advocates will have with Kevin Moore, Deputy Secretary of DHS, and other DHS leadership will be tomorrow at 10:00 (the meetings are scheduled for the second Friday of each month).

Ms. Neubauer discussed the current status of appointments to the Milwaukee County Mental Health Board.

Ms. Allen noted that the Bureau of Prevention, Treatment, and Recovery is actively working on implementing the program initiatives from the biennial budget and Speaker's Task Force legislation, such as CST and CCS expansion. A press release was issued today regarding peer-run respite centers (<http://www.dhs.wisconsin.gov/news/PressReleases/2014/061214.htm>); Grassroots Empowerment Project, NAMI Fox Valley, and SOAR (Madison) were awarded grants.

#### Federal policy updates; Murphy and Barber bills (Shel Gross)

Mr. Gross noted that an agreement has been reached in U.S. House of Representatives to move the non-controversial portions Rep. Murphy's bill, H.R. 3717 (<http://beta.congress.gov/bill/113th-congress/house-bill/3717>) forward.

### Plan for meeting with providers (Shel Gross)

The committee discussed future meetings with providers that would be used to determine areas in which the Council, advocates, and providers could collaborate and the differences in perspectives for other areas, as well as which organizations should be invited to such meetings. Mr. Gross will develop a statement of purpose and present the statement to the committee during the July meeting.

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

- Continue to discuss meaningful consumer and family involvement.
- Continue to plan for meeting with providers.
- Police shootings and crisis intervention training for law enforcement officers.

### Public comments

None.

The meeting was adjourned at 3:23 p.m.

Possible agenda ideas for the July 10, 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

Provide or create funding for the setting up of task force(s) that will:

1. Study and provide actionable recommendations to disentangle further the complicated legal and operational systems of mental health care delivery services within policy makers, service providers, and agencies.
2. Look into the feasibilities of further coordinated initiatives, systems of program performances and monitoring, available administrative supports and efficiencies with the aim of avoiding contradictions in policies and or duplication of services within the Department of Health Services, Department of Children and Families, Department of Public Instruction, Department of Corrections, Office of Children's Mental Health, and other various government and non-governmental agencies involved in aspects of mental health issues in the state.
3. Provide a mechanism for the simplification, the interpretation, and the implementation of state mental health legislative codes in ways that will be understandable and meaningful to both consumers and providers of mental health policies and services in the state.

Attachment 2

**Mental Health 2.0  
Funding and Policy Recommendations for the Next Biennium  
June 6, 2014**

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 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.
- Items that did not make it through the 2013-2014 legislative process or may need some modifications.
- Targeted new initiatives.

**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. We should evaluate whether the current funding and support structure is adequate to ensure the viability of these programs.

c. 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.

d. Funding to implement Parent Peer Specialist (PPS) certification

Parent peer specialists have been designated as part of the service array for both the Coordinated Services Team (CST) and the Comprehensive Community Services (CCS) benefit. Parent peer specialists will need to receive state certification in order for counties to receive Medicaid reimbursement for services provided as a PPS (although parent peer specialists who are not certified may also be reimbursed if they meet the qualifications for another allowable provider type). In July 2013, the Parent Peer Specialist Certification Workgroup submitted recommendations for a state parent peer specialist certification process, serving families whose children experience mental health and/or substance abuse challenges. Funding will be necessary to put those recommendations into practice.

e. Facilitated Employer Training on Benefits of 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 rather than focusing on peer support. Funds are needed to support training for these potential employers to facilitate hiring and appropriate use of this workforce and also to address potential stigma and discrimination in the workplace. Explore coordination of efforts with the Department of Workforce Development (DWD) and the Department of Corrections (DOC).

**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.

### **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. The director should identify and the budget should provide needed funds. Such needs may include:

- ✓ *Collaborative System of Care:* Sufficient funding to support a statewide Collective Impact initiative and technical assistance to support this effort.
- ✓ *Travel:* Sufficient funding to support national and statewide travel for 4 staffs.
- ✓ *Diversity considerations:* The office may also require cultural/linguistic competence modifications and access accommodations such as sign language interpreters, plain language and health literate print materials in alternate formats (including Braille, large print, etc.).
- ✓ *Data analytics:* The field of ‘data analytics’ offers the public sector an opportunity to improve governmental efficiency and effectiveness. By statute, OCMH is required to ‘study and recommend ways, and coordinate initiatives, to improve the integration across state agencies of mental health services provided to children and monitor the performance of programs that provide those services.’ This task will require increased personnel for data coding and collection, as well as data analytics’ consultation. Access to quality mental health services for children and youth services varies significantly across Wisconsin. Access to child and adolescent psychiatrists, in-home family therapy, day treatment, evidence-based psychotherapy, respite services and inpatient hospitalization is limited to nonexistent in many areas of rural Wisconsin. In order to better understand and target efforts to address these challenges, a comprehensive analysis of the type of service, geographic distribution, extent (wait times and distance from services) and contributing factors needs to occur.
- ✓ *Web and logo development. Office space, equipment and supplies.*
- ✓ *Infrastructure support*

### **4. Child Psychiatry Consultation Program for the entire state.**

Act 127 creates 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.

### **5. Continued Funding for Individualized Placement and Support**

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. 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. The single year of funding may also make it difficult to obtain proposals from private entities who will be challenged to create a training system that is only guaranteed one year of funding.

**B. Items that did not make it through the 2013-2014 legislative process or may need some modifications.**

**1. Expand Programs that Support Effective Diversion or 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. 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.

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 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.

b. 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. These efforts will support the success of OARS and potentially reduce the costs associated with that program.

c. 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. DHS and DOC should take active roles in the Legislative Council Study Committee formed to review TAD programs and problem-solving courts, including veterans courts.

**2. Reduce the stigma associated with mental illness and reduce discrimination against individuals living with mental disorders.**

a. Fund efforts in support of thoughtful disclosure by those living with a mental illness.

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 and an evaluation of those efforts. 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.

b. 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. Medical Assistance Purchase Plan**

The Governor’s budget proposed a number of changes to the Medical Assistance Purchase Plan (MAPP). 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 first goal for individuals with mental illnesses, some of the alternative arrangements have represented reasonable goals for the particular individuals. Individuals associated with the WCMH worked with people from the Governor’s Council on People with Disabilities and others on an alternative so that premiums can be lowered and people with non-traditional work can be served. Advocates and DHS should work together to explore the feasibility of this compromise language.

**C. Targeted new initiatives.**

**1. Children and Youth Priorities**

a. Address infant and early childhood mental health. Support efforts to enhance social and emotional development.

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. This funding will support facilitation of stakeholder meetings and program

implementation to collaboratively address the needs not currently covered as identified by the data and the stakeholders.

- Use the strategic Questions template to identify current services for infant and early childhood mental health. Identify needs not addressed by current services.
- Facilitate the development of a strategic plan to address infant and early childhood mental health. Many public and private agencies contribute to the social and emotional development of young children but there is no strategic plan reaching across all agencies.

b. Increase in funding for telehealth

While the Legislature passed a bill developed by the Speaker's Task Force to clarify provision of telehealth services, it did not provide funding to increase the capacity of providers to offer this service. And while legislation was also passed to provide grants to psychiatrists locating in underserved areas the shortages, particular of child and adolescent psychiatrists, suggest the continued need to increase funding for telehealth. The funding for telehealth would pay for videoconferencing infrastructure and/or increase reimbursement.

c. 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).

d. Address transparency and any inequity in use of Children's Long-Term Support waiver for children with Serious Emotional Disturbance (SED)

CLTS has largely been silent on how many children with a true SED are served and how many are found functionally eligible under CLTS but not served by CLTS. Monitoring the data on both CST & CCS as well as CLTS is critical. The DHS Division of Long Term Care should be required to produce, and funds should be allocated for, an annual report that details CLTS waiver access (including wait lists), utilization, eligibility and outcomes by disability group.

e. Identify options to fund psychosocial interventions, crisis respite and preventative/proactive respite that doesn'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.

f. Eliminate charges for child support for kids removed to group home.

Chapter 51 specifies the mental health services that can be provided to children, while Chapter 48 specifies the types of Out of Home Care (OHC) providers that are licensed to care for children, including foster care (FC), group home (GH), and residential care center (RCC). OHC providers are an important resource for crisis stabilization services, and many placements of children are made under Chapters 48/938/948 to address mental health needs. The requirements for Medicaid reimbursement of crisis services are specified in the Medicaid Online Handbook. RCC is not a Medicaid allowable crisis stabilization setting. Parents are financially responsible for all or a portion of the cost of the services as established by the mental health agencies billing policies and DHS. After the crisis stabilization, some children are admitted to OHC beyond the 5 days. Parents are charged child support. This is an unfair practice as parents do not pay child support if their child has a physical illness such as cancer. The State should explore options that will remove this undue burden from families.

g. Expand programming to support parents for youth re-entry

While many factors affect the successful community reintegration of youth who have been placed at juvenile corrections facilities, research repeatedly points to parents as having significant influence in their teens' lives. This program works to equip parents with the information, resources and support needed to improve outcomes for previously-incarcerated youth. Piloted by the Division of Juvenile Corrections in 2013-14 as part of the Transformation Transfer Initiative grant, the program utilizes parent peer specialists to prepare and support parents in reintegrating their children into their homes and communities. During the demonstration pilot, parents found housing, gained employment, and accessed needed medical care. By addressing families' basic needs, the pilot increased parental capacity to focus on the emotional and behavioral needs of their children. This item requests an increase in Department of Corrections funding to expand the program and use of parent peer specialists to work with families of incarcerated youth.

## 2. 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 (both of which are currently awarded to Mental Health America of Wisconsin) 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.

## 3. 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 one area where the WCMH has had some involvement 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. DHS should also look to the regional pilot programs to understand how their needs and challenges in this area may inform policy development.

#### 4. Medicaid Reimbursement Issues

##### a. Incentive Payments for Evidence-Based Practices

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.

##### b. Explore other reimbursement models that could improve access to mental health services in Medicaid.

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.

**Description of Stigma Reduction Legislation & Funding**

**June, 2014**

Reduce the stigma associated with mental illness and reduce discrimination against individuals living with mental disorders:

Fund statewide stigma reduction efforts:

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 build the capacity of local communities to address stigma, utilizing Regional Coordinators who engage communities and local organizations, including healthcare, schools, and workplace, to learn about best practice approaches to stigma reduction and consult with them as they plan, implement and evaluate local efforts. Regional coordinators provide training, consultation, and evaluation with an evidence based model focused on targeted, local, credible (peer), continuous, change-focused, contact with people living with mental illness via individual stories of recovery. Trainings include basics of stigma reduction and support for careful decisions around personal disclosure by story tellers. Regional coordinators are supported by the Wisconsin Initiative for Stigma Elimination (WISE) coalition, comprised of statewide mental health and partner organizations and individuals, the majority with lived experience, in conjunction with academic and research partner, Dr. Patrick Corrigan ([www.ncse1.org](http://www.ncse1.org)).