Wisconsin Council on Mental Health
2011-2013 Budget Priorities

Mental Health Infrastructure Study

The WCMH recognizes that the Department of Health Services (DHS) views implementation of recommendations responding to last year's Mental Health Infrastructure Study as a priority for the coming budget. The WCMH is represented among the stakeholders involved in the workgroups. We will continue to provide input throughout the process and will monitor the recommendations coming from the workgroups.

System Development

The WCMH recognizes a number of core initiatives that we would like to see as part of mental health systems development, whether as part of the pilots envisioned in the infrastructure study follow-up or as separate initiatives.

- ***Evidence-Based Consumer-Run Services****:* WCMH recognizes that with the initiation of peer specialist certification Wisconsin has taken a significant step towards formalizing the involvement of consumers as a part of the mental health workforce. However, while this certification will allow some consumers to be hired within existing programs many key consumer-run services are not adequately funded in Wisconsin. WCMH recommends the following:

  - ✓ *Begin piloting consumer run respite centers* as a way of gathering additional data on their cost effectiveness and understanding the barriers to implementing more broadly in Wisconsin. Peer-run respite is a safe house where people learn new skills for managing emotional crises. Peer run respites reduce the stigma associated with involuntary treatment. A California study showed significantly greater improvement and dramatically higher satisfaction with a peer-run residential program than with a locked psychiatric ward. Peer-run respite costs about $250/day; about one-fourth the cost of treatment in a psychiatric facility.
  - ✓ *Phase in funding to support peer run programs in all counties*. Currently, the block grant supports peer run programs in only a few counties and these funds are time-limited. A more robust approach is needed to develop a strong infrastructure of peer support programs. Data from the 2009 survey of Wisconsin consumer-run organizations found that:
    - ➢ Over 60% of consumers reported 1-6 hospital visits prior to involvement with the organization; the same percentage reported no hospital visits following use of consumer-run services.
    - ➢ Nearly 40% had reduced the negative use of drugs and/or alcohol.
    - ➢ Reported instances with law enforcement dropped by approximately 25%.
  - ✓ *Ensure there is statutory language and adequate funds in other programs to support the use of peer specialists.* Peer specialists can be used in Family Care,

Partnership, Corrections, Independent Living Centers, CSPs, CCS, CST, crisis programs, ADRCs, forensic facilities—anywhere other mental health professionals are used. Peer specialists use their personal recovery experience as a unique tool to aid others. They facilitate self-direction and goal-setting, assist in identifying resources for consumers and both present and model recovery concepts. A longitudinal study of 104 consumers found that clients who received services from teams with Peer Specialists posted the largest gains on 20 of 31 outcome measures. A study of 25 New York consumers found that those randomly assigned to inpatient peer support had costs averaging $4,831 less per year for their set of services than those receiving standard care.

- ✓ *Fund additional peer specialist training:* Peer specialist certification provides individuals the skills to take on jobs in various settings, as described above. However, there is a need for ongoing support such as finding jobs, interviewing, accommodations, and job coaching and support. This skill development is critical in order to ensure that peer specialists realize their full potential within the human service system. WCMH recommends funding of $100,000/year for this effort.
- ✓ *Promote supported employment.* Unemployment for individuals with serious mental illness is estimated at 80-90% despite the fact that many people with these disorders want to work and work is an important piece of recovery. Supported employment is an evidence-based practice that may or may not be provided by consumers but it is a consumer-preferred option. Despite efforts by the Division of Vocational Rehabilitation to address the unique employment needs of those with mental illnesses the lack of a stable, long-term funding source undermines the ability to achieve systemic change in this area. There must be adequate funding to allow the DVR to work collaboratively with the DMHSAS to implement supported employment.

- ***Children's Services****:* The development of the children's mental health system needs considerable attention. Clearly identifying both the core services and the system organization elements for children's services will be an important aspect of the Infrastructure Study follow-up. However, additional steps are critical.

  - ✓ *Coordinated Services Teams (CST):* The cornerstone of the children's service system—coordinated service teams—needs to continue to be strengthened. The small amount of additional funding made available this biennium was helpful, but long term success of CSTs requires a significantly greater infusion of funds to support local programs.
    - ➢ The US Dept of Health and Human Services report "Mental Health: A Report of the Surgeon General" in 1999 found that "systems of care" as exemplified by CSTs are an effective way of addressing childhood mental health and addictive disorders. Evaluation of the CST process shows it is cost effective, significantly reducing public expenditures for inpatient placements here in Wisconsin,
    - ➢ As one example, after La Crosse County implemented a CST, the percentage of youth receiving crisis services able to be diverted from institutional

placement increased from 51% to 87%. As another example, Manitowoc County began their CST in 2002. In the year before that, in 2001, the county sent 16 youths to Lincoln Hill at a cost of just under $1,000,000. By 2006, the county has only 2 youths at Lincoln Hills and had reduced their total placement costs to about $75,000.

- National data from the Federal Substance Abuse and Mental Health Administration (SAMHSA) found that after 18 months in systems of care programs, the percentage of youth who used inpatient facilities decreased 54%, school attendance increased 54%, and school achievement (grade C or better) improved 21%. Emotional and behavioral problems were reduced significantly or remained stable and did not worsen for nearly 90% of children.

WCMH recommends $1.5m. per year be added to the budget to provide the following:

- Fund all remaining counties/tribes interested in implementing CST at $70,000/yr.
- Provide more modest grants to "old" sites that have completed 5-year grants to support their ongoing efforts.
- Fund family/peer support. Family support for and by families with children with emotional disturbances is a critical piece of the children's service system. The availability of peer support needs to be expanded so that more families in more areas of the state can benefit. $392,000 would be provided to find this activity in counties currently without family support staff.
- Fund Training and Assistance: Currently there is a range of formal and informal statewide responses to the development of effective crisis response planning. By expanding the efforts found in HFS 34 and modeling successful functional crisis response planning utilized by many counties and tribes through their Coordinated Services Team Initiative, the state could establish a consistent approach that has proven success coupled with qualified training and technical assistance.

- Funding for screening and evaluation activities.

✓ *Respite Care:* Respite continues to be an area where demand far exceeds available supply. Respite supports caregivers to that they can continue to provide the support their children need. Wisconsin needs to aggressively increase recruitment of respite care providers and explore how existing funding sources (Medicaid, children's long-term support waivers, foster care) can be utilized to support respite care.

- ***Independent Living Centers:*** Restore or increase state funding to at least FY 09 State ILC base funding level. Because of additional funding provided to ILCs through the

ARRA, the state reduced funding to ILCs for the current biennium. However, since increased ARRA funding is not expected to be available after this year the State needs to return to its prior base level of funding to ensure that ILCs can continue to provide services and supports to persons with disabilities, including people with mental illnesses. The State had argued that ADRCs were replacing the functions provided by ILCs but this is clearly not the case as ADRCs routinely refer individuals to ILCs for services.

Prevention/Wellness

- ***Suicide Prevention:*** Concerted efforts at youth suicide prevention by state and private agencies have contributed to a 50% reduction in youth suicides over the past six years. However, Wisconsin has lost its federal funding to support this effort and there is a need to expand suicide prevention across the lifespan. Increasingly, local communities are developing suicide prevention coalitions and there is a continuing need to provide training, consultation and technical assistance. Additionally, a statewide summit in 2009 identified the need for increased public awareness and enhanced networking among those involved in suicide prevention. In order for all this to occur WCMH recommends funding of $150,000/year to continue to support leadership of these efforts, training, consultation and networking. Currently the state is utilizing $95,000 from the MHBG to support this initiative.
- ***Reinstate funding for the Tobacco Control Board for specialized smoking cessation programs for people with MH/SA disorders***. People with MH/SA disorders continue to have smoking rates significantly higher than the general population. And there are special challenges in smoking cessation for this population. Wisconsin has done a considerable amount of work to develop and promote smoking cessation ideas for this population through WiNTiP, but the ability of practitioners to put treatment into place has been undermined by reductions in funding to the Tobacco Control Board.

Medicaid

As a key driver of public mental health services, adequate Medicaid funding is critical for the system to function. The sorry state of Medicaid funding for mental health services was inadvertently highlighted during the Medicaid rate reform process when mental health services were essentially exempted from cuts because there was not enough funding in the system to produce significant savings. WCMH recommends the following:

- ✓ *Increase the state share of funding for currently county matched services*. The distortions in service delivery and inequities across counties that are created due to the county-match requirement cry out to be addressed more broadly than in only a few pilot counties, as might be proposed through the Infrastructure Study follow-up. The state must begin the process of relieving counties of the inordinate burden they bear to provide mental health services. Options to accomplish this could include:

- having the state assume the state share of funding for crisis intervention services and phasing-in a partial assumption of costs for other county-matched services; or
- picking up an equal portion of the match for all services.

✓ *Change Mental Health Institute billing practices.* There are a variety of issues around how the State handles billing for individuals utilizing the two State Mental Health Institutes. For instance, DHS bills counties in full and then reimburses them after receipt of Medicaid and Medicare payments. Changes in these practices are needed to relieve the county fiscal burden and impact on cash flow.

✓ *Increase Medicaid reimbursement rates for MH professionals*. Provider rates, with the exception of psychiatry, have not seen increases in many years and are leading to a decline in providers willing to participate in Medicaid.

✓ *Ensure that Wisconsin maximizes federal funding opportunities.* The WCMH supports efforts to extend the enhanced FMAP that was part of ARRA. The WCMH also recognizes that federal health care reform has the potential to result in positive impacts on mental health services, from Medicaid eligibility expansions to extension of parity to additional populations. WCMH calls on DHS, the Governor and the Legislature to work closely with advocates to ensure timely and comprehensive implementation of these regulations.

Corrections

The Department of Corrections estimates that approximately 31% of its inmates have mental illnesses requiring treatment. This number has increased 14.3% from June 2006 to June 2008. However, the number of mental health staff, especially in the male facilities, is significantly below national standards. This leads to problems in inmate safety and mental health status. Re-incarceration is also a problem; 46% of persons with mental illness who are released from prison in Wisconsin return within the first two years. However, if adequate community treatment and support were provided this number could be significantly reduced. The Department of Corrections will be piloting a reentry program for 52 inmates with mental illness released from the Wisconsin Resource Center and 36 from Taycheedah. However, this is a fraction of the number of persons needing this service; in FY 2007-08 815 inmates with serious mental illness were released into the community.

While Wisconsin does not have data on the number of persons with mental illness in county jails, national estimates are that 64% have mental health problems. Of these individuals 74% have a co-occurring substance abuse problem. There are very few programs in Wisconsin aimed at diverting persons with mental illness from jail. Jail standards for mental health care have not been revised in 20 years. After care services depend on the county mental health system and are often unavailable.

The WCMH is encouraged by the Department of Correction's (DOC) continued efforts to improve mental health services. Additional funding to support women's treatment at

Taycheedah and to establish the Becky Young fund were important budget victories in 2009-2011. We need to build on these:

- ✓ *Continue improvement of mental health services in the prisons and jails* by addressing the need for more mental health professionals, especially in male facilities, eliminating the practice of having guards pass medications without appropriate training, and revising the standards for mental health services in the jails.
- ✓ *Invest $8m. in community mental health care for high risk individuals placed on extended supervision, as recommended by the Justice Reinvestment Initiative.*
- ✓ *Provide funds for C.I.P. training for jail and prison personnel.*
- ✓ *Provide grant funds for pilot programs in jail diversion.*

No Cuts

First do no harm. As noted earlier the mental health system is characterized by chronic underfunding of services. It is critical that the system not be further undermined by cuts to Medicaid or community aids that worth further weaken a fragile system. We certainly hope that implementation of mental health/substance abuse parity at the federal and state levels will begin to take some pressure off of the public mental health system. And further down the line implementation of health care reform may also improve access to services in the private sector. But it is premature to assume any savings in the next biennium from these important initiatives.