2019-2021 WCMH Budget and Policy Priorities

The budget priorities of the Wisconsin Council on Mental Health (WCMH) are guided by the following principles:

- Improving outcomes for individuals and their families
- Increasing system collaboration
- Reducing stigma
- Promoting recovery
- Implementing best practices and continuous quality improvement
- Integrating of cultural and linguistic competence
- Promoting of an individual/family/parent driven system
- Reducing mental health disparities
- Promoting total health integration

Recovery and resiliency principles should inform all new programs, service enhancements or reforms. Recovery and resiliency principles help ensure that services and supports promote connection, healing, hope and empowerment. These principles also require meaningful integration of peer and parent support. Specific recommendations for doing so are included in the narrative for the individual priorities.

From Dependence to Independence: Mental health disorders are consistently among the top causes of disability leading to loss of ability to work or reductions in productivity. Children with emotional disorders have the lowest rate of completing high school among all children with disabilities. Provision of effective mental health services and supports are critical for children and adults to achieve optimum health.

Focus should be on prevention services and programs over crisis response services as prevention is more cost effective and leads to better health outcomes for the individual.

With any new funding for programs or services, the following should be recognized as vital to achieving successful implementation:

- Orientation and education of mental health professionals on new or existing resources that are available to them (ie: peer support services in emergency rooms)
- Recruitment and development of adequate workforce to build and sustain new initiatives
- More resources for full implementation of new funding initiatives including involvement of people with lived experience in development, implementation, evaluation, and leadership of these new initiatives.
- Inclusion of people with lived experience at all levels of planning and implementation.

2019-2021 WCMH Budget and Policy Priorities

A. Improve Treatment Services

a. Strengthen suicide prevention treatment and support

i. Requested Action: Allocate dedicated funding to support statewide suicide prevention infrastructure development and training.

ii. Potential cost: $150,000 in GPR to support efforts across the lifespan and across populations.

iii. Staffing: The Department of Health Services (DHS) currently contracts with a non-profit agency to support similar services and these funds could be added to that existing contract or subcontracted separately.

iv. Need Statement: Wisconsin has been averaging over 800 suicide deaths per year and has a suicide death rate that is generally at or above the national average. Detailed data on deaths by age, gender, region as well as information for the Wisconsin Violent Death Reporting System are available on the Prevent Suicide Wisconsin website: www.preventsuicidewi.org Suicide prevention is a priority for Wisconsin's Mental Health Block Grant (MHBG) plan.

While the DHS has been providing funds in support of suicide prevention through contract since 2004, these funds, which come from the MHBG must be targeted to adults with serious mental illnesses and youth with serious emotional disturbances. The current yearly amount of these funds is about $125,000 and supports a statewide conference, the Prevent Suicide Wisconsin website, coordination of a statewide steering committee and dissemination of Zero Suicide, a quality improvement initiative for health and behavioral health care organizations. The DHS also contracts with the same agency for about $20,000/yr. for managing a learning community of local health departments working on adolescent suicide prevention. The contractor previously administered two federal grants on behalf of the State of Wisconsin for youth suicide prevention.

The current funding limits suicide prevention activities. Many evidence-based suicide prevention activities, such as those focusing on limiting access to lethal means, general public awareness and support to local coalitions working on suicide prevention cannot be funded through the MHBG. The public health funds are limited to working with youth but the largest population of people who die by suicide are men in the middle years (45-64). The amount of funding also limits the scope of what can be accomplished. The quality improvement work could reach more organizations if additional funds were available.

The DHS has acknowledged the need for additional funds in this area by targeting $100,000 in one-time MHBG funds made available through the FFY2019 budget. These funds are specifically targeted to expansion of the quality improvement efforts. There was also interest in providing funds for work with populations at disproportionate risk of suicide. However,

there are no plans for how these activities will be continued in future years.

v. Relevant history: The WCMH identified this area in prior budgets without success.

b. Support Workforce Development

i. Requested Action: Enhancement of coaching and supervision in service areas identified in the Gaps Analysis. Priority will be given to addressing gaps related to coaching and supervision of providers (public and private) within wraparound programs serving children and families.

ii. Potential Costs: To maximize current initiatives the MHC proposes a set aside of $100,000 to be used toward coaching and supervision needs identified in gaps analysis.

iii. Staffing: The Department of Health Services (DHS) currently provides directly, and uses contracted agents, for training and technical assistance for wraparound programs serving children and families, individual adults and elderly populations. Funds could be allocated for DHS staff already addressing the development of supervision within programs such as CST and CCS, or the provision of contract agents who can recruit and provide seasoned supervisors from county and private agencies who are able to share their expertise with developing agencies.

iv. Need Statement: Behavioral health workforce shortage and access issues are significant for the State of WI and will require high-level involvement such as a task force to comprehensively address the array of factors that must be addressed. At the same time, actionable strategies are within reach if adequately funded within this biennium. The recommendation supports actionable strategies to strengthen supervision and coaching of mental health workforce while sustaining the broader request for high-level intervention.

Across the nation there is a high degree of concern about the state of the behavioral health workforce and pessimism about its future. Workforce problems have an impact on almost every aspect of prevention and treatment across all sectors of the behavioral health field. The issues encompass difficulties in recruiting and retaining staff, the absence of career ladders for employees, marginal wages and benefits, limited access to relevant and effective training, the erosion of supervision, a vacuum with respect to future leaders, and financing systems that place enormous burdens on the workforce to meet high levels of demand with inadequate resources (SAMHSA 2007).

When persons with mental health diagnoses are not able to access appropriate services, their mental health conditions can become more disabling, difficult to manage and more expensive to treat. The mental health workforce shortage contributes to worsening symptoms; increased risk of suicide, homelessness and substance use; increased

incarcerations; inability to keep up with supply and demand; lack of primary prevention techniques and more money spent by taxpayers (MN State University Policy Brief 2017).

Isolation, burn out, lack of adequate collegial and supervisory support and few opportunities to collaborate and partner with other professionals were common factors reported across mental health professionals as reasons for recruitment and retention issues.

Current DHS MH Block Grant Requests have been made for funding projects that will lead to workforce developments. These include: Family Supports and Parent-Peer Specialist Training- $151,000, Consumer and Peer Leadership Development- $55,000, Technical Assistance for Underserved Populations-$50,000, Evidence-Based Practice Technical Assistance- $200,000, Early Serious Mental Illness (ESMI) Technical Assistance and Implementation- $300,000, and Mental Health Gaps Analysis- $150,000.

These and many other important initiatives rely on a service infrastructure of supervision, coaching and management support to be implemented and effectively sustained. The need for competent and capable supervision exists across the private and public mental health delivery system. Programs such as Comprehensive Community Services provide ample support for training on specific interventions but often lack the supervision and coaching necessary to implement services to fidelity. This area is slowly improving within the county/tribal system. Private providers are frequently at a loss with how to incorporate psychosocial rehabilitation into their practice. In addition, career ladders have not been available to support talented service coordinators moving up into supervisory roles. Wisconsin is at risk of losing valuable talent by not supporting clinical supervision for those serving vulnerable populations.

c. Enhance mental health services for the Deaf/Hard of Hearing based on legislation introduced in 2017

- **i.** Requested Action: To establish and assure a state-wide continuum of services for Wisconsin citizens who are hard-of-hearing, deaf and deaf-blind and have mental illnesses, substance use disorders or developmental disabilities (MH/SUD/DD).
- **ii.** Potential Costs (How Will We Achieve This): $500,000. We are asking for a new state entity to be located in the Division of Care and Treatment Services in the Department of Health Services (DHS) to focus on the MH/SUD/DD needs of Wisconsin citizens who are hard-of-hearing, deaf and deaf-blind. This will not replace the current Office of the Deaf and Hard of Hearing, which provides important advocacy and information and referral services to the broader population of those who are hard-of-

hearing, deaf and deaf-blind. Based on the experience in other states, such an entity will support the long-term development of an increased capacity to provide direct behavioral health services to this population.

iii. Staffing: Staff would consist of an Office Director, two coordinators (one for Deaf and one for Hard-of-Hearing), a communication specialist, one specially trained psychologist or psychiatrist to provide assessments, two qualified behavioral health providers who would be specialists in the mental health needs of hard-of-hearing and deaf consumers to provide direct therapy service, one interpreter with mental health interpreter certification, and an office assistant. See attached.

iv. Needs Statement (The proposed positions are necessary to):

1. Develop policies and procedures to set a necessary standard of care to serve this population in order to ensure delivered services will be experientially, culturally and linguistically appropriate.
2. Educate and advocate for MH/SUD/DD services to persons who are hard-of- hearing, deaf and deaf-blind. Ensure that organizations responsible for providing and paying for services are doing so.
3. Obtain and coordinate services pertaining to MH/SUD/DD for this population.
4. Provide direct MH/SUD/DD services as needed when culturally and linguistically appropriate services are not available to individuals.
5. Work to build the capacity in Wisconsin to provide direct MH/SUD/DD services to this population.
6. Coordinate and consult with other state agencies, local units of government and other organizations serving this population.
7. Collect data and report on the number of individuals needing and receiving services._The office would also have funds available to contract with a psychologist/psychiatrist for assessments when the specialized expertise required goes beyond that possessed by the staff psychologist/psychiatrist, purchase sign language interpreters as needed to augment the capacity of the staff interpreter, and provide CART (Computer Assisted Real-Time Transciption) services and equipment necessary to ensure adequate communication. Additionally, the office would have the authority to collect reimbursement for direct services provided from entities otherwise responsible for providing these-.

v. Relevant History (Rationale): Persons who are part of the hard-of-hearing, deaf and deaf-blind populations face more mental health risks than their hearing counterparts. Research has shown that thousands of such individuals have experienced experiential and language deprivation in their early years. This deprivation creates harms in the form of educational, social-emotional and cognitive delays. It also limits the ability of this population to access information incidentally and

to self-advocate.

Studies have shown that deaf youth and adults are three to five times more likely to have a serious emotional disturbance than their hearing peers.

People who are disabled are not well served by the nation's mental health system and within this population, hard-of-hearing, deaf and deaf-blind consumers have been identified as one of the most underserved of any disability group. Nationwide there are 48 million hard of hearing, deaf and deaf-blind people 12 years and older in the United States with a hearing loss.

When seeking mental health treatment, research has shown that hard-of-hearing, deaf and deaf-blind consumers with mental health issues are less likely to be appropriately diagnosed or treated because mental health clinicians are not properly trained to work with them.

Wisconsin has a large number of trained and certified mental health interpreters but they are not a replacement for direct accessible services. The presence of a third party often shifts the client/clinician relationship and can inhibit counseling in sensitive situations. Accessibility does not always mean appropriate. The use of interpreters is second best when compared to direct service. Likewise the simple addition of amplification devices does not result in appropriate services when the mental health provider lacks knowledge and sensitivity about the profound effects of hearing loss.

For more than 50 years professional organizations, providers and the deaf community have advocated for specialized mental health services (NAD 2003). The ADA and other landmark legislation as well as litigation made it possible to have some direct service but only a few states (Minnesota, South Carolina and Alabama) provide a true continuum of mental health services to serve this population.

B. Strengthen Community Living Services and Supports

- **a. Provide funding for training and technical assistance to community-based programs for the purpose of implementing Individualized Placement and Support (IPS - a supported employment program for people with mental illnesses**.)
  - **i.** Requested Action: Increase IPS staff to a total of 5 to fully cover the state: Three individuals to provide technical assistance and training for the entire state. 1 lead trainer and 2 other trainers to provide guidance and assistance to new and existing sites. Two individuals to complete quality improvement/fidelity reviews statewide (after training from state team) to increase compliance with national IPS standards (IPS reviews 2x

per year for teams until they reach good fidelity, 18 months at exemplary fidelity). Additionally, improve the responsiveness of IPS programs to the employment training needs of individuals moving to work under the Medical Assistance Purchase Program (MAPP).

ii. Potential Cost: $100,000 per trainor for a total cost of $500,000

iii. Staffing: 5 full-time staff. Similar sized states (KY, IL) have 5 full-time staff working on IPS in a similar configuration or with technical assistance/fidelity combined, except where there are enough trainers that they do not review their own IPS sites.

iv. Need Statement: The expansion of staffing for IPS would allow for the expansion into interested counties. There are currently 12 counties interested including: Vilas, Oneida, Forest, Wood, Portage, Waupaca, Juneau, Adams, Waushara, Marquette, Green Lake and Jefferson. The expansion would also make it possible for existing counties to reach compliance with national IPS standards and achieve "exemplary fidelity". Of the 22 counties implementing IPS, currently only five sites/teams are identified as "exemplary". These include: Chrysalis- Dane Co., RCS- Sheboygan Co., Aurora- Pierce Co., Aurora- Dunn Co., and FCC operating in LaCrosse, Jackson and Monroe.

v. Relevant history: Wisconsin started in 2010 with three counties (LaCrosse, Marathon and Washington). It is now active in 22 counties including: Milwaukee, Dane, Washington, Sheboygan, Outagamie, Lincoln, Langlade, Marathon, Washburn, Dunn, Polk, Barron, Chippewa, St. Croix, Pierce, Pepin, Buffalo, Jackson, Monroe, LaCrosse, Vernon and Crawford. Within the first year, IPS had a total of 65 people enrolled. 2nd quarter data from 2018 shows that 706 individuals are enrolled in IPS. Employment rate in the program has also grown from 12 people (18% statewide) in 2011 to 305 (43% statewide) in 2018. Wisconsin has steadily become in alignment with national averages.

b. Make investments in transportation to support community living for people with mental illness.

i. Requested Action: Increase funding for transit and specialized transportation programs to support community living for people with mental illness, and support the mental health workforce by providing transportation for service providers.

ii. Potential Cost: The WCMH requests a 10% increase in transit and specialized transportation funding to counties and tribes and ongoing increases of at least 3.5% to account for the growth over the past five years and accelerating growth in the future.

iii. Staffing: The Department of Transportation allocates these funds to counties.

iv. Need Statement: Transportation is critical to maintaining the independence of people living with a mental illness. Many do not drive or own a vehicle because of limited income, and, in some cases, because of their disability. When people with mental health needs cannot access

transportation or the transportation network does not get them where they need to go when they need to, they are not able to access supportive services and healthcare, get to work or school, attend worship, or visit family and friends. Limited access to transportation impedes recovery by contributing to isolation and making it difficult to meet basic needs, and may ultimately result in more people in crisis. At a time when we are seeing significant shortages in the mental health workforce, transportation is also important to ensuring service providers can get to work. A recent report, "Arrive Together: Transportation Access and Equity in Wisconsin" noted that "Lack of access to transportation disproportionately impacts Communities of Color in Wisconsin, exacerbating problems of residential segregation and limiting upward economic mobility."

v. Relevant history: The previous biennial budget increased funding (2% each year) for seniors and individuals with disabilities aids and increased tribal elderly transportation grants by $148,500 annually

c. **Pilot "Housing First" initiatives**

i. Requested Action: The WCMH asks policy makers to support the following initiatives to address homelessness and increase access to affordable and stable housing.

1. Homeless Prevention Funding (HPP) – Budget Ask
   The Homeless Prevention Program is a state program authorized under Wisconsin Statutes Section 16.303. HPP can be used for rapid re-housing, homelessness prevention, and administrative costs.) Homeless Prevention dollars can be used to make payments to landlords in order to avoid eviction, keeping someone in their home and out of the homeless system altogether.
   Another potential way to use HPP would be for Diversion. A good Diversion program has a trained staff member working with a person who is about to become homeless to help that person identify resources they can use outside the mainstream homeless system to help them get back on their feet. If Diversion is an eligible use for HPP, with adequate funding, it could mean a reduction in those entering shelter. Tying it to HPP would also mean there could be some light financial assistance if needed to help that person stay in their current living situation.
2. State Shelter Subsidy Grant (SSSG) – Budget Ask.
   "The State Shelter Subsidy Grant Program (SSSG) provides up to 50% of an emergency shelter or voucher program's annual operating budget…. An eligible applicant may be a county or municipal governing body or agency, a community action agency, or other private non-profit or for-profit organization." It is authorized by Wisconsin Statutes Section 16.308.
   The Interagency Council on Homelessness has identified a need

for a funding increase for SSSG. In many cases, this is the only state money that a shelter is eligible for. The Council has also identified that there are some shelters that rely on SSSG for a large part of their funding, while there are many others that only use it to supplement a small part of their programming.
The WCMG supports increased funding for the SSSG program.

3. Submit Waiver – In Motion
   The last state budget authorized a position at DHS to write the Medicaid Waiver. This position is playing a key role in submitting the waiver that will ensure Wisconsin can join the 14 other states that allow for Medicaid billing for housing support services. The WCMH supports continued funding for this position to advance the Medicaid Waiver and to administer it moving forward. The position authorization in last budget is on Page 336 of this document, item #13: https://docs.legis.wisconsin.gov/misc/lfb/budget/2017_19_biennal_budget/033_comparative_summary_of_provisions_2017_act_59_entire_document.pdf
4. Homeless Case Management – Budget Ask. This program was created by last year's budget. It was $500,000 annually in TANF funds redirected to DEHCR at DOA to grant to homeless service providers and shelters. The DEHCR website has a good summary of the four eligible uses of the funding: https://doa.wi.gov/Pages/HomelessCaseManagementServicesGrants.aspx There were 18 applicants of very high quality for this grant; 10 grants were awarded of $50,000 each. The Council supports increasing funding for this program, either through extra TANF funds or through GPR.

ii. Potential Cost: The WCMH

iii. Staffing: The Interagency Council on Housing is advancing these priorities which impact multiple departments.

iv. Need Statement: People who live with a mental illness or substance abuse disorder often struggle to find stable, affordable housing. A high percentage of Wisconsinites experiencing homelessness have significant mental health and/or substance use disorder needs. With the creation of the new Interagency Council on Homelessness, Wisconsin policymakers have recognized the need to develop and expand programs and policies to relieve homelessness and promote Housing First. Housing First has two components; 1) safe and stable permanent housing with limited barriers to entry; 2) optional, person-centered wraparound services that allow for people to get the assistance they need in order to sustain their housing. Multiple counties throughout the nation have taken on the Housing First approach to end homelessness. The WCMH includes support for key policy initiatives of the Interagency Council on Homelessness, because of their benefit for many Wisconsinites who live

with a mental illness or substance abuse disorder.

v. Relevant history:

C. **Strengthen Early Identification and Treatment for Children and Youth**

a. **Provide funding for School Mental Health and Special Education**

i. Requested Action: Support DPI budget requests

ii. Potential cost: $659 million (total)

iii. Need statement: State support remains far short of demand for programs to assist students with mental health challenges. One in five students faces a mental health issue. Over 80 percent of incidents go untreated, and roughly 75 percent of mental health services occur at school.

In the 2017-19 state budget, a new collaborative mental health grant program was created with $3.25 million in funding for the first year. The proposals from school districts far exceeded the available funding, indicating the extent of the student mental health struggles in districts across the state.

Funding has not kept pace with the need for the student services staff who are generally the front-line supports for mental health in schools. According to a 2017 USA-Today analysis, Wisconsin would need more than six times as many social workers, more than twice the nurses and nearly double its school counselors and psychologists to meet recommendations by professional organizations.

Meanwhile, students with mental health challenges often qualify for special education services and supports. Special education funding in Wisconsin has been frozen for a full decade, while needs and costs have continued to rise.

WCMH supports the following DPI state budget requests:

$10 million to fully fund and expand grants for collaboration between schools and community providers (previously funded at $3.25 million)

$44 million to extend a categorical aid that matches district funds when hiring pupil services staff. The previous program focused solely on social workers (with $3 million of state support)

$5 million statewide training and support, including $110,000/year to the Center for Suicide Awareness to support operating a text-based suicide prevention program, and $310,000/year to Wisconsin Family Ties for parent peer specialist support to help empower and assist families in overcoming emotional and mental health challenges.

$300,000 to fund the Youth Risk Behavior Survey

An additional $600 million to support students with disabilities through the special education categorical aid, bringing the state's reimbursement rate to 60% by the end of 2019 and moving Wisconsin closer to the national average.

iv. Relevant history: WCMH supported DPI's school mental health requests, passed in the 2017-19 state budget, and both the DPI and legislative requests for increased special education funding in the past session, which did not advance.

b. **Remove statutory ceiling on MHBG funds used for provider training**

i. Requested Action: Remove the statutory ceiling regarding the Mental Health Treatment Provider Training appropriation from the Federal Mental Health Block Grant, defined under s. 20.435 (5) (md).

ii. Potential Cost: No impact on state funding.

iii. Need Statement: The Wisconsin State Mental Health Authority allocates a relatively small proportion of Federal Mental Health Block Grant dollars for professional development and education. Further, Wisconsin appears to have disproportionately high utilization of state hospital psychiatric beds for youth and adults, somewhat elevated rates of suicide, increasing child welfare costs and regionally (Midwest) high disability rates.

This perpetuates a situation in which Wisconsin behavioral health consumers, both adult and youth, are experiencing significant challenges accessing evidence-based therapies. The goal in providing additional funding for training would be to strengthen the skills of current clinicians, enhance the development of new clinicians, encourage clinician retention and, through the application of evidence-based practices (EBP), improve consumer outcomes. This in turn has the potential reduce the costs associated with unnecessary hospitalizations.