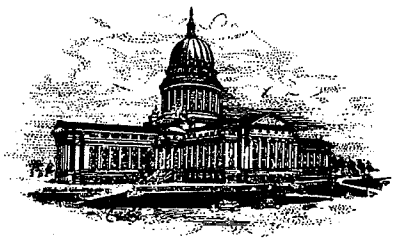

Wisconsin State Assembly

P.O. BOX 8952 • MADISON, WI 53708

TO: SPEAKER ROBIN VOS

FROM: The Speaker's Task Force on Mental Health

RE: Report of the Speaker's Task Force on Mental Health

DATE: October 9, 2013

This report contains the recommendations of the Speaker's Task Force on Mental Health. The Task Force was established on February 6, 2013 by Speaker Vos and charged with:

- Eliminating barriers to treatment, and promoting early and voluntary intervention for juveniles and adults in need of mental health services.
- Improving coordination of care among those who treat people with mental illness.
- Increasing awareness and reducing the stigma that often accompanies mental health diagnoses.
- Identifying and promoting best practices for addressing the link between mental illness and substance dependence and abuse.
- Addressing mental illness in the prison population.

Appendix 1 lists the members of the Task Force. The recommendations in this report are based on testimony received by the Task Force at meetings and public hearings that it held throughout the state. The Task Force met and held hearings on the following dates, at the locations indicated:

February 27, 2013: Madison

March 27, 2013: Neenah

April 18, 2013: Milwaukee

May 9, 2013: Balsam Lake

July 23, 2013: Madison

Several of the recommendations contained in this report were initially developed by the Legislative Council's Special Committee on Review of Emergency Detention and Admission of Minors Under Chapter 51, hereafter referred to as the Special Committee, which was

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comprised of both legislators and public members. The Special Committee held eight meetings between August 2010 and October 2012, and developed the following four bills which were introduced by the Joint Legislative Council on April 3, 2013:

- 2013 Senate Bill 125, relating to disabled offender recidivism reduction pilot programs.
- 2013 Senate Bill 126, relating to admission of minors for inpatient treatment.
- 2013 Senate Bill 127, relating to emergency detention, involuntary commitment, and privileged communications and information.
- 2013 Senate Bill 128, relating to requiring county community programs board appointees to include consumers and their family members, law enforcement personnel, and hospital employees or representatives, and increasing the size of county community programs boards.

These bills have been referred to the Senate Health and Human Services Committee. Additional information on these bills may be found in Joint Legislative Council Report 2013-04, "Joint Legislative Council's Report of the Special Committee on Review of Emergency Detention and Admission of Minors Under Chapter 51", dated April 5, 2013. The report is available online at: http://www.legis.wisconsin.gov/lc.

This report is organized by the following topics:

2013 Senate Bills 125, 126, 127, and 128 3

Hospital Diversion, Emergency Detention, and Civil Commitment 3

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2013 SENATE BILLS 125, 126, 127, AND 128

Background

As described above, four drafts relating to various mental health topics were developed by the Joint Legislative Council's Special Committee on Review of Emergency Detention and Admission of Minors Under Chapter 51. Following Joint Legislative Council custom, these drafts were introduced by the Joint Legislative Council as Senate bills because the chair of the Special Committee was a member of the Senate.

Recommendation

Introduce Assembly versions of Senate Bills 125, 126, 127, and 128.

HOSPITAL DIVERSION, EMERGENCY DETENTION, AND CIVIL COMMITMENT

Establish and Train Crisis Intervention and Mobile Crisis Teams

Background

Several individuals provided testimony to the Task Force in support of expanded crisis intervention teams and mobile crisis teams. Crisis intervention teams (CIT's) are comprised of law enforcement officers who are specially trained in responding to individuals with mental health issues who are acting out in the community. Mobile crisis teams typically include mental health professionals such as nurses, social workers, psychologists, peer counselors, and addiction specialists. One CIT model, the Memphis Model, provides a 40-hour course for law enforcement officers to inform officers about mental illness, recognize symptoms, and utilize nonviolent de-escalation techniques to reduce the possibility for harm to the individual, the officer, and the community. Wisconsin counties that have implemented CIT include Milwaukee, Brown, Winnebago, and Racine.

Recommendations

- Provide grants for CIT trainings throughout the state and within the Department of Corrections (DOC).
- Provide matching funds to counties to establish mobile crisis teams to serve individuals in mental health crisis in rural areas.

Provide Funding and Support for Peer-Run Respite Centers

The Task Force heard testimony that peer-run respite centers are an effective alternative to detention or hospitalization for certain individuals experiencing a mental health crisis. In other states that have implemented this alternative, peer-run respite centers are usually community-based residential facilities (CBRFs) with beds available to people in a mental health or substance abuse crisis situation, with services provided by staff who have

successfully participated in mental health or substance abuse recovery or treatment programs. There is no requirement that peer-run respite centers be licensed as CBRFs.

2013 Wisconsin Act 20 (the 2013-14 Biennial Budget Act), provides $64,600 in 2013-14 and $1,282,700 in 2014-15 and 1.0 position, beginning in 2013-14, to distribute grants to regional peer-run respite centers for people with mental health or substance abuse concerns, with the goal of improving crisis treatment and reducing inpatient hospitalizations. The funding will support: (1) three regional peer-run centers, beginning in 2014-15, each with an annual allocation of $400,000; and (2) 1.0 position to administer the program ($64,600 in 2013-14 and $82,700 in 2014-15).

Recommendation

Provide matching funds, in addition to the funds provided in Act 20, to counties to enter into contracts with peer-run organizations to pilot peer-run respite services.

Study on Utilization of Certified Peer Specialists

Background

A certified peer specialist is an individual who has lived with mental illness and has also had formal training in the peer specialist model of providing support to individuals with mental illness. To become certified as a peer specialist in Wisconsin, an individual must attend a week-long training session and pass an exam. The training is offered through the University of Wisconsin-Milwaukee School of Continuing Education. A peer specialist must also complete specified continuing education requirements to maintain their certification. Currently, Wisconsin has 253 certified peer specialists, and there will be an estimated 100 additional individuals who will become certified peer specialists in Wisconsin.

According to testimony provided to the Task Force, national statistics show that individuals working with a certified peer specialist show an average of a 40% reduction in hospital stays and crisis events within one year, and remain in recovery longer.

Recommendation

Commission a study to determine how health care providers and systems can best utilize and collaborate with certified peer specialists in various settings.

Modify the "24-Hour Rule" for Emergency Detentions in Milwaukee County

Background

Current law provides different procedures for emergency detention in counties with a population of 500,000 or more (currently, only Milwaukee County) and those with a population of less than 500,000. In counties with a population of 500,000 or more, the treatment director of the facility in which the person is detained, or his or her designee, must determine within 24 hours whether the person is to be detained. If the individual is detained,

the treatment director or designee may supplement in writing the statement filed by the law enforcement officer or other person undertaking the emergency detention. This requirement does not apply in other counties.

Concerns have been raised with the 24-hour requirement and the difficulty in complying with this requirement when it is not possible to evaluate an individual within that time period due to physical incapacities of the individual.

Recommendation

Support the provision in Senate Bill 127 to modify the 24-hour emergency detention rule, described above, for individuals in need of nonpsychiatric stabilization before psychiatric evaluation.

This provision specifies that any time delay that is directly attributable to evaluating or stabilizing any nonpsychiatric medical conditions of the individual is excluded from the calculation of the 24-hour time period.

Request an Attorney General Opinion Regarding Several Issues Pertaining to Emergency Detention

Background

In testimony provided to the Task Force, it was stated that health care providers often perceive that they could be viewed as responsible for decisions made by law enforcement or county crisis agencies to not initiate and approve a psychiatric emergency detention for an individual who the health care provider believes is a danger to himself or herself or others.

Testimony also indicated that under the federal Emergency Medical Treatment and Active Labor Act (EMTALA), hospital emergency departments have certain obligations regarding the evaluation, stabilization, and transfer of patients, though the extent of obligation may depend on the wishes of the patient or an agent of the patient making decisions on behalf of the patient. The WHA asserted that, there has been some confusion, including among federal regulators, as to whether Wisconsin's emergency detention law is compatible with the federal EMTALA law.

Recommendation

Request an Attorney General's opinion to clarify two areas of confusion regarding psychiatric emergency detentions:

- Whether a health care provider has fulfilled his or her duty to warn regarding an individual's dangerousness, if the provider requests law enforcement to initiate an emergency detention.
- Whether a law enforcement officer with custody of an individual under an emergency detention is an agent entitled to make decisions on behalf of the

individual under Wisconsin law. If so, clarify which decisions about the individual's evaluation, stabilization, or transfer in or from the emergency department must be made by the individual rather than the law enforcement officer with custody.

Expand Authority to Initiate Emergency Detention to Additional Parties

Background

Under current law, in counties with a population under 500,000, a law enforcement officer must sign the statement of emergency detention, which must provide detailed specific information concerning the recent overt act, attempt, or threat to act or omission which forms the basis for the detention, and the names of persons observing or reporting the recent overt act, attempt, or threat to act or omission. [s. 51.15 (5), Stats.] In addition, in Milwaukee County, the facility treatment director (or designee) must determine, within 24 hours of the subject being taken in to custody, that the individual must be detained. [s. 51.15 (4), Stats.]

In addition, in all counties, the county department of community programs in the county in which the individual was taken into custody must approve the need for detention. [s. 51.15 (2) (intro.), Stats.]

Recommendation

- Create a way for interested parties to formally request that a county initiate an emergency detention or to petition a judge to order an emergency detention if a county will not proceed.
- Establish a pilot program in Milwaukee County to expand the authority to initiate emergency detentions to designated mental health professionals. Sunset the pilot program after two years and require an evaluation of the program to be conducted including a recommendation as to whether this authority should be expanded statewide.

MENTAL HEALTH CARE AND TREATMENT FOR MINORS

Establish a Pediatric Telephone Consultation Line

Background

Pediatric primary care physicians are the main providers of health care, including mental health care, to children in Wisconsin. Testimony provided to the Task Force indicated that, according to the American Academy of Pediatrics, 13% of school aged children and 10% of preschool children in the United States have parents expressing concerns about their children's behavior or mental health. Wisconsin primary care clinicians have expressed the desire for additional support from child psychiatrists. According to testimony provided to the Task Force, this support is difficult to provide in person, since in 2009, most counties had

fewer than four child and adolescent psychiatrists, and many counties had none. Massachusetts and Minnesota have provided $3 million and $1 million per year, respectively, to fund pediatric telephone consultation lines to facilitate consultation between primary care physicians and psychiatrists.

Recommendation

Support a program that provides a pediatric telephone consultation line to allow primary care physicians to have access to consultation with child and adolescent psychiatrists and an access coordinator to facilitate referrals to community resources.

Facilitate the Provision of Mental Health Services in Schools

Background

Testimony received by the Task Force indicated that DHS currently requires mental health outpatient clinics to obtain branch office certification in order for clinic staff to provide therapy to children in a school setting. This requirement creates extra work and licensing fees that are unnecessary to protect consumers.

Testimony also indicated that due to the shortage of mental health professionals in most of the state, it is difficult to find licensed therapists willing to travel to multiple schools to work with children. Masters-degreed therapists who are gathering hours towards licensure (referred to as qualified treatment trainees) are willing to take these positions, but MA HMOs and private insurers nearly always refuse to pay for the services of these individuals.

The Task Force also heard testimony that some providers have a consultation meeting with parents to discuss treatment needs and options before therapy with a child is started. Providers using this approach have no mechanism to bill Medicaid for this meeting. While the meeting is clearly related to the child's treatment and in the child's best interest, it does not fit neatly into a diagnosis code. A non-diagnostic "V" code would create a mechanism to bill for this time that allows for parent engagement in the process and sound planning for the treatment to follow.

Recommendations

- Modify s. DHS 35.07, Wis. Adm. Code, to allow mental health services to children in a school setting without requiring clinic branch office certification for the school setting.
- Require MA HMOs to pay for the services of qualified treatment trainees.
- Require DHS to develop a MA payment mechanism to support mental health consultation.

Modify Statutes Governing Inpatient Mental Health Treatment of Minors

Background

Under current law, s. 51.13, Stats., governs inpatient mental health treatment of minors. Testimony provided to the Special Committee indicated that, in some areas of the state, there is little awareness of the ability of a parent of a minor age 14 or older to obtain treatment for the minor even if the minor does not want treatment. In some cases, this lack of awareness has resulted in the failure to provide treatment that could have prevented harm to a minor.

Recommendation

Support the passage of 2013 Senate Bill 126, relating to mental health treatment of minors, which was created by the Special Committee. The bill, which streamlines some of the procedures in s. 51.13, Stats., does all of the following:

- Eliminates the need to file a petition for review of an admission of a minor under age 14 for treatment of mental illness, alcoholism or drug abuse, or developmental disability. Because under current law, parents have the authority to consent to inpatient admission for minors under age 14 without the minor joining in the petition, the committee determined that the petition and hearing requirements in current law for minors under age 14 are unnecessary and should be eliminated. A petition would still be required if the minor wanted treatment but the parent refuses; if a parent with legal custody or guardian cannot be found; or if there is no parent or guardian.

- Eliminates the need to file a petition for a minor age 14 or older who voluntarily participates in inpatient treatment for mental illness. A petition would still have to be filed if the minor age 14 to 17 refused to join in the application, or if the parent with legal custody or guardian cannot be found, or there is no parent with legal custody or guardian. A petition would also still be required if the minor wanted treatment but the parent refused. It should be noted that a minor age 14 or older may request discharge from the inpatient facility at any time. If the request is denied, current law sets forth a procedure for determining the continued appropriateness of the admission. This procedure is retained, and provides protection of the minor's rights if the minor withdraws his or her consent to the treatment.

- Eliminates the petition requirement at the expiration of the 12-day time period if the admission was voluntary on the part of the minor and the parent.

- Eliminates the provision that allows for no more than one short-term (up to 12 days) voluntary admission of a minor every 120 days.

The bill also creates subsection and paragraph titles within s. 51.13, Stats., to provide guidance to the reader regarding the subject matter of the subsections and paragraphs, and also eliminates some redundant language in s. 51.13, Stats.

JAILS AND THE CORRECTIONS SYSTEM

Expand the Treatment Alternatives and Diversion (TAD) Program

Background

Under current law, the Department of Justice (DOJ) administers a grant program which provides funds to counties to establish and operate programs that provide alternatives to prosecution and incarceration for criminal offenders who abuse alcohol or other drugs. These include suspended and deferred prosecution programs and programs based on principles of restorative justice. [s. 165.95, Stats.]

There are currently nine counties receiving funding under the program: Ashland, Bayfield, Burnett, Dane, Milwaukee, Rock, Washburn, Washington, and Wood. In addition to the ongoing funding for the current projects, the 2013-14 Biennial Budget Act provided $1 million for grants for new projects in counties that do not currently have a TAD program. Applications for new projects are due in October 2013. Projects will be funded for the 2014 calendar year, and projects that continue to meet program requirements may reapply for funding through December 31, 2016.

A county receiving grant funds must provide matching funds that are equal to 25% of the amount of the grant.

A county is eligible for a grant if all of the following apply:

- The program is designed to meet the needs of a person who abuses alcohol or other drugs and who may be or has been charged with or who has been convicted of a crime related to the person's use or abuse of alcohol or other drugs.
- The program is designed to promote public safety, reduce prison and jail populations, reduce prosecution and incarceration costs, reduce recidivism, and improve the welfare of participants' families by meeting the comprehensive needs of participants.
- The program establishes eligibility criteria for participation and specifies that a violent offender is not eligible to participate.
- Services provided are consistent with evidence-based practices in substance abuse and mental health treatment, as determined by DHS, and the program provides intensive case management.
- The program uses graduated sanctions and incentives to promote successful substance abuse treatment.

- The program provides holistic treatment to its participants and provides them services that may be needed, to eliminate or reduce their use of alcohol or other drugs, improve their mental health, facilitate their gainful employment or enhanced education or training, provide them stable housing, facilitate family reunification, ensure payment of child support, and increase the payment of other court-ordered obligations.

- The program is designed to integrate all mental health services provided to program participants by state and local government agencies and other organizations. The program must require regular communication among a participant's substance abuse treatment providers, other service providers, the case manager, and any person designated under the program to monitor the person's compliance with his or her obligations under the program and any probation, extended supervision, and parole agent assigned to the participant.

- The program provides substance abuse and mental health treatment services through providers that are certified by DHS.

- The program requires participants to pay a reasonable amount for their treatment, based on their income and available assets, and pursues and uses all possible resources available through insurance and federal, state, and local aid programs, including cash, vouchers, and direct services.

- The program is developed with input from, and implemented in collaboration with, one or more circuit court judges, the district attorney, the state public defender, local law enforcement officials, county agencies responsible for providing social services, including services relating to alcohol and other drug addiction, child welfare, mental health, and the Wisconsin Works program, DOC, Children and Families, and DHS, private social services agencies, and substance abuse treatment providers.

- The county complies with other eligibility requirements established by DOJ.

On December 22, 2011, the Office of Justice Assistance (OJA), in collaboration with DOC and DHS, submitted a report to the Legislature identifying savings generated through implementation of the TAD program. The Executive Director of OJA summarized the report as finding that "TAD projects effectively divert non-violent offenders with substance abuse treatment needs from incarceration thereby avoiding costs associated with incarceration." Specifically, the report concluded, based on five years of program data, that the seven funded TAD projects generated $1.93 of savings in the form of reduced incarceration and reduced future crime for every $1.00 spent.

Recommendation

Provide funding to expand the TAD program to include offenders with mental health and co-occuring disorders. The funding should be used to support the development of new

county or regional TAD diversion and treatment court programs designed to work with this population.

Establish a Pilot Program to Assist Former Jail Inmates to Obtain Benefits

Background

Among the population of incarcerated individuals in Wisconsin, offenders who, upon release from incarceration, are eligible for but who fail to obtain certain benefits such as SSDI, SSI, or MA are particularly at risk of recidivism. There is often a gap between an offender's date of release and the date that he or she begins to receive benefits for which he or she is eligible. During this period, an offender may be at higher risk of recidivism.

DOC has taken significant steps to address this issue among Wisconsin's prison population. In the last several years, DOC has secured funding for a program to provide individualized assistance to prisoners in 14 Wisconsin prisons in obtaining benefits for which they are eligible as of release. The program is known as the Disabled Offender Economic Security (DOES) project. It is administered through DOC, via a contract with Legal Action of Wisconsin, in collaboration with DHS. DOC considers the program a success and has expressed an interest in continuing the program and eventually expanding it to prisoners across the state.

Thus far, efforts to address this issue in Wisconsin have been limited to offenders housed in prisons. No similar form of individualized assistance is currently available to offenders housed in county correctional facilities (i.e., county jails, houses of correction, and rehabilitation facilities). The committee concluded that replicating DOES at a county level would help reduce recidivism and potentially save county funding.

Recommendation

Streamline the MA application process for released offenders, such as proposed in the pilot program in 2013 Senate Bill 125, developed by the Special Committee. That bill creates a pilot program at a small number of county correctional facilities to provide individualized assistance to eligible offenders in obtaining SSDI, SSI, or MA, including any applicable MA-related program, upon release.

The bill directs the OJA to seek funding for the pilot program and, after at least $300,000 in funding has been obtained, to make grants to up to four counties to administer the pilot program. Participating counties must operate the pilot program for at least two years and include performance outcome measurements and data collection to allow for program evaluation. The counties must create an oversight committee to advise the county in administering and evaluating the pilot program. The bill provides that DOC and DHS may participate in the activities of the oversight committee and must provide consultation services to the oversight committee.

In addition to the basic program requirements set forth in the statutes, the bill allows OJA to establish additional eligibility requirements, criteria, and procedures that a county must meet in order to be eligible for the program. The bill expressly provides that OJA is not required to promulgate administrative rules in establishing criteria for the grant program.

MEDICAL ASSISTANCE (MA)

Simplify MA Prior Authorization Requirements for Mental Health Therapy

Background

Under current DHS policy, prior authorization is required before mental health therapy may be provided under MA.

Recommendation

Implement changes to MA's prior authorization process to increase access to mental health therapy as follows:

- Allow children with severe emotional disturbance (SED) to access in-home therapy without requiring them to first fail at outpatient therapy.
- Allow qualifying families to participate in in-home therapy even if their child is enrolled in day treatment programs. In-home therapy with families can complement the gains that children make during the day in mental health day treatment.
- Reduce the MA outpatient prior authorization form to these elements: diagnostic criteria and symptoms, patient and provider identification, modality and frequency of treatment, goals, and discharge criteria for treatment.

Provide MA Reimbursement For Tele-Healthcare Provided by Out-Of-State Physicians

Background

Mental Health and Substance Abuse TeleHealth is generally described as the use of telecommunication equipment to link mental health and/or substance abuse providers and consumers in different locations. TeleHealth is sometimes referred to as telepsychiatry, however treatment professionals other than psychiatrists may use telehealth.

According to the DHS Community Mental Health and Substance Abuse Prevention and Treatment Block Grant Application for fiscal year 2014-15, the use of TeleHealth for mental health and substance abuse services in Wisconsin has been increasing since 2007. TeleHealth is used approximately twice as much for mental health services compared to substance abuse services. TeleHealth seems to be currently used more often for regular outpatient services and less for emergency/crisis services and psychosocial rehabilitation programs.

There were 113 TeleHealth certifications in Wisconsin in 2012 for an array of MH/AODA services. The number of providers offering TeleHealth is less than the 113 certifications as some providers are certified to provide multiple TeleHealth services.

Under current DHS policy, MA reimbursement for TeleHealth is provided only for services provided by professional staff who are affiliated with a program that is certified under one of the following chapters: DHS 34, Emergency Mental Health Service Programs; DHS 36, Comprehensive Community Services Programs; DHS 40, Mental Health Day Treatment Services For Children; DHS 61, Community Mental Health and Developmental Disabilities; DHS 63, Community Support Programs for Chronically Mentally Ill Persons; or DHS 75, Community Substance Abuse Services, Wis. Adm. Code.

Recommendation

Allow MA reimbursement of Wisconsin-licensed physicians providing services to MA patients via telehealthcare from an out-of-state location.

HIPAA AND ELECTRONIC MEDICAL RECORDS

Background

The federal Health Insurance Portability and Accountability Act (HIPAA) law allows for broader disclosure of medical records among treatment providers than does the Wisconsin law. HIPAA law provides that if the state law provides greater privacy protections to patients than HIPAA does, the state law provisions, rather than the HIPAA provisions, apply. Therefore, Wisconsin's provisions supersede HIPAA law. Wisconsin law on the confidentiality of mental health treatment records generally provides that all treatment records must remain confidential and are privileged to the subject individual. Generally, these records may be released only to designated persons with the informed written consent of the subject individual. [s. 51.30, Stats.] In addition, the Wisconsin definition of "treatment records" does not include notes or records maintained for personal use by an individual providing treatment services for DHS, a county department, or a treatment facility, if the notes or records are not available to others. [s. 51.30 (1) (b), Stats.]

Wisconsin law permits the release of records to a health care provider, or to any person acting under the supervision of the health care provider who is involved with an individual's care, if necessary for the current treatment of the individual. However, as stated above, the information that may be released under this provision is limited to the following:

- The individual's name, address, and date of birth.
- The name of the individual's provider of services for mental illness, developmental disability, alcoholism, or drug dependence.
- The date of any of those services provided.

- The individual's medications, allergies, diagnosis, diagnostic test results, and symptoms.
- Other relevant demographic information necessary for the current treatment of the individual.

Under federal HIPAA regulation [45 C.F.R. s. 164.506], a covered entity may use or disclose protected health information for its own treatment, payment, or health care operations. In addition, a covered entity may disclose protected health information for treatment activities of a health care provider. A covered entity must obtain an authorization for any use or disclosure of psychotherapy notes. Psychotherapy notes may only be released in the following circumstances:

- Use by the originator of the psychotherapy notes for treatment.
- Use or disclosure by the covered entity for its own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling.
- Use or disclosure by the covered entity to defend itself in a legal action or other proceeding brought by the individual.

Several persons testifying before the Task Force indicated that the restriction in state law on release of treatment notes or records for personal use inhibits the provision of appropriate care for someone who may enter the emergency room for emergency mental health treatment.

A memorandum to the Task Force members on this issue was prepared and distributed on April 17, 2013.

Recommendation

Enact legislation to harmonize Wisconsin law with HIPAA as needed to remove barriers to mental health care coordination. Explicitly cross-reference in state statute the federal HIPAA law rights to request privacy protection for health information. The legislation would allow health care providers and others subject to HIPAA to communicate mental health information about a patient with other health care providers and entities subject to HIPAA, if the communication is made for treatment purposes, payment purposes, or health care operations purposes, and the communication is made in compliance with HIPAA.

Direct the DHS to develop a comprehensive, accessible, and comprehendible document explaining patient privacy rights. Make the document easily accessible online and at health care facilities across the state.

PRIMARY CARE AND PSYCHIATRY SHORTAGE GRANT PROGRAM

Background

Testimony received by the Task Force proposed the establishment of a grant program to encourage primary care physicians and psychiatrists to locate in medically underserved areas of the state. Under the proposal, service-based financial assistance would be provided to a physician who graduates from a Wisconsin medical school, completes a medical residency training program in Wisconsin with a primary care or psychiatry emphasis, and practices primary care medicine or psychiatry in a medically underserved area of the state.

Enrollment in Program

Participants must sign up for the program prior to accepting an employment offer within a designated health shortage area in Wisconsin and may enroll (but may not receive grant payments) while still participating in an eligible graduate medical education (GME) training program. These GME programs include: Family Medicine; Internal Medicine; Pediatrics; Psychiatry; and General Surgery. Qualifying GME programs may be located anywhere in the state.

Practice Requirements

Following completion of a qualifying GME program, participants must begin practicing primary care medicine or psychiatry within a medically underserved area of the state. Primary care practice is defined as the following Medical Examining Board licensure codes: Family Medicine; Pediatrics; Internal Medicine; and General Surgery. The practice of psychiatry includes the following codes: Psychiatry and Child Psychiatry. Medically underserved areas are defined as Health Professional Shortage Areas (HPSA's); Medically Underserved Areas/Populations (MUA/MUP); and Governor's Designation of Shortage Areas for Rural Health Clinics.

Annual Grant Payments

Annual grant payments would be made directly to participants and would be unrestricted (i.e., they would not have to be used toward loan repayment). Eligibility would be lost if a participant leaves the shortage area or begins practicing within a nonqualifying subspecialty. There would be no repayment penalty for leaving the program early, as payments are based on previously completed service. The program would be administered by the Wisconsin Higher Educational Aids Board (HEAB). Rule-making authority would be provided to administer, track, and enforce the program.

Funding

The program would be funded with a one time, $2 million appropriation; $1 million would be used for grants directed to primary care physicians and $1 million would be directed

to psychiatrists. The number of participants would be limited to 17 primary care physicians and 17 psychiatrists that may receive annual grant payments over a three-year period.

The program would begin providing assistance to participants who complete GME training programs in calendar years 2014 and beyond. Grant assistance would be exempt from Wisconsin income tax.

Recommendation

Implement the Primary Care and Psychiatry Shortage Grant Program, a service-based, tuition assistance program designed to increase the number of medical students who enter primary care medicine and practice and stay in medically underserved areas of the state.

CERTIFICATION OF OUTPATIENT MENTAL HEALTH CLINICS

Background

Under current law, outpatient mental health clinics must be certified under ch. DHS 35, Wis, Adm. Code. Testimony received by the Task Force indicated that some of these clinics are also required to meet standards for accreditation by the Accreditation Association for Ambulatory Health Care in order to be eligible to participate in the MA or Medicare programs.

Recommendations

- Determine whether ch. DHS 35, Wis. Adm. Code, certification should be required for an organization that is accredited by the Accreditation Association for Ambulatory Health Care.
- Review ch. DHS 35, Wis. Adm. Code, which regulates outpatient mental health clinics, as part of the Assembly's "Right the Rules" project.

MENTAL HEALTH SERVICES PROVIDED BY COUNTIES

Require Consumer Members on Community Programs Boards

Background

Under current law, county departments of community programs are run by "county community programs boards", which are governing and policy-making boards comprised of members of the county board of supervisors and citizen members. [s. 51.42 (4) (b), Stats.]

In a single-county department, the community programs board must be composed of nine to 15 members. Members must have a recognized ability and demonstrated interest in the problems of mentally ill, developmentally disabled, alcoholic, or drug dependent persons and must have representation from interest groups of all of the following: the mentally ill, the developmentally disabled, alcoholics, and the drug dependent. At least one member must be either a consumer of services or a family member of a consumer. No more than five members may be members of a county board of supervisor.

In a multi-county department, the board is composed of 11 members, with three additional members for each county in excess of two counties that are in a multi-county department of community programs. A multi-county department board must have representation from the same interest groups as a single-county department board and at least one member must be a consumer of services or a family member of a consumer. Each of the counties in the multi-county department of community programs may appoint not more than three members from its county board of supervisors.

Recommendation

Support the adoption of 2013 Senate Bill 128, developed by the Special Committee, which requires county community programs boards to include consumers, family members of consumers, law enforcement personnel, and hospital employees or representatives, and increases the size of county community programs boards.

The bill retains the interest group representation requirements and the family member of a consumer requirement, and, in addition, requires at least one of the members appointed to a single- or multi-county community programs board to be each of the following:

- A person who has received services for mental illness, developmental disability, alcoholism, or drug dependence.
- A law enforcement officer.
- A hospital employee or representative.

The maximum number of members for a single-county department is accordingly increased to 17. The number of members for a multi-county department is increased to 13, with three additional members for each county in the multi-county department in excess of two.

The bill also revises the references to interest group representatives who must serve on the boards.

Require a Report on the Department of Health Services (DHS) Regional Mental Health Services Pilot Projects

Background

In September 2009, DHS issued the "Wisconsin Public Mental Health and Substance Abuse Infrastructure Study," which reviewed the funding and delivery of public mental health and substance abuse services in Wisconsin and other states. The study also identified models and pathways for system reform.

From this study, a shared-services regionalization pilot grant program was developed and awarded in the Summer of 2012. The Request for Proposals stated that the pilot programs

are expected to serve as models for the future administration and delivery of mental health and substance abuse services.

Grants were awarded to two multi-county consortia which are each piloting three-year demonstration projects that use shared public services across organizations or in multi-county regional networks. The two consortia are the Western Region Recovery and Wellness Consortium (WRRWC) and the Western Region Integrated Care (WRIC) Consortium. These consortia, both located in the western part of Wisconsin, encompass both urban and rural populations. Each plans to carry out extensive needs assessments and involve multiple stakeholders in program redesign. The redesign seeks to increase "core benefit" access for consumers, and increase administrative efficiencies, including moving toward shared information technology infrastructure in the regions.

Recommendation

Request DHS to report to the Legislature its interim findings of the regional pilots for mental health and substance abuse services and, by January 1, 2015, make recommendations to the Legislature for expanding the pilot statewide.

Require a Legislative Council Study on the Iowa Regional Public Health System

Background

In July, 2011 legislation was enacted in Iowa which initiated a redesign of the Iowa mental health system. Previously, the mental health system was county-based, with each county responsible for providing mental health services. The legislation directed the state department of health services to appoint and lead workgroups to recommend steps to transition to a regional system.

Since that time, workgroups have met to analyze numerous issues relating to the transition and develop recommendations for the implementation of the reorganization. Several pieces of legislation have been enacted to facilitate the transition, including legislation that identifies required core services, provides for the establishment of service regions, and revises property tax provisions.

Special Committees are established by the Joint Legislative Council to examine major issues and problems identified by the Legislature. During the summer and fall interim of each even-numbered year, the Legislative Council selects a number of subjects for study from suggestions submitted by members of the Legislature. Often these topics are issues that are difficult to resolve in the regular course of legislative business or that legislators feel require further consideration prior to the introduction of legislation.

Special Committees are chaired by legislators and are comprised of legislative and public members with expertise or interest in the issue under study by the committee. Each committee is charged by the Legislative Council to study their issue and recommend legislative solutions as needed. Special Committees generally meet from three to six times

during the interim and ultimately report their recommendations, in the form of bill drafts, to the full Joint Legislative Council for approval and introduction in the next legislative session.

Recommendation

- Request the Legislative Council to study Iowa's recent transition from a county-based to a regional public mental health system.

Require Counties to Report Which Mental Health Services They Provide

Background

Current law specifies the services that county departments of community programs must provide, within the limits of available state and federal funds and of county funds required to be appropriated to match state funds, for the program needs of persons suffering from mental disabilities, including mental illness, developmental disabilities, and alcoholism or drug abuse. Those services are:

- Prevention programs.
- Comprehensive diagnostic and evaluation services, including certain statutorily required assessments.
- Inpatient and outpatient care and treatment, residential facilities, partial hospitalization, emergency care, and supportive transitional services.
- Related research and staff in-service training.
- Continuous planning, development, and evaluation of programs and services for all population groups. [s. 51.42 (3) (ar) 4., Stats.]

Some counties provide mental health services and programs in addition to those which are required by statute.

Recommendation

Require DHS, by January 1, 2016, to enact rules that create a mechanism for counties to report to DHS which mental health services and programs they each provide.

INDIVIDUAL PLACEMENT AND SUPPORT

Background

IPS is a type of supported employment for individuals with mental illness. It was developed at Dartmouth College Psychiatric Research Center, which conducts interdisciplinary research on services for individuals who have mental illness. According to the Dartmouth IPS website, IPS is three times more effective than other vocational approaches in helping people with mental illness to work competitively.

The eight practice principles of IPS are as follows:

1. Every person with severe mental illness who wants to work is eligible for IPS supported employment.
2. Employment services are integrated with mental health treatment services.
3. Competitive employment is the goal.
4. Personalized benefits counseling is provided.
5. The job search starts soon after a person expresses interest in working.
6. Employment specialists systematically develop relationships with employers based upon their client's work preferences.
7. Job supports are continuous.
8. Client preferences are honored.

According to the materials provided by the WCMH, there are currently nine counties in Wisconsin with an IPS site: Washington, La Crosse, Marathon, Barron, Dunn, Chippewa, Dane, Jefferson, and Lincoln.

Recommendation

Support the rollout of the IPS program by providing funding for regional technical assistance and training positions.

REDUCTION OF STIGMA

Background

Wisconsin's Initiative for Stigma Elimination (WISE) is a statewide collaboration of organizations and individuals seeking to reduce the stigma of mental illness in the state by promoting the use of evidence-based practices and outcome evaluation. Research on addressing the discrimination and stigma has shown that individuals' attitudes improve when they have direct contact with persons with mental illnesses, when they can get to know people beyond labels and myths.

Recommendation

Provide funding for an evidence-based stigma reduction plan throughout Wisconsin through WISE.

\ksm

Attachment

APPENDIX

Members of the Speaker's Task Force on Mental Health

Representative Erik Severson, Chair

Representative Sandy Pasch, Vice Chair

Representative Joan Ballweg

Representative Jim Steineke

Representative John Jagler

Representative Kevin Petersen

Representative Joe Sanfelippo

Representative Paul Tittl

Representative Chris Danou

Representative Josh Zepnick

Representative Debra Kolste