

2016 Budget
Testimony – March 25, 2015

Milwaukee County Mental Health Board - Finance Committee

My name is Tamara Wess Ferber, and I would like to first thank the Finance Committee of the Milwaukee County Mental Health Board for the opportunity to speak to you today. We need your continued investment, continued commitment and acknowledgment as to the need in Milwaukee County to expand the growth in Community Based Services. I am speaking today as a Consumer, State Certified Peer Specialist, and Co-Chair to the Recovery Advisory Committee for CCS (Comprehensive Community Services) a required committee developed to establish the Service Array for this entitlement program. With that being said I must bring to light some uncomfortable, yet progressive things happening in our county that must not be overlooked, or discredited.

In my experience personally and professionally the gaps in available services are causing negative outcomes for persons receiving or those not having access to services in our entire community. This in return creates an inability to build and maintain a cohesive, effective, supportive, and evidence based practices in a community based recovery environment. It is this very thing that created the need for the Milwaukee County Mental Health Redesign.

The investment in Community Based Recovery Services in Milwaukee County has just begun. With that said, resources, and services accessible in the community have yet to be implemented. Our continued focus on crisis services and hospitalization is not only traumatizing for the individual, but fiscally negligent. To not provide investments in the 2016 BHD budget for any Community Based Services in Milwaukee County conflicts with the outcomes of the Milwaukee County Mental Health Redesigns' 16 SMART (**S**pecific, **M**easurable, **A**chievable, **R**elevant, and **T**ime-bound) goals. The implementation of these SMART goals are in their infancy. Not following through with funding to realize their potential is irresponsible and possibly a violation by which they were developed.

We have made progress within the Housing Division to develop innovative, alternative housing for those living with mental health and or substance abuse disorders. This includes supportive and transitional housing, such as the "Pathways to Permanent Housing", a model which I was closely involved in, that utilizes the imperative evidence based practice of Certified Peer Specialists. What I experienced were ineffective transition times due to the consistent lack of available services for entitlement programs such as CSPs (Community Support Programs). This often causing an elongated stay, or early discharge due to the lack of service providers, funding and availability although there is to be "no waiting list". This, in conjunction to limited access to necessary psychiatric care, has created a culture in which consumers may be caught in a revolving door, involving homelessness, and a direct correlation within our criminal justice system. Some individuals may become repeat offenders, often placing the responsibility of

psychiatric or limited therapeutic care on the criminal justice system. Taking this into consideration, we are re-traumatizing consumers, not addressing their issues at hand, and again costing Milwaukee County unnecessarily by treating crisis rather than making necessary services available.

The progressive introduction of CCS (Comprehensive Community Services), an entitlement benefit available across a lifespan, is in its early stages of implementation. This has brought to light that more funding is needed for organizations to be able to fully provide what is required to comply with the CCS regulations. Most importantly, an ability to provide the entire Service Array, including Certified Peer Specialist now a Medicaid billable service. Continued funding is necessary to train contract agencies and organizations in order to provide the required CCS Service Array and serve a larger number of individuals in the community in an effective manner. We need to be on the cutting edge of providing the best training and continued education to serve those in need receiving CCS services.

I urge you all to continue the investments in Community Based Services in 2016, and remind you that to invest in a non-progressive, restrictive, non-trauma informed care environment that fosters continued hospitalization, is not fiscally sound. It is not only the responsibility of Milwaukee County Behavioral Health Division, and its providers, but also our appointed Milwaukee County Mental Health Boards' duty to ensure we procure and secure the funds to stay the course of our obligation and commitment to Community Based Services.

**Priorities for the 2016 Milwaukee County Budget
Milwaukee County Mental Health Board Finance Committee
Barbara Beckert, Director – Milwaukee Office
Liz Ford, Advocacy Specialist
March 26, 2015**

Thank you for the opportunity to share priorities for the 2016 Milwaukee County Behavioral Health Division Budget. The Milwaukee County budget plays an essential role in funding services that are critical to the lives and independence of people with mental illness and it is important for the Mental Health Board to hear directly from community members. We strongly recommend providing multiple opportunities for community input and holding these sessions in the community rather than exclusively at the Mental Health Complex which is far away from where most individuals who receive publicly funded services live.

Disability Rights Wisconsin (DRW) is the federally mandated Protection and Advocacy Agency for the State of Wisconsin, charged with independently investigating instances of abuse and neglect in institutions. Our Milwaukee office is responsible for providing advocacy assistance to people with disabilities in southeastern Wisconsin. One of our highest priorities has been protecting the rights of people served at the Milwaukee County Mental Health Complex, including addressing neglect and abuse, and supporting the right of residents to live in the community with the services and supports needed to support their independence. DRW has served as a member of the closing team for Hilltop and Rehab Central, as well as providing individual advocacy to residents of the long term care facilities and their guardians, and to patients on the acute care units, and individuals living in the community.

We worked closely with the authors of Act 203 as they sought community input for this legislation. The two major themes that were shared by community members at the hearing and in community meetings related to the urgent need to expand community services and provide earlier access to mental health services and supports, and the importance of addressing safety and quality of care at the Complex. We hope these two priorities will guide you in the 2016 county budget.

Priorities for the Behavioral Health Division in the 2016 Milwaukee County Budget

We urge the Finance Committee to work with community stakeholders to advance the goal that has been recommended by a host of studies and reports – expand access to community based mental health and substance abuse services and related supports including housing, employment services, and benefits counselling. Milwaukee County has begun the expansion of community services but the efforts to date have been small incremental changes – not a system transformation. Bold change and additional investment is urgently needed if we are to realize the vision we all share that was advanced in Act 203 - a community-based, recovery-oriented systems of care where community members can easily access a range of quality mental health and social services, leading to increased recovery and whole health.

In recent years, Milwaukee County has made some positive investments to expand community services including a second Crisis Resource Center on the North Side, a south side access clinic, a new peer run drop in center, implementation of the evidence based ACT/IDDT model, and new community coordination teams. We commend these expansions of community based services. County staff, providers and a Recovery Advisory Committee are working hard to move forward with implementation of Comprehensive Community Services. CCS, which is funded by state and federal dollars, holds tremendous potential for advancing recovery. The recent loss of CARS Director Sue Gadacz, who was providing outstanding leadership for these efforts, may slow some of the momentum. Investments have also been made to expand community based crisis services with the addition of a second CART team and an effort to expand mobile crisis team cover to 24/7 which has been slow to get off the ground.

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Although we commend the positive investments that have begun to expand community services, to date these have been modest incremental changes. We hear from consumers, families, and law enforcement that it continues to be very difficult to access community services and it has become more difficult to access inpatient services. Here are some of the concerns we are hearing which we hope you will take into consideration as you identify priorities for the 2016 BHD budget.

Individuals with significant mental health needs continue to experience a long wait for Medicaid case management services such as Targeted Case Management (TCM) and Community Support Program (CSP). This causes delays in discharge from the hospital and/or people are discharged without access to the case management services that are urgently needed to support a successful return to the community. We recommend that you request the following data to help you determine the unmet need which should be addressed in the 2016 budget:

- Annual enrollment numbers for CSP and TCM from 2010 through 2015 so that you can compare the number of people being served and to what extent it is increasing.
- How are waiting lists tracked for these programs? Is there a formal process for doing so and what have the monthly numbers been over the past 24 months? Is there a need for a more formalized process to track those waiting for services? The waiting lists should include those who are eligible and not yet receiving services – “waiting”.
- How many people being discharged from the hospital are referred for TCM and CSP? How long does it take for them to actually receive these services?

Although there has been a decrease in the number of people coming to the county’s emergency room (PCS), the numbers continue to be high (approximately 10,000 in 2014). The continued reliance on emergency room services suggests that the need for community supports far exceeds the available services.

- As noted in the December 2014 DHS sponsored audit report *Mental Health Service Delivery in Milwaukee County*, individuals seen at the County emergency room (PCS) but not admitted to the hospital generally do not also receive an assessment to determine eligibility for community services and /or get connected with these services during their stay at PCS. This is a missed opportunity – as a result many people come back to PCS multiple times and in some cases are ultimately admitted to the hospital.
 - What would be the cost of providing 24/7 coverage by County Community Services staff who could assist individuals who are assessed at PCS but not admitted to the hospital with determining eligibility for other community services – and follow up after the PCS visit to assist with enrollment?
- State budget provisions currently under consideration would repeal current procedures for emergency detention and crisis assessment in Milwaukee County and require a community based in person assessment. (see attached DRW testimony on this provision for details) If this becomes law, it will require significant funding in the 2016 budget. Law enforcement would require prompt assistance from a qualified person; this would require many additional mobile crisis teams, at least one for each police district, 24-7 mobile crisis coverage, and designated community locations where a crisis assessment could occur. Law enforcement needs more options for diversion for individuals experiencing significant mental health concerns that do not rise to the level of justifying a detention. It will take time and significant funding to develop capacity.

The entry point for community services continues to be based at the institution – at the Milwaukee County Mental Health Complex, far away from where most people with mental health and substances abuse needs live. In the 2016 budget, we urge that Milwaukee County establish three Community Resources Centers (north side, south side, central city). These would be access points to learning about available services, receiving assistance with enrollment, benefits counselling, education, etc. Community groups such as DRW, MHA, and NAMI could partner with the county to provide education and host support groups. The *Mental Health Redesign Cultural Intelligence Team* has advanced such a model which includes the Community Resource Centers as well as a network of holistic health centers – we hope you will schedule an opportunity at a future board meeting to learn about this proposal. We strongly endorse this type of model and hope that initial components can be advanced in the 2016

budget. We ask you to prioritize establishment of these community access points in the central city and north side. To date, much of the community expansion has been based on the south side including the Access Clinic and peer run drop in center for the south side, and the Pathways to Permanent Housing established in the 2013 and 2014 budget.

Improved access to healthcare through the Affordable Care Act and BadgerCare expansion to the “childless adult” population has provided many uninsured adults with significant mental health and/or substance abuse needs with coverage. Milwaukee County, as well as the healthcare systems, has done excellent work in supporting outreach and enrollment. There are new concerns that provisions in the state budget may result in loss of BadgerCare coverage for some childless adults with mental health needs – due to the plans to require payment of premiums by this very low income population, a 48 month cap on eligibility, possible drug testing, and penalties for risky behavior. We have shared concerns with DHS leadership that this may have unintended consequences for people with mental health needs who may lose BadgerCare coverage and due to disenrollment would no longer be eligible for Medicaid programs such as CCS. This will result in continued reliance on “deep end” services including crisis services and inpatient care.

In addition, for individuals who are newly insured as well as those covered by Medicaid (especially fee for service), coverage does not ensure access to a prescriber, as the need for psychiatrists far exceeds the demand. Many psychiatrists do not accept new patients. In addition, a number of psychiatrists choose not to accept patients enrolled in Medicaid. Despite the promise of mental health parity to provide equitable access to mental health services, people may have to wait six months to a year for an appointment. As you work on the 2016 budget, we ask that you consider how the county can make strategic investments to support access to psychiatric care and/or other knowledgeable prescribers. Without improvements in access, we can expect a continued reliance on crisis and inpatient care and continuing high numbers of people with mental illness in jail.

Although investments in community services have the potential to reduce the need for inpatient care, it is essential that adequate inpatient capacity be maintained. The County has an important role in either directly providing such capacity or funding the needed inpatient beds by contracting with private providers to serve individuals who are uninsured and/or have complex needs. We are very concerned that the recent reduction in inpatient beds has contributed to individuals experiencing a psychiatric crisis who have a level of need that justifies an inpatient hospitalization – yet they are not being admitted to the hospital and in some cases are being sent to jail.

Law enforcement report that very acutely ill people brought by law enforcement to the County psychiatric hospital are being sent to jail instead of being admitted at the Mental Health Complex or other hospitals. This is a change from past policy and in conflict with the policies and system change being actively advanced by the Milwaukee County Community Justice Council to divert people with mental illness who have not committed violent crimes from the criminal justice system, and instead connect them with wraparound services and supports. In addition, based on calls we have received from community members and families, as well as discussion with law enforcement and other stakeholders, we hear many concerns that very ill people who would have been admitted to the hospital in the past, are now being turned away. The perception in the community is that the bar for a hospitalization has been raised and that this has been driven by the reductions in inpatient beds. We have also heard concerns about pressure to discharge patients sooner than is clinically advisable, due to the limited number of beds. We have shared these concerns with BHD leadership.

As you deliberate on funding for inpatient capacity in the 2016 budget, we recommend that you ask for PCS disposition data over the past two years to better inform your deliberations – this will show the number of people admitted to the hospital, sent to detox, sent to jail, and other dispositions. This information should be reviewed to determine if there have been significant changes since the bed reduction. For example has there been a significant change in the percentage of people being sent to jail in recent months, and if so, why? Has the percentage of people at PSC being admitted to either the county hospital or transferred to a private hospital stayed the same, or decreased, and if so, why? Have other protocols been put in place to connect people with the Crisis Resource Center or other alternatives to hospitalization.

The County has made positive strides in downsizing the long term care units at the Complex including the recent closing of the Hilltop Facility, a 72 bed long term care center for people with co-occurring mental health and intellectual and developmental disabilities. Residents are now enrolled in Family Care, living in the community with individualized wraparound supports. DRW has taken an active role in this process and we ask that you provide continued funding for the Community Consultation Team which has the potential to support individuals with complex needs who have moved to the community after years of living in an institution. In addition, we hope that there will be follow through on past commitments to invest savings from downsizing at the Complex to help to fund expansion of community services. This was recommended by many studies and included in a County Board resolution (RES 11-516) authored by then County Supervisor Sanfelippo and signed by the County Executive, which directed that any savings from downsizing would be reinvested to allow for expanded community services".

HOUSING

Although the Mental Health Board does not oversee funding for housing, we wanted to reinforce that safe, affordable and accessible housing is a critical component to reforming our mental health system and reducing the reliance on crisis and institutional services. There is currently a crisis in Milwaukee County regarding access to such housing –lack of housing is one of the most significant barriers for people with mental illness to maintain their health and independence. There are long waiting lists for HUD vouchers for subsidized housing and for the BHD supportive housing units.

The vast majority of people with mental illness served by Milwaukee County are low income and unable to afford housing that is not subsidized. The average income for someone on SSI is around \$750 a month. Subsidized housing is income based – rent is one third of the individual's income. The price for an unsubsidized efficiency or one bedroom that is safe and decent is close to \$500 a month. Because that is well over half of the monthly income for an individual on SSI, landlords will not even consider renting to them. In addition, a significant number of homeless people in Milwaukee County have serious and persistent mental illness; the 2009 Point in Time Survey, Milwaukee Continuum of Care, indicates that 41% of homeless persons in Milwaukee County have a mental illness. We cannot move forward with reform of our mental health system without addressing the housing crisis.

Thank you for your commitment to expanding community based services and reforming our mental health system. We look forward to dialogue with you regarding the 2016 Milwaukee County budget.

**TESTIMONY TO JOINT COMMITTEE ON FINANCE
DRW Concerns Regarding
Mental Health Crisis Assessment and Emergency Detention Budget Revisions
March 20, 2015**

Thank you for the opportunity to speak to you today about a very significant provision in the budget related to Wisconsin's emergency detention procedure. Disability Rights Wisconsin is the federally mandated protection and advocacy agency for Wisconsinites with disabilities, designated by the Governor to protect the rights of people with disabilities. Part of our charge is to protect the human and civil rights of children and adults with serious mental health conditions, as well as Wisconsinites with developmental disabilities.

I want to thank you for the positive investments made in community mental health services in the 2013 – 2015 biennial budget and by the Speaker's Task Force. The investments in Comprehensive Community Services, Peer Respite, Crisis Intervention Team training, and other community services will help to increase access to recovery oriented community based services and reduce reliance on expensive and traumatizing crisis and institutional services. We also want to commend the inclusive process for developing these proposals which included multiple town hall meetings and ongoing workgroups with stakeholders. The major policy changes proposed in the budget for crisis assessment and emergency detention raise many questions and require a slower process outside of the budget which will allow for input from counties, advocates, people with lived experience and other stakeholders.

The Governor's budget proposes modifications to the emergency detention procedure under Section 51.15(2) of the Mental Health Act. Under this statute, if certain conditions are met, individuals a law enforcement officer believes to be mentally ill, developmentally disabled or drug dependent and a danger to themselves or others, may be detained and transported to a mental health detention facility for assessment, diagnosis and treatment. One of the conditions that currently exists in statute is the requirement that the county department must approve the need for the detention.

Under the revision that has been proposed, the county department's approval must be predicated on the agreement of a psychiatrist, licensed psychologist or mental health professional, who has completed a crisis assessment on the individual. Both the definition of who is considered a "mental health professional" and what comprises a "crisis assessment" is left undefined by the amendment to the statute. The budget provides 1.5 million dollars in flexible funding in FY 16, made available through grants by DHS, to assist counties with acquiring whatever capacity, staff or expertise is necessary to come into compliance with this measure.

As so often is the case, "the devil is in the details," with this proposal. If done with thought, flexibility and properly funded it could be helpful in deflecting individuals from unnecessary and expensive hospitalizations to more effective, consumer-preferred community alternatives. DHS has indicated that its intent for the revision was to require counties to engage in in-person assessments in the community and decreased incidents of hospitalizations. However, although some more specific language exists in administrative rules for Medicaid certified mobile crisis programs (DHS 34.22(b)(2) which are in a

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number of counties, there is only a requirement that the mobile crisis services be available 8 hours a day, which leaves the other 16 hours open to question. Additionally, there appears to be significant variability even among the various county certified programs – in many counties the assessment process currently occurs over the phone. Furthermore, there is some skepticism whether the increased requirement of a face-to-face encounter would actually result in the desired result. On the other hand, if a telephonic assessment is done in the field and an emergency detention is not recommended, what alternatives is law enforcement left with when the individual is obviously in crisis, even if not subject to emergency detention, might it lead to arrest on minor charges such as disorderly conduct as a last resort?

It does appear clear that if the fundamental questions are left unclear or vague what might have been a positive influence on the detention process could lead to the opposite result. Some of these questions are: what are the clinical requirements of a crisis assessment? Where can it take place - at the facility? In the community? What credentials are required of a mental health professional? Can it be done over the telephone or must it be done in person? What are the 24/7 crisis assessment procedures currently in place in counties? (There appears to be variability depending on the county, and the time of the shift) Would the proposal require significant changes in these procedures? What would various models of crisis assessment require and cost to operationalize?

Equally important, if there is little or no funding available to a county to help it adjust its current practice, this could be considered an unfunded mandate, since it is likely that the cost in many circumstances will not be insignificant.

Additional Changes Proposed to Emergency Detention Procedures in Milwaukee County

In addition, the budget proposes repealing provisions that establish special procedures for emergency detention in Milwaukee County and a pilot program for alternative emergency detention procedures in Milwaukee County. Under this item, the Milwaukee County emergency detention procedures would be the same as for other counties. Current differences in detention procedures for Milwaukee County include the following:

1. In all of Wisconsin, except Milwaukee County, a formal chapter 51 court case is started when an officer detains a person. In Milwaukee, a court case is not started until a treatment director decides to detain the person the officer brought to the facility.
2. Only in Milwaukee must a doctor make a detention decision within 24 hours. The doctor's opinion, or Treating Director Supplement (TDS), must be done in the first 24 hours that the person has been detained; other counties have a 72 hour window.

DRW and other stakeholders have urged caution in requiring Milwaukee County to follow the same detention procedure as the rest of the state because the number of people being assessed is significantly higher. For example, in 2013, there were 11,464 admissions to the county's psychiatric emergency room (PCS), the majority detained by law enforcement. If the detention procedure for Milwaukee is changed to be the same as the rest of the state, a formal chapter 51 court case would be started for each individual detained by an officer. This will significantly increase the workload for law enforcement and the Public Defender caseload.

In addition, there would no longer be a requirement that a doctor make the detention decision within 24 hours; individuals could be detained for up to 72 hours before the decision would be made. By significantly increasing the period of time that an individual could be detained before a final decision is made, there will likely be a significant increase in the need for observation beds at the Mental Health Complex - at the same time that the County has made a commitment to reduce beds.

The recommendations specific to Milwaukee originate in part from a December 2014 DHS sponsored audit report *Mental Health Service Delivery in Milwaukee County*. This report was a requirement of Act 203 which established the Mental Health Board. It noted that the majority of individuals seen at PCS are returned to their home or the community without inpatient hospitalization; in many cases these individuals are not assessed for eligibility for community services and/or supported in connecting with these resources. The reports suggest these individuals could have been better served by more robust community based programs if they were available, and further suggests requiring a community based assessment to determine if an emergency detention is justified.

To successfully implement this model of a community based assessment, **there must first be significant expansion of community based crisis assessment services.** Law enforcement would require prompt assistance from a qualified person; this would require many additional mobile crisis teams, at least one for each police district, 24-7 mobile crisis coverage, and designated community locations where a crisis assessment could occur. Law enforcement needs more options for diversion for individuals experiencing significant mental health concerns that do not rise to the level of justifying a detention. It will take time and significant funding to develop capacity.

Recommendations

Answers to these questions and others should be known before this change is undertaken so that the result can be to actually keep people in the community and divert them to resources that will support them there. Therefore, since this measure is in actuality a policy measure, rather than a budget initiative it should be removed from the budget and considered separately as the policy issue it is and under a timeline that will allow it to develop properly. The major policy changes proposed in the budget for crisis assessment and emergency detention raise many questions and require a slower process outside of the budget which will allow for input from counties, advocates, people with lived experience and other stakeholders. DRW would have a strong interest in participating in such a work group.

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