WISCONSIN
COUNTIES
ASSOCIATION

22 EAST MIFFLIN STREET, SUITE 900
MADISON, WI 53703
TOLL FREE: 1.866.404.2700
PHONE: 608.663.7188
FAX: 608.663.7189
www.wicounties.org

MEMORANDUM

TO: Honorable Members of the Special Committee on Review of Emergency Detention and Admission of Minors Under Chapter 51

FROM: Sarah Diedrick-Kasdorf, Senior Legislative Associate

DATE: August 31, 2010

SUBJECT: Testimony on Mental Health Services in Wisconsin

Thank you so much for the opportunity to address the committee this morning.

There are currently a number of initiatives occurring with regard to the provision of mental health services in the state of Wisconsin. These initiatives include the Department of Health Services' *Wisconsin Public Mental Health and Substance Abuse Infrastructure Study*, the Chief Justice's Criminal Justice Mental Health Leadership Task Force, the Department of Corrections' DOC 350 committee to review jail mental health standards, the Wisconsin County Human Services Association's Visions Committee, and this Legislative Council study committee. Our association has committed to working on these initiatives to improve the provision of mental health services in the state of Wisconsin.

Unfortunately, the need for public mental health services outweighs the resources, defined as the availability of service providers and revenue, currently available to provide these services. Wisconsin has a total of 67 county-based systems for mental health services. The array of services provided varies from county to county. For example, some counties do not have psychiatric providers available in their communities, requiring counties to examine other service options, such as tele-health.

According to the *Wisconsin Public Mental Health and Substance Abuse Infrastructure Study,* "Overall, counties provide a significant share of funding to support MH/SA programs, while the specific level of local contribution varies from county to county. Nearly all of this funding comes from county property tax levies..." According to the Human Services Revenue Report, in 2007, counties provided just over $449 million in community aids overmatch, $126.5 million of that amount allocated for mental health services (28.2% of the total). With decreasing state aids and increasing pressure on the tax levy, it is unlikely counties will be able to continue to support

funding amounts at these same levels. Counties need additional financial assistance from the state to carry out vital mental health services on the state's behalf.

The 2009-2011 state biennial budget also made several changes affecting the provision of mental health services at the county level. First, the budget required counties to be responsible for the nonfederal share of expenditures associated with inpatient stays for individuals under 21 and over 64 years of age in the state mental health institutes. The purpose of the change was to encourage counties to provide community-based mental health services, rather than place individuals in one of the state institutes. Approximately $4 million in additional funding was allocated to counties over the course of the biennium for community-based services. However, as counties successfully implement community-based programs, it has a negative impact on the rates charged for placements in Winnebago and Mendota.

The adult civil unit populations at Winnebago and Mendota have decreased significantly since 2008. As a result, the daily rate charged to counties for placements in the facilities has increased. Last week, new rates were released for placements in the institutions. The adult psychiatric services per day inpatient rate will be $969 per day, beginning October 1. This represents a 9 percent increase at the Mendota Mental Health Institute and a 9.5 percent increase at the Winnebago Mental Health Institute. The emergency detention add-on for the first three days of services is another $200 per day. There is concern that as the rates go up, funding available for community-based mental health services decreases.

The state budget also made statutory changes with regard to the use of emergency detention, a change we advocated for and hope will assist counties in providing appropriate mental health services at the appropriate time. The budget modified the provisions relating to the emergency detention of individuals by permitting a law enforcement officer or other person authorized to take an individual into custody to transport the individual to a treatment facility only if the local county department of community programs in the county in which the individual was taken into custody approves the individual's detention. This provision applies to all emergency detentions. Mr. Blackburn will discuss this provision in more detail with the committee.

While counties have several ideas with regard to improved funding for the public mental health system, including state pick-up of the county match for CSP and CCS, crisis services, etc., as well as allocating state funding for adult mental health institute placements (there is no financial incentive for the state institutes to move individuals to a less restrictive setting), there are two proposals I would like the committee to consider in its deliberations.

Medical Assistance Funding for Jail Inmates: Under federal law, individuals are ineligible for federal medical assistance (MA) benefits while incarcerated, regardless of their conviction status and regardless of their eligibility for MA. Once incarcerated, inmates in Wisconsin have their MA benefits terminated; therefore, once incarceration ends, inmates must reapply for MA benefits. The reapplication process results in the interruption of health care services. On May 25, 2004, CMS issued a memorandum to State Medicaid Directors reiterating that payment exclusions for incarcerated individuals under Medicaid do not affect the eligibility of those individuals, and encouraging states to adopt a policy of suspending, rather than terminating, Medicaid eligibility upon incarceration. If benefits are suspended rather than terminated, the effective date of approval is the date of application, allowing costs to be covered upon release from jail. If we can ensure individuals leaving our county jails have access to mental health services and medications, the likelihood those same individuals will be in crisis and end up back in jail or under an emergency detention decreases.

Crisis Intervention for Youth: Mental health crises arise for youth and their families or caregivers on a regular basis. When these crises occur the current options are generally to return the child home with a safety plan or admit the child to a psychiatric hospital/unit. Sometimes an immediate return home is not in the best interest of the child or the family. Inpatient admissions are costly and traumatic. County crisis workers need access to an array of transitional placement options. Currently, viable alternatives are limited, and accessing them is unnecessarily cumbersome. We ask the committee to consider allowing for the use of crisis stabilization facilities for children. Based upon the experience of counties with the adult population, stabilization services have proven to be cost effective and demonstrated improved psychosocial outcomes. We would expect the same type of results with the youth population. The attached proposal was shared with both the Department of Health Services and the Department of Children and Families. Both departments are currently reviewing the recommendation.

It is our hope to one day have a public mental health system in Wisconsin that is appropriately funded and able to provide mental health services to anyone in need, regardless of location, to avoid unnecessary and costly hospitalizations.

Thank you for considering our comments.

Crisis Intervention for Youth

The following are recommended Statutory Language changes:

48.135 Referral of children and expectant mothers of unborn children to proceedings under chapter 51 or 55.
(1) *If a child alleged to be in need of protection or services or a child expectant mother of an unborn child alleged to be in need of protection or services is before the court and it appears that the child or child expectant mother is developmentally disabled, mentally ill or drug dependent or suffers from alcoholism, the court may proceed under ch. 51 or 55. If an adult expectant mother of an unborn child alleged to be in need of protection or services is before the court and it appears that the adult expectant mother is drug dependent or suffers from alcoholism, the court may proceed under ch. 51.*
(2) *Except as provided in ss. 48.19 to 48.21 and s. 48.345 (14), any voluntary or involuntary admissions, placements or commitments of a child made in or to an inpatient facility, as defined in s. 51.01 (10)* ***or stabilization facility as defined in s. 51.01(x),*** *shall be governed by ch. 51 or 55. Except as provided in ss. 48.193 to 48.213 and s. 48.347 (6), any voluntary or involuntary admissions, placements or commitments of an adult expectant mother of an unborn child made in or to an inpatient facility, as defined in s. 51.01 (10)* ***or to a stabilization facility as defined in s. 51.01(x),*** *shall be governed by ch. 51.*

938.135 Referral of juveniles to proceedings under *ch. 51 or 55.*
(1) Juvenile with developmental disability, mental illness, or alcohol or drug dependency. If a juvenile alleged to be delinquent or in need of protection or services is before the court and appears to have a developmental disability or mental illness or to be drug dependent or suffering from alcoholism, the court may proceed under ch. 51 or 55.
(2) Admissions, placements, and commitments to inpatient facilities. Any voluntary or involuntary admissions, placements, or commitments of a juvenile made in or to an inpatient facility, as defined in s. 51.01 (10) ***or to a stabilization facility as defined in s. 51.01(x),*** *other than a commitment under s. 938.34 (6) (am), are governed by ch. 51 or 55.*

51.01(10) *"Inpatient facility" means a public or private hospital or unit of a hospital which has as its primary purpose the diagnosis, treatment and rehabilitation of mental illness, developmental disability, alcoholism or drug abuse and which provides 24–hour care.*

51.01(x) "stabilization facility" means a facility certified under a regulated comprehensive crisis response system which has as its primary purpose the diagnosis, treatment and stabilization of apparent mental illness and which provides care up to 24–hours per day in keeping with a consumer's assessed needs.

51.13 Admission of minors. ***(1)*** *ADMISSION. (a) Except as provided in par. (c) and ss. 51.45 (2m) and 51.47, the application for admission of a minor who is 14 years of age or older to an approved inpatient treatment facility for the primary purpose of treatment for alcoholism or drug abuse and the application for admission of a minor who is under 14 years of age to an approved inpatient treatment facility* ***or to an approved stabilization facility*** *for the primary purpose of treatment for mental illness, developmental disability, alcoholism, or drug abuse shall be executed by a parent who has legal custody of the minor or the minor's guardian. Any statement or conduct by a minor who is the subject of an application for admission under this paragraph indicating that the minor does not agree to admission to the facility shall be noted on the face of the application and shall be noted in the petition required by sub. (4).*
(b) The application for admission of a minor who is 14 years of age or older to an approved inpatient treatment facility ***or to an approved stabilization facility*** *for the primary purpose of treatment for mental illness or developmental disability shall be executed by the minor and a parent who has legal custody of the minor or the minor's guardian, except as provided in par. (c) 1., except that, if the minor refuses to execute the application, a parent who has legal custody of the minor or the minor's guardian may execute the application on the minor's behalf.*

RATIONALE: Denial of this proposal will continue to force youth into inpatient settings that are costly, traumatic, and counterproductive to treatment. Youth should not be removed from their homes until all other efforts have been made to provide the needed service. However, there are times when immediate return to the home is not therapeutic. Currently the only option is inpatient.