Health Services

Community Based Behavioral Health

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Legislative Fiscal Bureau
One East Main, Suite 301 • Madison, WI 53703 • (608) 266-3847 • Fax: (608) 267-6873
Email: fiscal.bureau@legis.wisconsin.gov • Website: http://legis.wisconsin.gov/lfb

June, 2021 Joint Committee on Finance Paper #370

Regional Crisis Response System Grants (Health Services -- Community Based Behavioral Health)

[LFB 2021-23 Budget Summary: Page 298, #1]

CURRENT LAW

All counties are required to have an emergency mental health service program, also known as crisis intervention service, to respond to individuals experiencing a crisis. Crisis intervention services involve the assessment, intervention, and stabilization of an individual experiencing a crisis stemming from a mental disorder. Services can be provided at any location, including in a person's home, a school, hospital, nursing home, or public place.

At a minimum, county emergency mental health programs must offer 24-hour crisis telephone service and 24-hour in-person service on an on-call basis. Telephone service must be staffed by mental health professionals or paraprofessionals or by trained mental health volunteers, backed up by mental health professionals. In order to receive reimbursement under the state's medical assistance (MA) program (for services provided to persons who are eligible under that program), an emergency mental health services program must have additional features, such as a mobile crisis team for on-site in person response, walk-in services, and short-term voluntary or involuntary hospital care when less restrictive alternatives are not sufficient to stabilize an individual experiencing a mental health crisis. All but seven counties (Bayfield, Douglas, Florence, Iron, Trempealeau, Vernon, and Washburn are the exceptions) have a crisis intervention service that meets MA certification criteria or participate in a multi-county certified program.

Chapter 51 of the statutes (State Alcohol, Drug Abuse, Developmental Disabilities and Mental Health Act) establishes procedures for the involuntary emergency detention of persons who are deemed a threat to themselves or other as a result of mental illness. Under these provisions, a law enforcement officer may take a person into custody if the officer has cause to believe all of the following: (a) the person is mentally ill or drug dependent; (b) the person evidences a substantial probability of physical harm to himself or herself or to others, including an inability to

satisfy his or her basic needs due to mental illness or drug dependency; and (c) taking the person into custody is the least restrictive alternative appropriate to the person's needs.

Once a person is in custody, the county department of human services must conduct a crisis assessment, either in person, by telephone, or by telemedicine or video conferencing technology, to determine if the person meets the criteria for emergency detention. If, following this assessment, the county department agrees for the need for detention, the person must be transported to an approved treatment facility, if the facility agrees to take the individual, or to a state mental health institute. The Winnebago Mental Health Institute, in Oshkosh, accepts all individuals transported for emergency detention. DHS charges counties a daily rate and some service add-on fees to cover the cost of the care and treatment services provided at Winnebago. Private hospitals and county-operated psychiatric hospitals also accept individuals for emergency detention. The Milwaukee County Behavioral Health Division operates its own mental health complex for mental health emergency services for Milwaukee County residents, although the Division is in the process of transitioning to a contracted facility to serve that purpose.

DISCUSSION POINTS

Background

1. Under DHS administrative code, a "crisis" is defined as a situation caused by an individual's apparent mental disorder which results in a high level of stress or anxiety for the individual, persons providing care for the individual or the public which cannot be resolved by the available coping methods of the individual or by the efforts of those providing ordinary care or support for the individual. As defined in this rule and used in this context, a "mental disorder" includes psychiatric conditions, but also dementia and substance addiction.

2. In some cases, a behavioral health crisis may cause an individual to pose a threat to themselves or others. In these circumstances, law enforcement officers, mobile crisis teams, or both may be called upon to intervene. If the Chapter 51 statutory criteria of dangerousness are met, and the individual does not voluntarily submit to intervention, the individual may be taken into custody and transported to a treatment facility for emergency detention. If a court subsequently determines, during the period of emergency detention, that a person continues to meet criteria related to dangerousness (among others), it may order involuntary civil commitment for ongoing treatment, usually on an inpatient basis.

3. Only some behavioral health crises entail a threat of harm to the individual experiencing the crisis or a potential threat of harm to others. But even when not posing an imminent danger of physical harm, a crisis may lead to other serious consequences, such loss of employment or wages, substance abuse, a deterioration in physical health, family stress and dissolution, disruption to any ongoing education or training, criminal behavior, long-lasting impacts of crisis-related traumatic experiences on self and others, and overall loss of life satisfaction.

4. There are some indicators that the incidence of behavioral health crises has increased over the past several years. For instance, according to DHS data, the suicide rate in Wisconsin rose

by 40% between over the past two decades. Likewise, in Wisconsin as well as nationally, drug overdose deaths and hospitalizations have increased, with the rate of opioid-related deaths increasing by 45% and hospitalizations by 70% between 2014 and 2019. Nationally, there is an increased awareness of the prevalence of these and other so-called "deaths of despair," which, collectively, are sometimes blamed for a recent decrease in average life expectancy in the United States.

5. The multi-faceted impacts of the COVID-19 pandemic have caused, and may continue to cause, additional crisis episodes. Mental health professionals have warned that even after the immediate threat of COVID-19 has subsided, the impacts on certain vulnerable individuals may linger and lead to more crisis episodes, due to the stress of social isolation, economic losses, the death of family members or friends, and long-term health impacts of COVID-19.

6. While there are indicators that the number of crisis episodes has been increasing, the capacity of inpatient psychiatric hospital beds has decreased. The Department of Health Services notes that the number of available private and county psychiatric inpatient beds has declined by approximately 20% in the last ten to fifteen years. This reduction in inpatient beds is likely one factor in an increase in admissions at the Winnebago Mental Health Institute occurring over the past decade. Total admissions at Winnebago, of which emergency detention comprise the vast majority, have increased from just under 2,000 in 2011 to over 3,000 annually in recent years.

7. In recent years, law enforcement agencies, mental health advocacy organizations, mental health practitioners, and county human services agencies have increasingly expressed concerns regarding the adequacy of the current behavioral health crisis system. Among the challenges they cite are a shortage of trained personnel to staff crisis teams and facilities, inadequate options for crisis stabilization, and a decrease in the availability of private hospital beds for when hospitalization is required. At the same time, law enforcement and county human service agencies note that crisis calls have increased, driven by opioid and methamphetamine addiction, an increase in suicidality, and more frequent crisis contacts related to dementia.

8. While these challenges impact the entire range of the crisis system services, the emergency detention process has been an area of particular concern. In some emergency detention cases, a private or county hospital can take the individual for treatment. However, if such a hospital is not available, and the person is medically cleared for transport, the person must be transported to the Winnebago Mental Health Institute in Oshkosh. In addition to being a potentially difficult experience for the individual, the trip to Winnebago can impose a significant burden on law enforcement personnel, particularly if the person is transported from a great distance away.

9. The Attorney General and a coalition of groups representing Wisconsin law enforcement associations, healthcare provider groups and professional associations, Wisconsin counties, and mental health advocacy organizations recently issued a statement on the emergency detention process and a set of recommendations for improvements to the mental health crisis system. The coalition's statement identifies two broad goals underlying the recommendations. The first relates to crisis diversion, meaning improvements to elements of the crisis systems that are intended to reduce the need for emergency detention. The second goal relates to the emergency detention process and the need for enhanced inpatient bed capacity for individuals who require emergency detention.

10. The coalition's crisis diversion recommendations include:

- *Regional Crisis Stabilization*: Funding to establish "a continuum of voluntary and involuntary crisis stabilization options that includes both inpatient services for high and moderate acuity crisis stabilization and sub-acute crisis stabilization facilities for lower acuity needs."

- *Peer Support Respite Centers*: Additional funding to support peer-run respite centers.

- *Mobile Crisis Teams*: Additional funding to support mental health mobile crisis teams, including teams that follow a model that "aims to blend the social service response and the law enforcement response to mental health crises."

- *Regional Crisis Assessment Services*: Establishment of "regional hubs specializing in psychiatric emergency assessment and triage through in-person or telehealth services" to serve as an alternative of hospital emergency departments for this kind of assessments.

- *Community-Based Treatment for Suicidality*: Expanded treatment for suicidality by increasing medical assistance reimbursement rates for outpatient mental health and substance abuse services and for child and adolescent day treatment.

11. With respect to emergency detention process and inpatient bed capacity, the coalition has the following recommendations:

- *Crisis Intervention Training for Law Enforcement*: Increase funding for law enforcement crisis intervention training (currently $125,000 per year) and allow funding to be used for replacement officers and lodging during training.

- *Additional Mental Health Bed Space*: Investment in "incorporating additional inpatient beds into an evidence-based model where a coordinated set of crisis services, from triage and stabilization to inpatient, are delivered on-site."

12. The coalition's recommendations related to crisis diversion appear to be largely consistent with the broad consensus among behavioral health providers and administrators, law enforcement and judicial system professionals, and mental health advocates for the best practices for establishing mental health crisis systems. For instance, a 2020 report from the federal Substance Abuse and Mental Health Services Administration, entitled *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit* outlines recommendations for crisis system improvements that include establishing a set of three core crisis services: (a) a regional call crisis center, to engage individuals in crisis, perform risk assessment, and coordinate crisis care; (b) mobile crisis teams, to reach individuals wherever they are in the community; and (c) a crisis receiving and stabilization service, typically a facility used for observation and assessment in a non-hospital setting for a period of 24 hours or less. In addition to these specific core elements, the report discusses best practices for all core services and highlights the importance of robust collaboration between levels within the system, including with non-crisis behavioral health services.

13. As another example, in 2018, the National Association of State Mental Health Program

Directors released a publication, entitled "*A Comprehensive Crisis System: Ending Unnecessary Emergency Room Admissions and Jail Bookings*," which identifies the three essential elements of a crisis system: (a) regional or statewide crisis call centers; (b) mobile crisis units available at all times; and (c) regional crisis stabilization and observations centers.

Administration's Crisis System Grant Proposals

14. In order to support crisis system improvements, Assembly Bill 68 and Senate Bill 111 would establish two regional crisis system grant programs. Under the first program, the Department would make two grants to establish regional crisis response systems with a continuum of services. Each of these grants (hereafter referred to as "continuum of services" grants) would be $6,149,100, for a total of $12,298,300. Under the second grant program, DHS would award five grants of $1,000,000 each, for a total of $5,000,000, to establish stand-alone regional crisis stabilization centers. The proposal in AB 68/SB 111 envisions that both programs would establish service hubs to enhance county emergency response programs within its regional area.

15. The two regional crisis response system grant programs would be among several measures proposed by AB 68/SB 111 to improve county mental health crisis response and related systems. In addition to the grant programs discussed in this paper, the bill would: (a) provide funding to facilitate law enforcement-behavioral health services collaboration teams; (b) establish a statewide call center to support county crisis call services in small counties; (c) provide a grant to expand the capacity of mobile crisis teams in Milwaukee County; and (d) increase funding for crisis intervention training for law enforcement agencies. These and other behavioral health grant proposals are discussed in another LFB budget paper.

16. The administration indicates that the crisis system proposals are intended to address two broad goals. The first is to provide additional regional facilities with the capability to accept individuals for emergency detention, thereby reducing the need for long-distance transportation. The second goal is to help establish regional crisis systems with a range of treatment options at a sub-acute level to address crisis situations before they escalate to the point of requiring hospitalization or emergency detention.

17. The proposed continuum of crisis services grants would be intended to support two centers, with a regional set of services. Each center would have three components: (a) a crisis urgent care and observation center; (b) a crisis stabilization facility; and (c) inpatient psychiatric hospital beds. The Department of Health Services indicates that it would be intended that each component would be located at a single site or within a close distance of each other, to facilitate movement between levels of care. The role of each of these components is discussed below.

Crisis Urgent Care and Observation Center

18. The crisis urgent care and observation center would serve as a hub for initial triage and observation for individuals experiencing a crisis, including individuals transported for emergency detention. In addition to assessment, the urgent care center would provide medication management and counseling, and would provide referral to, and coordination with, other behavioral and physical health care services.

19. The Department envisions that these facilities would serve as an alternative to a hospital emergency department, which is where individuals experiencing a mental health crisis are frequently taken. The Department notes that a hospital emergency room can be a stressful environment for a person experiencing a mental health crisis. Moreover, since a person experiencing a mental health crisis often requires intensive monitoring, these crisis episodes are an intensive use of hospital emergency room staff resources.

20. The Department also notes that the staff of a crisis urgent care and observation center would work closely with mobile crisis teams, and provide backup support for those teams, if necessary.

21. The Department indicates that since many individuals transported to Winnebago Mental Health Institute for emergency detention involve stays of fewer than three days, some of these admissions could likely be avoided if there were more community-based treatment options. The Department believes that the urgent care and observation center could be one measure to reduce the transport to Winnebago or another inpatient hospital by first stabilizing the individual and providing a more comprehensive assessment of the need for hospitalization. After a period of observation and medication management, an individual who would have otherwise been taken to an inpatient facility, including Winnebago, may be transferred to a crisis stabilization facility or to other treatment providers in the community.

22. The Department indicates that it may be necessary or desirable to create a new facility certification category for crisis urgent care and observation centers. The purpose of certification would be to establish standards for, among other things, the staffing requirements for the centers, as well as center responsibilities concerning relationship with other providers in the treatment continuum. The certification process would be used to ensure that the standards for receiving a grant are met and maintained, and would be a prerequisite for receiving payment under medical assistance or other insurance. The bill would authorize DHS to promulgate administrative rules for this purpose, and would include authorization to establish emergency rules.

Crisis Stabilization Center

23. The second component of the continuum would be a crisis stabilization center, a facility for voluntary, short-term treatment and continued observation in a residential setting. The Department indicates that the crisis stabilization center would most likely be in a facility licensed as a community-based residential facility (CBRF). A CBRF can have a maximum of 16 beds.

24. Crisis stabilization facilities are intended to reduce the need for hospitalization, including emergency detention, but would not serve as an alternative site for when involuntary emergency detention or civil commitment is required. Individuals could come to the crisis stabilization center directly, or arrive upon referred from the urgent care and observation center.

25. The adult crisis stabilization facilities are intended to play a role similar to that of youth crisis stabilization facilities. The 2017-19 biennial budget act (2017 Act 59) required DHS to establish standards and a certification process for youth crisis stabilization facilities (YCSF). The purpose of these facilities is to provide a residential center for youth age 17 or younger to receive immediate care

to prevent or treat a mental health crisis, with the intention of averting hospitalization, as well as connecting the youth with resources for ongoing treatment. Act 59 also established a grant program to support the operation of a limited number of YCSFs in the state. In 2020, DHS awarded grants totaling $1,178,500 to county social services agencies to establish three YCSFs, as follows: (a) $705,400 for Milwaukee County; (b) $363,300 for North Central Healthcare (joint agency for Langlade, Lincoln, and Marathon counties), and (c) $109,800 for Ashland County.

Inpatient Psychiatric Beds

26. The third component of the continuum of services grants would be to support psychiatric inpatient beds for more intensive treatment, as needed, including treatment in the course of involuntary emergency detention, as well as voluntary treatment for more acute crisis.

27. The inpatient psychiatric bed component of the grant would be intended to help establish more regional facilities for the use of emergency detention, but would not support the full cost of the facility. It is expected that a subsidy would allow a hospital to hold the beds for emergency detention, increasing the likelihood that an existing psychiatric hospital or psychiatric unit of a general hospital could be more financially viable and be available as a regional facility.

28. While a significant part of the impetus for the calls to changes to the emergency detention system has been a need to find regional alternatives to transporting individuals to Winnebago, the continuum of services proposal places an emphasis on the development of services for crisis diversion. Thus, a grant is intended to increase the number of inpatient psychiatric beds available for emergency detention, but a grant recipient would also be required to establish the other elements of the continuum as a means to avoid the need for hospitalization.

Basis for Continuum of Services Grant Funding

29. The Department assumes that some of the costs of maintaining the crisis service facilities could be billed to counties, medical assistance, or other third-party payers. However, the share of costs that could be billed is uncertain. For the purposes of developing the grant program, the Department assumed that 20% of the cost of the urgent care and observation centers and of the crisis stabilization facilities could be billed to MA or other third payers, but the grant would cover the rest.

30. For the inpatient psychiatric component of the grant, the Department used the cost of two beds for one year at the Winnebago Mental Health Institute. In this case, the Department assumed that some level of subsidy would be required to create incentives for hospitals to provide a guarantee of bed space for emergency detention cases.

31. The grant funding estimate is based on the Department's assumptions for staffing and other costs for each component of the system. The following table summarizes the capacity, estimated costs, and the Department's basis for the estimate.

Component	Beds Supported	Estimated Cost	Basis of Estimate
Crisis Urgent Care /Observation Center	15	$4,977,800	56 total staff; 80% of cost covered.
Crisis Stabilization	8	328,100	Nursing home daily rate in MA; 80% of cost covered
Inpatient Psychiatric Beds	2	843,200	Average cost of two bed-years at Winnebago.
Total Grant per Center		$6,149,100	

32. Although the continuum of services grant model is based on existing models and recommendations from recent studies, the Department indicates that the first step in fully developing grant parameters would be to issue a request for information (RFI) from county agencies, provider groups, and other stakeholders. While the bill would provide funding for the Department to develop the continuum of services grant program, many of the details would need to be developed further before the program is implemented. Thus, while the proposal for the grant program identifies a specific funding amount associated with each component, it is possible that the funding shares would shift between the different service types. With the preparation time needed to develop more detailed program specifications, the Department anticipates that the grants would be made in 2022-23.

33. In order to develop and administer the grant program, as well as develop standards for certification of crisis urgent care and observation facility, the bill would provide 2.0 GPR positions, beginning in 2021-22. The funding associated with these positions is $130,500 GPR in 2021-22 and $167,300 GPR in 2022-23.

Standalone Crisis Stabilization Facility Grants

34. In addition to providing grants for two regional crisis continuum of services hubs, AB 68/SB 111 would provide $5,000,000 for five regional crisis stabilization facilities. As with the continuum of services grant, the funding would be provided in 2022-23. Although crisis stabilization facilities are one component of the continuum services, these additional grants would be standalone facilities distributed at various locations throughout the state, and would be available for any county referrals within the region surrounding each facility.

35. Crisis stabilization facilities are intended to reduce the need for hospitalization, including emergency detention, but would not serve as an alternative site for when involuntary emergency detention or civil commitment is required. Thus, crisis stabilization facilities are intended to be a diversionary measure.

36. Some counties currently operate crisis stabilization facilities. To the extent possible, existing crisis stabilization facilities bill MA or commercial insurance for services. While the continuum of services grant proposal was developed with the assumption that the facilities could cover 20% of the operating cost from billing for services, the standalone grants make no assumptions on the amount of the operating costs that could be covered from billing. Instead, the grant funds would be intended to fully support start-up costs for regional, 16-bed centers, or provide ongoing support for centers that would not otherwise have the volume to remain self-sufficient on the basis of charges alone.

Discussion of Grant Proposals and Alternatives

37. While stakeholders have consistently noted the deficiencies in county-based crisis systems, there are some counties that have established or are planning to develop crisis systems that offer a continuum of services that is similar to the model envisioned in proposed grant program. As an example, the Department cites the crisis system of North Central Health Care, a joint agency serving Langlade, Lincoln, and Marathon counties. North Central has established a crisis center for short-term stabilization, triage and referral to other services. North Central also operates its own 16-bed inpatient psychiatric hospital, which serves both voluntary and involuntary admissions.

38. The Department also cites Milwaukee County crisis system as a model. The Milwaukee County Behavioral Health Division has been in the process of redesigning its entire mental health system over the past decade. One of the last remaining components is the establishment of a new mental health emergency center, in collaboration with area health systems. Previously, the county has expanded mobile crisis services, peer support services, and residential treatment facilities.

39. Some counties operate their own psychiatric hospitals, providing an alternative to Winnebago for emergency detention or voluntary inpatient treatment. In addition to North Central, the counties that have their own hospitals include Brown, Fond du Lac, Milwaukee, Waukesha, and Wood. Other counties have established arrangements to place emergency detention patients in private hospitals, either in Wisconsin, or for some border counties, in other states.

40. Counties that have their own hospitals, stabilization facilities, and a more robust set of diversionary services may elect to do so because the savings to the county of avoiding emergency detention at Winnebago outweighs any additional cost incurred for county-based crisis services. The Department bills counties a daily rate, which is currently $1,174 for adult psychiatric services and $1,201 for child and adolescent services. In addition, DHS charges $274 per day for the first three days of emergency detention. In contrast to these county costs for emergency detention, many of the measures that might be employed in a mental health crisis system that are alternatives to adult emergency detention, or that might reduce the severity of a crisis to avoid the need for emergency detention, can be at least partially billed to medical assistance.

41. Despite the potential to avoid costs associated with emergency detention at Winnebago, most counties do not have the full range of crisis diversionary measures and alternatives, or may have them but not with sufficient capacity to meet the demand. In particular, smaller counties, with a lower population density may not experience a volume of crisis episodes that is sufficient to outweigh the savings associated with avoiding emergency detention at Winnebago. While taking a multi-county, regional approach to delivering crisis services may allow some counties to share the upfront and fixed costs, this is not common in practice.

42. One perspective on the crisis system deficiencies is that counties, not the state, have the responsibility for making the necessary investments in the infrastructure to deliver a full spectrum of community-based treatment and support services to reduce the need for detention. In some cases, this may require working with neighboring counties to pursue integrated, regional crisis systems. Furthermore, counties, again working with others if necessary, can pursue contractual arrangements with private hospitals in the region or other county psychiatric hospitals to hold psychiatric beds open

for emergency detention. From this perspective, additional state funding should not be required to fill gaps in the county crisis system since clearly some counties are taking these measures without state assistance.

43. A different perspective on the crisis system is that the state should have a role to play in helping improve crisis services for all residents, regardless of their county of residence. In particular, counties may need financial assistance to establish and operate regional, comprehensive systems for both crisis diversion and for emergency detention. Likewise, the state should play a role by establishing standards for urgent care and observation centers that have the capability to serve as a facility for triage as well as emergency detention. This position is consistent with recommendations of the coalition discussed previously, as well as with the grant proposal in AB 68/SB 111.

44. Another approach, also reflecting the perspective outlined in the previous point, is to provide a direct state subsidy for one or more hospitals, contingent upon securing an agreement to admit patients under emergency detention. Legislation has been introduced in both houses (AB 92/SB 86) that would provide a grant of $15,000,000 to a hospital in Eau Claire County if the hospital agrees to expand psychiatric inpatient capacity by 22 beds between the Eau Claire hospital and a hospital in Chippewa County owned by the same health system. As a condition of receiving the grant, the hospital would have to agree to give preference in admissions to individuals under emergency detention from one of 29 counties, generally in the northwest quadrant of the state.

45. AB 92/SB 86, which has bipartisan sponsporship, is intended to increase the availability of inpatient beds for emergency detention in the northwest region. If the bill were to be enacted, it could be viewed as complimentary to the grant proposals in AB 68/SB 111 or could stand alone. Unlike the proposal in AB 68/SB 111, the Eau Claire hospital grant would be for capital improvements to the hospitals, rather than operating costs. In addition, while the hospital grant is intended to address inpatient hospital capacity for emergency detention, a significant portion of the funding in the AB 68/SB 111 would be directed instead to diversionary measures, or for accepting individuals subject to emergency detention in the proposed crisis urgent care and observation center, a non-hospital facility.

46. As noted previously, some details of the grant programs, particularly for the continuum of services grants, remain uncertain. One of the key elements of the proposal that is unknown is the respective shares of total cost that would be paid by grant funds, county funds, and revenue from reimbursement for services from medical assistance or other insurance coverage. Although the funding for the grants was based on assumptions regarding what portion of the cost could be billed to medical assistance or other sources, the Department notes that it is not clear, once established, what level of ongoing support for regional systems would be needed to maintain the system.

47. It is not unusual for legislation, including the biennial budget, to provide funding for general purpose, such as a grant program, with the expectation that the administering agency will need to specify standards for the use of the funds in the course of implementing the program. Several of the behavioral health grant programs administered by DHS were enacted this way. Nevertheless, the Committee may decide that the significant uncertainties that remain in how the funding would be used, as well as the magnitude of the state's commitment, mean that additional review by the Legislature, prior to the awarding of grant funds, is warranted. In this case, the funding approved for

grants could be placed in the Committee's program supplements appropriation. The Department could submit a request for release of the funding following the RFI process, and once a full grant proposal was developed.

48. The funding amounts included in AB 68/SB 111 were based on estimates of the operating costs of the facilities, assumptions regarding the percentage of these costs that could be recovered from patient revenues, and assumptions regarding the level of hospital subsidy needed to secure access to additional inpatient psychiatric beds for emergency detention. Because these estimates are built on several factors that cannot be known with certainty, it is possible the amount of funding proposed is either not sufficient to accomplish the intended purpose, or that a smaller amount would be sufficient. As with other decisions made by the Committee, the funding provided for this purpose must be considered in the context of other priorities for uses of state funding. Other funding amounts could be considered other than the alternatives presented in this paper.

ALTERNATIVES

A. Crisis Response Grant Funding

1. Approve one or more of the following:

a. Provide $130,500 in 2021-22 and $12,465,600 in 2022-23 and 2.0 GPR positions, beginning in 2021-22, to establish a continuum of crisis services grant program. Require DHS to award grants to entities to provide grants to entities to provide a continuum of crisis response services, including mental health crisis urgent care and observation centers, crisis stabilization and inpatient psychiatric beds, and crisis stabilization facilities. Authorize the Department to certify crisis urgent care and observation centers and establish criteria by rule for the certification of crisis urgent care and observation centers. Specify that if the Department establishes a certification process for crisis urgent care and observation centers, no person may operate a crisis urgent care and observation center without having a certification. Specify that the Department may limit the number of certifications it grants to operate crisis urgent care and observation centers. Authorize the Department to promulgate emergency rules establishing the criteria for the certification for crisis urgent care and observation centers, notwithstanding current law prerequisites for emergency rules. Create a GPR annual appropriation for the program.

ALT A1a	Change to Base	
	Funding	Positions
GPR	$12,596,100	2.00

b. Provide $5,000,000 GPR in 2022-23 for grants for regional crisis stabilization facilities. Require DHS to award no more than five grants under this program to fund services at facilities providing crisis stabilization services, based on criteria established by the Department.

ALT A1b	Change to Base
GPR	$5,000,000

2. Take no action.

B. Disposition of Grant Funding

1. Provide funding for any grants approved under the Part A alternatives in the DHS appropriation for crisis response grants.

2. Provide funding for any grants approved in the Part A alternatives in the Committee's Program Supplements appropriation. Under this alternative, the Department could request release of the funding following the request for information process and the full development of grant proposals.

Prepared by: Jon Dyck

Legislative Fiscal Bureau
One East Main, Suite 301 • Madison, WI 53703 • (608) 266-3847 • Fax: (608) 267-6873
Email: fiscal.bureau@legis.wisconsin.gov • Website: http://legis.wisconsin.gov/lfb

June, 2021 Joint Committee on Finance Paper #371

Community Based Behavioral Health System Grants (Health Services -- Community Based Behavioral Health)

[LFB 2021-23 Budget Summary: Pages 299 through 303, #2 through #15]

CURRENT LAW

Publicly-funded mental health and substance abuse services (collectively, "behavioral health") are provided through a variety of state and county programs, or by tribal governments, for members of tribal nations.

Chapter 51 of the Wisconsin Statutes requires every county to establish a county department of community programs or participate in a multi-county department for the provision of behavioral health services. These county agencies are usually part of a county department of human services.

Although counties are required to establish an agency to administer services, counties are responsible for addressing program needs only within the limits of available state and federal funding and county funds. Each county establishes its own program and budget for these services, and may limit service types and establish waiting lists to ensure that expenditures do not exceed available resources. For these reasons, the type and amount of available services varies among counties.

There are currently 67 agencies serving the state's 72 counties, including 64 single-county agencies, and three multi-county agencies (Forest/Oneida/Vilas, Grant/Iowa, and Langlade/ Lincoln/Marathon). There are 11 tribal human service agencies in Wisconsin.

The Department of Health Services has primary responsibility for state mental health and substance abuse programs. The Department's Division of Care and Treatment Services oversees and provides guidance to county mental health and substance abuse programs and administers several grant programs, using state and federal funds, to supplement behavioral health services offered by county and tribal governments.

DISCUSSION POINTS

1. In Wisconsin, counties (or tribal governments, where applicable) have the primary responsibility for coordinating and delivering publicly-funded behavioral health treatment services for their residents. For most counties, these services are administered by a county human service department (or, in some cases, a "department of community programs") that serves only one county; in a few cases, a multi-county collaborative agency has been established to provide these services.

2. Publicly-funded behavioral health services are generally targeted to individuals who are either enrolled in the state's medical assistance (MA) program or who are uninsured or underinsured. However, some services may be provided to any resident, including services not covered, or only partially covered, by insurance. This would include behavioral system crisis programs or programs designed to prevent substance abuse or mental health crisis.

3. County behavioral health programs are financed primarily through a combination of county funds and, where applicable, payments made by the MA program or other health insurance coverage. According to data collected by DHS from county program participation reports, in 2019 counties spent a total of $698.6 million for mental health services and $87.6 million for substance abuse services. These totals include revenues from all sources that flow through the county, including services provided by the county and reimbursed under MA. It does not include all MA services provided to individuals for which the reimbursement is made directly to a provider that is not a county, such as a private hospital, practitioner, or clinic.

4. The county contribution to these programs may consist of its own tax revenues, but the counties may also allocate a portion of the funding received under the community aids program to behavioral health programs. DHS distributes a total of approximately $170.0 million per year under the basic county allocation component of the community aids program and $24.3 million under a separate mental health allocation component. Basic county allocation funds can also be used for social service programs that are not related to behavioral health, such as programs serving the elderly and disabled and child welfare programs.

5. Another source of funding for behavioral health programs are targeted grants administered by the Department of Health Services. In some cases, these programs provide funding for county or tribal human services agencies, while in other cases, the funds are used to support statewide or regional services that supplement human service agencies' efforts. Targeted grant programs administered by DHS serve several purposes in the behavioral health system.

6. The following are some examples of the Department's behavioral health grant programs (with current annual funding): (a) the child psychiatry consultation program ($1,500,000 GPR); (b) the addiction medicine consultation program ($500,000 GPR), youth crisis stabilization facility grant program ($l, 178,500 PR); (d) opioid and methamphetamine center program ($3,016,000 GPR); and (e) peer-run respite center grants ($1,324,800).

7. In addition to targeted state grants, DHS also distributes federal grant funds to local governments and nonprofit entities under two block grant programs--the community mental health services block grant (MHBG) and the substance abuse prevention and treatment block grant (SABG).

Federal law establishes certain conditions for the receipt of these funds. For instance, the state must develop, and submit for federal approval, plans for delivering behavioral health services. The state must also establish advisory councils (one for mental health services and one for substance abuse services) to review and provide recommendations for the state plans. MHBG funds must be used only for services for adults experiencing serious mental illness or youth experiencing serious emotional disturbance, both of which are defined by federal regulations. In addition, these funds may not be used for inpatient services or for the purchase or construction of any building.

8. In recent years, Wisconsin has received approximately $27 million annually under the SABG and approximately $12 million annually under the MHBG. These two federal programs are administered by the Substance Abuse and Mental Health Services Administration (SAMHSA), within the U.S. Department of Health and Human Services.

9. Both state and federal grants are typically intended to supplement county efforts for behavioral health programs, usually fulfilling one or more state policy objectives. These objectives are varied and somewhat overlapping, but can include the following: (a) providing supplemental funding in areas of high need (geographic or specific condition), where the incidence of behavioral health conditions exceeds what counties can adequately address with their own resources; (b) providing incentive funding to encourage counties to adopt best practices for services or expand their capacity; (c) filling gaps in the system, to provide more uniform level of service across all areas of the state; and (d) providing supportive funding to maintain a baseline of service availability in sparsely-populated areas.

10. Despite the funding available from state and federal grants, many behavioral health advocates, county human service agencies, and behavioral health clinicians assert that the capacity of the behavioral health system is not sufficient to meet the need for treatment and supportive services. In addition to various national studies of the gaps in the behavioral health system, there are recent studies conducted by or for DHS that support this view.

11. In 2018, DHS contracted with the UW Population Health Institute to conduct a study with the purpose of identifying any gaps in the state and county behavioral health system. The study authors used interviews, surveys, and focus groups, collecting data and perspectives from a range of system providers, administrators, and consumers. In addition to identifying system gaps, the report assesses their relative impact on individual and population health, and summarizes the recommendations for improvement suggested by both providers and service consumers. The following points summarize the key findings of the report, which was published in August of 2020.

12. The Behavioral Health System Gaps report identified several specific system gaps, based on interviews with providers and administrators: (a) a shortage of child and geriatric psychiatrists; (b) shortage of inpatient and residential beds for the treatment of substance use disorders; (c) difficulty in finding transportation to access care; (d) inadequacy of crisis stabilization services; (e) overreliance on law enforcement officers to respond to mental health crisis situations; (f) a shortage of medication-assisted treatment providers; (g) long waiting times to receive services; (h) shortage of translation services; and (i) a lack or shortage of comprehensive supportive services, like housing and employment, for consumers and their families to promote recovery.

13. Based on surveys and interviews with consumers, the study authors identified the following barriers to accessing behavioral health services: (a) cost and insurance coverage; (b) geography (travel time or distance); (c) cultural mismatch between service providers and consumers; and (d) workforce and treatment facility shortages. In addition, perceptions of the stigma associated with behavioral health conditions was also identified as a barrier that keeps some persons from seeking services.

14. According to the gap analysis report, certain populations are more likely to face barriers to receiving services. Marginalized social groups, particularly racial and ethnic minorities, are both more likely to face conditions that contribute to or worsen existing behavioral health challenges, and to also confront barriers to accessing care, including lack of trusted providers. In rural areas, an increase in social and geographic isolation contributes to an increased risk for behavior health challenges and creates difficulties in accessing care.

15. The Behavioral System Gaps Report was a one-time report with the explicit purpose of gathering perspectives from system stakeholders, and was based primarily on qualitative analysis of interviews and focus groups. Another perspective on the functioning the behavioral health system is the Department of Health Services' biennial Mental Health and Substance Use Needs Assessment. The needs assessment, in contrast with the system gaps report, is a description of the current system, based on quantitative data collected from system usage reports and population surveys. The Department publishes this needs assessment primarily to inform the planning process used for submitting the application for the federal block grant programs (MHBG and SABG). The 2019 report (the latest available) is generally based on data from 2017.

16. The DHS behavioral health needs assessment examines three areas: (a) the prevalence of behavioral health conditions in the population; (b) the usage of system, to assess the adequacy of access to services; and (c) the number of behavioral system providers and their geographic distribution. One of the key indicators of need in the needs assessment is the "treatment gap," which is the difference between the estimated number of individuals who have a mental health or substance use disorder and the number of individuals who receive treatment services. In 2017, DHS reports that an estimated 47% of adults and 37% of youth with mental illness did not receive treatment services. In addition, an estimated 69% of adults with substance use disorder did not receive services (this calculation was not performed for youth).

17. There are several reasons that individuals with a behavioral health problem do not receive services, although not all are related to the service delivery system itself. The DHS report includes national survey data on the reasons that persons with a mental health or substance use diagnosis do not access services. Among the most frequent reasons given by respondents is lack of time, a belief that they can handle the problem without professional help, and perceived stigma associated with seeking treatment. Other reasons that may indicate gaps in the delivery system include not knowing where to go for service, an inability to afford the cost, and a perception that the services available would not help.

18. In recent months, mental health and substance use experts have noted that the COVID-19 pandemic has increased the need for treatment services, and that these effects may linger. A study published recently in the Journal of the American Medical Association Psychiatry found that during

the period from late March, 2020, to October, 2020, the rate of weekly hospital emergency department visits related to all mental health conditions increased by 18% compared to the same time period in the previous year. For emergency department visits for suicide attempts and drug overdose, the rate increased by 25% to 30% during this period. Similarly, the Centers for Disease Control published findings from survey data that the prevalence of anxiety, depression, substance abuse, and suicidal thoughts showed a marked increase during the pandemic.

19. These findings were recently corroborated in a memo from the Governmental Accountability Office (GAO 21-437R). Relying on a variety of sources, including household surveys, data reported by health care providers, and interviews with practitioners, GAO reports that "longstanding unmet needs for behavioral health services persist and were worsened by new challenges associated with the COVID-19 pandemic." The memo cites survey data indicating a large increase in the percentage of respondents who report experiencing anxiety and depression, compared to the year before, as well as emerging data showing an increase in suicide and overdose deaths.

20. In response to calls for more funding to address the need for more treatment resources, Congress has recently passed legislation to increase behavioral health funding to states. Both the Consolidated Appropriations Act (CAA) of 2021 and the American Rescue Plan Act (ARPA) of 2021 provide increases to the community mental health services block grant program and to the substance abuse prevention and treatment block grant program.

21. The following table shows the supplemental amounts that the state received under the block grant programs under both COVID-19 relief acts, in comparison with the state's regular allocation under these programs for federal fiscal year 2020-21. The regular allocation is similar to the annual amounts the state has received over the past several years.

Federal COVID-19 Relief Bill Supplements for Block Grant Programs
($ in Millions)

	FFY 2020-21	COVID-19 Act Supplements	
Block Grant Program	Allocation	CAA	ARPA
Mental Health Block Grant	$12.4	$14.3	$24.6
Substance Abuse Block Grant	27.2	25.5	22.0
Total	$39.6	$39.8	$46.6

22. As shown in the table, the federal COVID-19 legislation provides a significant increase for the block grant programs, equaling or exceeding the state's regular annual allocation. In providing the block grant funding, the Consolidated Appropriation Act of 2021 states that the purpose of the supplements is "to prevent, prepare for, and respond to coronavirus, domestically or internationally." The purpose for the block grant supplements provided under the American Rescue Plan Act are not indicated, although the Act does specify that the funds must be used by September 30, 2025.

23. The federal grant supplements are generally intended to respond, with one-time funds, to an immediate increase in treatment needs associated with the COVID-19 pandemic. Federal

guidance for these programs (applicable generally to the programs, not the supplements specifically) indicates that states are encouraged to assist individual grant recipients to transition to other funding sources to support ongoing operations, such as Medicaid, Medicare, and other health insurance payments. Thus, block grant funds may be viewed as a means to assist recipients with up-front costs associated with initiating new treatment programs or expanding treatment program capacity.

24. The Department indicates that it plans to allocate the bulk of the block grant funds received under the CAA to counties (the first round of supplements), although it is awaiting federal approval of a final plan. The Department indicates that it has been in consultation with the mental health and substance abuse advisory councils, as well as other system stakeholders, on how block grant funding received under ARPA will be allocated.

25. Assembly Bill 68 and Senate Bill 111 includes several proposals for new or expanded state behavioral health grants administered by DCTS. Generally, these initiatives can be divided into three categories: (a) initiatives for improving behavioral health crisis systems; (b) substance abuse treatment enhancements; and (c) general system enhancements. The following table lists the proposals, along with the proposed funding increase. With the exception of the crisis intervention training program (base funding of $125,000), mobile crisis grant program (base funding of $125,000), and the child psychiatry consultation program (base funding of $1,500,000), these would be new initiatives. Following the table is a brief description of the proposal, along with the stated purpose, need, or system gap that the grant would address.

Proposed Behavioral Health Grant Initiatives, GPR Funding

Proposed Grant or Initiative	2021-22	2022-23	Biennial Total
Behavioral Health Crisis Initiatives			
Behavioral-Law Enforcement Collaboration	$1,250,000	$1,250,000	$2,500,000
County Crisis Call Center	923,600	923,600	1,847,200
Milwaukee Mobile Crisis Unit	850,000	850,000	1,700,000
Crisis Intervention Training	375,000	375,000	750,000
Milwaukee Trauma Response	450,000	450,000	900,000
Peer-Run Respite Phone Line Support	313,800	313,800	627,600
Behavioral Health Bed Tracker	100,000	50,000	150,000
Substance Abuse Treatment			
Medication-Assisted Treatment	$500,000	$1,000,000	$1,500,000
Substance Use Harm Reduction	250,000	250,000	500,000
Methamphetamine Addiction Treatment	150,000	300,000	450,000
Substance Use Treatment Platform	0	300,000	300,000
System Enhancements			
Behavioral Health Technology	$0	$2,000,000	$2,000,000
Deaf and Hard of Hearing Behavioral Health	0	1,936,000	1,936,000
Child Psychiatry Consultation	500,000	500,000	1,000,000
Total	$5,662,400	$10,498,400	$16,160,800

26. Behavioral Health-Law Enforcement Collaboration Grants.

Description: Provide $1,250,000 GPR annually to establish and enhance behavioral health services emergency response collaboration. Grant recipients must provide at least 25% matching funds.

Purpose, needs, or system gap: There is growing interest in establishing a collaborative team approach to responding to mental health crisis situations. Several advocates of this approach cite the benefits for both law enforcement, county social service agencies, and individuals experiencing crisis. They credit these teams for a reduction in the need for involuntary commitments and a reduction in tension between law enforcement officers and community members in need of crisis support.

If these benefits are achievable, some counties and law enforcement agencies may establish these arrangements without the need for state grant support; several municipalities and county human service agencies in Wisconsin have already taken this approach. However, some law enforcement agencies may not have the resources to devote officers to collaborative teams since this reduces personnel available for other law enforcement duties. The availability of grant funds may allow more teams to be established.

27. County Crisis Call Center

Description: Provide $923,600 GPR annually to contract for a statewide crisis call and consultation center, and specify that any county that utilizes the call center must provide at least 10% of the cost of the services.

Purpose, needs, or system gap: According to a 2019 DHS survey of counties, many agencies report a lack of staff and high turnover as problems confronting telephone crisis services. At the same time, calls to crisis lines have increased rapidly in recent years. Nine counties only have crisis lines available during business hours. The proposed statewide call center would fill gaps in smaller counties that are unable to staff a full-time call service and provide back-up support for other counties during periods of high volume. Having a backup crisis line may allow those counties to be certified to receive medical assistance reimbursement for their crisis service programs.

The federal Substance Abuse and Mental Health Services Administration has established the Suicide Prevention Lifeline, but in most Wisconsin counties this service is usually staffed by national network representatives, rather than by a local or state call center. There are some other call services available that may handle mental health crisis situations if a county crisis line is unavailable. The 211 call center, for instance, fields some calls related to mental health crisis.

28. Milwaukee Mobile Crisis Unit Enhancement

Description: Provide $850,000 GPR annually to enhance mobile crisis teams in Milwaukee County.

Purpose, needs, or system gap: The use of mobile crisis teams, when accompanied by robust follow-up treatment referral and supportive services, has been demonstrated to reduce the need for

hospitalization and achieve better outcomes compared to when emergency response is done by law enforcement officers alone. Milwaukee County has established mobile crisis teams, but the capacity of these teams is not sufficient to provide rapid response at all locations in the county and at all times.

29. Crisis Intervention Training

Description: Provide $375,000 GPR annually for mental health crisis intervention training for law enforcement and correctional officers. This funding would be for the existing program, increasing annual funding from $125,000 to $500,000.

Purpose, needs, or system gap: Law enforcement officers are frequently the first to respond when a mental health crisis is reported, since the capacity of mobile mental health crisis teams is limited. Likewise, during the course of conducting policing duties, officers may need to interact with individuals who have mental illness, substance use disorder, or dementia. The existing program was created to increase training in techniques for addressing these situations. Many law enforcement agencies in the state have had their officers complete training in crisis response and de-escalation techniques provided through this program. Currently the program has the capacity to provide training in 26 counties. DHS reports that some agencies, particularly in more rural areas of the state have not received training.

30. Milwaukee Trauma Response Grant

Description: Provide $450,000 GPR annually to expand the capacity of the Milwaukee Trauma Response Team.

Purpose, needs, or system gap: There is a significant body of research on the association between traumatic events experienced by children (often called "adverse childhood experiences" or ACEs) and long term negative consequences for emotional and physical health. The Milwaukee Trauma Response Team initiative is a joint project of the Milwaukee Police Department, the City of Milwaukee, and Wraparound Milwaukee (a managed care organization for children with serious emotional disorders). The teams provide support and counseling to children and their families in the aftermath of a traumatic event. The goal of the trauma team intervention is to help minimize the lingering emotional and social effects associated with witnessing violence or other trauma. The grant is intended to increase the capacity of the team to cover evening hours.

31. Peer-Run Respite Phone Line Support

Description: Provide $313,800 GPR annually to establish phone line support to supplement phone service provided by peer-run respite centers.

Purpose, needs, or system gap: Currently, the Department provides grants to support the operating costs of four peer-run respite centers in the state. These facilities provide services, including short-term residential stays, to individuals who need support to cope with mental illness or substance abuse. The peer-run respite centers are staffed by individuals who have successfully completed mental health or substance abuse treatment. In addition to in-person service, the peer-run respite centers provide a 24-hour non-emergency phone line to assist individuals. In 2019, the peer-run respite

centers received an average of 33 calls per day at the three peer-run respite centers that were in operation during that year. However, answering these calls takes peer specialists away for in-person support. The proposed grant would be used to contract with six additional peer specialists to expand in-person and phone service at the peer-run respite centers.

32. Behavioral Health Bed Tracker

Description: Provide $100,000 GPR in 2021-22 and $50,000 GPR in 2022-23 to establish and maintain a statewide system to track bed availability for residential treatment, peer-run respite, crisis stabilization, and inpatient psychiatric hospital beds.

Purpose, needs, or system gap: The Department currently makes a payment of $30,000 annually to the Wisconsin Hospital Association to maintain an inpatient psychiatric hospital bed tracking system. The proposal would provide funding to develop and maintain a bed tracking system for space in other behavioral health settings, including peer respite, crisis stabilization, and residential treatment facilities.

33. Medication-Assisted Treatment Expansion Grant

Description: Provide $500,000 GPR in 2021-22 and $1,000,000 GPR in 2022-23 for grants to develop or support entities that offer medication-assisted treatment (MAT) for opioid use disorder.

Purpose, needs, or system gap: In February of 2020, DHS published the results of an examination of gaps and barriers in treatment systems for opioid use disorder. DHS found that there are several parts of the state, particularly in northern Wisconsin, where the opioid overdose incidence is high but where there are no providers of medication-assisted treatment within a 30 minute driving distance. With grant funding, DHS would support the establishment of new MAT providers or establish mobile MAT services.

34. Substance Use Harm Reduction Grant

Description: Provide $250,000 GPR annually for substance abuse harm reduction grants.

Purpose, needs, or system gap: While treatment for substance use disorder is intended to end a person's addiction to harmful substances, this can be a lengthy process and is not always successful. Alongside a treatment approach, a harm reduction strategy seeks to reduce or eliminate adverse events associated with addiction. Among the strategies employed are offering clean needles for injection to reduce the risk of infection with hepatitis and HIV, provide naloxone to block the effects of opioid overdose, and provide test strips to allow opioid users to detect the presence of fentanyl in the drugs. Many local public health, law enforcement, and EMS departments employ harm reduction strategies, but DHS reports that there is a shortage of such services is some parts of the state.

35. Methamphetamine Addiction Treatment Grants

Description: Provide $150,000 GPR in 2021-22 and $300,000 GPR in 2022-23 for grants to provide training to substance use disorder treatment providers on treatment models for methamphetamine addiction.

Purpose, needs, or system gap: In the past five years, the number of individuals seeking treatment through county social service agencies for methamphetamine addiction increased by more than 100%. Although the incidence of methamphetamine addiction is lower than addiction to other substances, such as opioids or alcohol, it is growing faster. Unlike treatment for opioid use disorder, there are no medication assisted treatment approaches for methamphetamine addiction. Instead, treatment takes a number of approaches that include cognitive behavioral therapy, motivational interviewing, group support, relapse prevention, and regular drug testing. Because of the lower incidence of methamphetamine addiction, some substance abuse treatment providers are not as familiar with the most effective treatment methods. The proposed grant program would fund a vendor to provide training on these methods.

36. Substance Use Disorder Treatment Platform

Description: Provide $300,000 GPR in 2022-23 for the development of a substance use disorder treatment platform that allows for the comparison of treatment programs in the state.

Purpose, needs, or system gap: With a shortage of providers and treatment options, individuals who need and want treatment may find it difficult to locate available treatment options, or may be unaware of what options are available. The proposed initiative would allow individuals seeking behavioral health treatment, treatment practitioners, or case managers to locate available treatment options throughout the state.

37. Behavioral Health Technology

Description: Provide $2,000,000 GPR in 2022-23 for making grants to behavioral health providers to implement electronic health records and to establish linkages with the state's health information exchange.

Purpose, needs, or system gap: Nearly all physician practices and hospitals have adopted electronic health records systems (EHRs), but, according to surveys conducted by DHS, only about one-half of behavioral health providers use EHRs. While federal funding has been made available to help some health care providers adopt EHRs, behavioral health providers have not been eligible for this assistance. Without an electronic health records system, the exchange of patient information between providers is inhibited, complicating the delivery of coordinated care.

A health information exchange is a central database of health records that allows a provider to access their patients' records, such as test results, prescribed medications, and services patients received, including information relating to services rendered by other providers. The Wisconsin Statewide Health Information Network (WISHIN) serves as the health information exchange for providers in Wisconsin. DHS indicates that participation in WISHIN, which is a subscription-supported service, is uncommon for behavioral health providers.

The proposed behavioral health technology program would provide grants to providers to adopt an electronic health records system and to encourage WISHIN participation by paying the initial subscription fees.

38. Deaf, Hard of Hearing and Blind-Deaf Behavioral Health Service

Description: Provide $1,936,000 GPR in 2022-23 to allow DHS to establish a statewide behavioral health service for individuals who are deaf, hard of hearing, or blind-deaf. Under the proposal, the Department would contract with a vender to employ healthcare providers who are fluent in American Sign Language (ASL), to provide services. The funding is based on the estimated cost of supporting eight staff members for providing and coordinating services.

Purpose, needs, or system gap: The Behavioral System Gaps report indicates that there are significant barriers to accessing behavioral health services for individuals who are hearing impaired. If a mental health practitioner who is fluent in ASL is not available, deaf and hard of hearing consumers must rely on the services of an ASL interpreter to receive counseling or other treatment, and providers are required to provide interpretation services under state and federal law. However, even if interpreters are provided, the report notes that there may be an obstacles to establishing a trusting relationship between the practitioner and the consumer if the provider does not have training or experience in the unique issues confronted by many individuals deaf and hard of hearing community. Moreover, the presence of an interpreter may inhibit the client-clinician relationship.

39. Child Psychiatry Consultation Program

Description: Provide $500,000 annually to increase from $1,500,000 to $2,000,000 the annual funding for the child psychiatry consultation program. Under the program, DHS contracts with the Medical College of Wisconsin to provide professional consultation services to assist primary care physicians and clinics in providing care to pediatric patients with mental health care needs.

Purpose, needs, or system gap: The child psychiatry consultation program was established by 2013 Act 127 to address a shortage of child psychiatrists in the state. Act 127 included a requirement that, beginning in 2016, the Department must establish service hubs to expand the program statewide. The 2019-21 budget increased funding for the program by $500,000, allowing the service to extend to 57 counties. The proposed funding would be intended to provide consultation services in all counties, meeting the statutory mandate.

40. The Committee may decide, with any of these grant proposals, that providing additional state funding is warranted to address a significant need or gap in the behavioral health system. These proposals, as included AB 68/SB 111, are presented as alternatives at the end of this paper.

41. The Committee may decide that with additional federal funding provided to respond to COVID-19, the administration could elect to fund some of these initiatives with block grant funds if state GPR funding is not provided. This may mean that some initiatives that are not a good fit for federal funds, including some that require a sustained, ongoing commitment, will not be funded. In addition, using supplemental federal block grant funds to the new initiatives represented by these programs would divert block grant funding that may otherwise be used for immediate, direct treatment needs within the current county system framework.

ALTERNATIVES

		GPR Fiscal Effect		
		2021-22	2022-23	Biennial Total
Behavioral Health Crisis Initiatives				
1.	Behavioral-Law Enforcement Collaboration	$1,250,000	$1,250,000	$2,500,000
2.	County Crisis Call Center	923,600	923,600	1,847,200
3.	Milwaukee Mobile Crisis Unit	850,000	850,000	1,700,000
4.	Crisis Intervention Training	375,000	375,000	750,000
5.	Milwaukee Trauma Response	450,000	450,000	900,000
6.	Peer-Run Respite Phone Line Support	313,800	313,800	627,600
7.	Behavioral Health Bed Tracker	100,000	50,000	150,000
Substance Abuse Treatment				
8.	Medication-Assisted Treatment	$500,000	$1,000,000	$1,500,000
9.	Substance Use Harm Reduction	250,000	250,000	500,000
10.	Methamphetamine Addiction Treatment	150,000	300,000	450,000
11.	Substance Use Treatment Platform	0	300,000	300,000
System Enhancements				
12.	Behavioral Health Technology	$0	$2,000,000	$2,000,000
13.	Deaf and Hard of Hearing Behavioral Health	0	1,936,000	1,936,000
14.	Child Psychiatry Consultation	500,000	500,000	1,000,000

Prepared by: Jon Dyck