Alberta Darling

Wisconsin State Senator

Joint Committee on Finance

TESTIMONY BEFORE THE SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES
Senate Bill 359
Senator Alberta Darling
January 9, 2014

Thank you Committee Chair Vukmir and members for giving me the opportunity to testify in favor of Senate Bill 359 which creates a child psychiatry consultation program overseen by the Department of Health Services. With Rep. Steineke's help, the companion bill passed 94-0. I would like to commend the work of the Speaker's Task Force on Mental Health and the package of bills they have introduced.

This bill requires DHS to create and administer a child psychiatry consultation program to assist participating clinicians in providing enhanced care to pediatric patients with mental health needs, to provide referral support for those patients and to provide additional services. The consultation program is not an emergency referral service. Before January 1, 2015, DHS must review proposals submitted by organizations seeking to provide consultation services through this consultation program and must designate regional program hubs based on organizations' submitted proposals. Beginning on January 1, 2016, DHS must create additional regional program hubs to expand the consultation program statewide. Under the bill, DHS must select qualified providers to provide consultation program services. To be a qualified consultation provider, an organization must demonstrate it meets certain criteria as specified in the bill. A consultation provider must report to any information that is requested by DHS. The program will be funded by $1 million GPR over the biennium. The Joint Committee on Finance approved AB 352 14-1 yesterday.

I ask that the committee support Senate Bill 425, to increase access to psychiatry consultation for clinicians who serve children that have mental health treatment needs. Thank you again for allowing me to testify in favor of this important piece of legislation.

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Wisconsin Senate • Committee on Health and Human Services
Testimony in support of Senate Bill 359 (2013)

Dipesh Navsaria, MPH, MSLIS, MD
dipesh@navsaria.com
9 January 2014

Thank you for the opportunity to comment on this important bill today. I am Dr Dipesh Navsaria, a primary-care pediatrician here in Madison. I am also a board member of the Wisconsin Chapter of the American Academy of Pediatrics, which is in support of this bill. In this, we are joined by the Wisconsin Council of Child and Adolescent Psychiatry, the Wisconsin Academy of Family Physicians, and the Wisconsin Alliance for Child Psychiatry and Pediatrics, among others. The Wisconsin Chapter of the American Academy of Pediatrics has a long-standing dedication to improving outcomes for children and adolescents with mental and behavioural health issues — one of these has been an effort to improve communication and support between primary care providers and specialists.

My clinical practice is at a federally-qualified health center, where virtually 100% of my patients are living under or near poverty. As you are aware, behavioural concerns and mental health disproportionately impacts children and youth living in poverty. I am able to handle a good number of the many small mental health concerns that arise—ADHD, depression and the like. However, a strikingly large number of my patients have needs that go above and beyond my training; I am able to prescribe necessary pharmaceuticals, but the appropriate choice of medication, dosage, and proper combinations of those requires deeper training and experience than I am able to provide.

I am very lucky in that my clinic is one of a small number of systems which has created a small version of the proposed consultation model within itself. I am able to periodically refer a complex patient to a child and adolescent psychiatrist who can perform a one-time evaluation which will conclude with careful, extensive written comments and recommendations back to me. While the psychiatrist will not routinely see the patient back, she is available to me via phone or secure messaging for ongoing advice as the situation evolves. This system is generally *not* available to my colleagues throughout Wisconsin, and they struggle as a result to access quality mental health advice for their patients.

Let me tell you clearly how important this is: in my prior career as a physician assistant in a rural area of another state, I regularly witnessed how terrible children's mental health was. The few specialists that existed were miles away and frequently would not take certain types of insurance coverage. In the meantime, responding to the pleas for help from families, school and others, primary-care providers would use medications that largely had the effect of essentially sedating children, without a clear rationale for their use. I once even encountered a young woman who, before the age of 19, had been labeled with schizophrenia, depression and bipolar disorder — none of which she truly had.

As I am sure you are all aware, mental health has deep and profound effects on physical health and can greatly tax the ability of a family to keep up with daily life. Without appropriate and timely care with the correct expertise, the consequences can be at the least wearing, and at the most can escalate to the point of florid suicidality or homicidality.

I would like to make one other point: our health care system frequently "divides" traditional health care from mental health. While I fully understand and appreciate privacy around mental health, the system often makes it very difficult for me to know what is going on with my own patient with respect to their mental health. Consultation models such as this one preserve the integrity of the medical home and allow me to have the "full picture" of my patients' health and well-being. Additionally, by allowing the patient to receive the majority of their care in their local medical home, we reduce the often significant barriers which exist in having a patient seen by a specialist elsewhere. A regional hub-based program maximizes local resources and builds relationships. This model is well-researched and successful — Massachusetts is the "gold standard", but Minnesota and Oregon have also had similar models.

While this model may temporarily pull child and adolescent psychiatrists from direct patient care, past experiences have shown that by having more than one child and adolescent psychiatrist staff the line each week, this can work — and with the goal of keeping the patient in the care of their primary care medical home, the psychiatrist is freed up to see more patients with the most serious issues.

The Speaker's Task Force on Mental Health was an important move forward, and I am grateful for both the awareness the Task Force brought to this topic as well as the recommendations promulgated — this child psychiatry consultation line is one of them.

In summary, this proposal would be a key, important step forward in improving the health of children in Wisconsin by leveraging the relationships with primary care medical home, combining it with the power of expert specialty care, and connecting via modern communications. I ask the Senate Committee on Health and Human Services to give strong support to this bill.

Thank you.

MEDICAL COLLEGE OF WISCONSIN

Office of Government and
Community Relations

TO: The Honorable Members of the Senate Committee on Health and Human Services

FROM: Jon A. Lehrmann, MD
Charles E. Kubly Professor in Psychiatry and Behavioral Medicine
Chairman and Professor
Department of Psychiatry and Behavioral Medicine
Medical College of Wisconsin

DATE: January 9, 2014

RE: Testimony in Support of Senate Bill 359, related to the creation of a child psychiatry consultation program in Wisconsin

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Good morning Chair Vukmir and members of the Senate Committee on Health and Human Services. Thank you for holding this public hearing on Senate Bill 359, related to the creation of a Child Psychiatry Consultation Program in Wisconsin.

My name is Dr. Jon Lehrmann. I Chair the Medical College of Wisconsin's (MCW) Department of Psychiatry and Behavioral Medicine, and am also the Associate Chief of Staff for Mental Health at the Clement J. Zablocki VA Medical Center in Milwaukee.

I am here today representing MCW's support for this legislation. We are very grateful for Senator Alberta Darling and Representative Jim Steineke's leadership efforts in authoring and advancing this legislation. We would also like to credit Assembly Speaker Robin Vos for his leadership in the creation of the Speaker's Task Force on Mental Health.

The creation of the Task Force represented a vitally important endeavor, and could not have been timelier. Task Force Chairman Severson, along with the other Task Force members, should also be applauded for their tremendous leadership efforts and dedication toward advancing mental health care policy in Wisconsin.

Because the psychiatry shortage is so acute, primary care providers – such as pediatricians and family physicians - have by necessity become the front-line mental health care providers. Unfortunately, however, many of these clinicians do not receive extensive mental health care training in medical school or within their medical residency programs. These factors have unfortunately created a critical deficit of mental health care for patients within our state – and indeed across the nation as well.

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MCW's Patient Care mission is to provide cutting-edge, interdisciplinary and compassionate clinical care of the highest quality, and includes approximately 1,350 physicians and more than 500 nurse practitioners, physician assistants, and other health care practitioners. Within this mission, MCW and the Children's Hospital of Wisconsin have partnered to create the *Charles E. Kubly Child Psychiatry Access Project* – a pilot program to improve and expand mental health care to children by providing pediatricians increased access to child psychiatrists.

This project started in 2013 due to a generous gift from Michael and Billie Kubly, and is one of two child psychiatry consultation programs currently operating in the state. In Milwaukee, 92% of the clinicians who enrolled in the *Charles E. Kubly Child Psychiatry Access Project* initially reported being unable to meet the needs of children with psychiatric problems. One clinician even stated, "*I don't feel like we are good guides.*" 75% of these clinicians also believed that they should be able to deliver basic mental health services.

Even more concerning, the clinicians stated that there were no mental health resources to easily access in the region, creating frustration and the critical deficit of necessary care I mentioned earlier. One clinician said, "*There's just nothing... there are no answers,*" while another stated, "*It's extremely frustrating in Milwaukee where there are no services to refer to.*"

Only a year later, however, these same clinicians are reporting significantly increased levels of confidence in treating a variety of mental health care needs. One physician said, "*I needed my hand held for a bit... (but now I'm) feeling confident.*"

Milwaukee's experiences are not unique. This bill speaks directly to the needs and shortages across our entire state. By enacting this legislation, Wisconsin can reap two important benefits:

1) First, we can significantly increase mental health care access to children and adolescents on a case-by-case basis, without having to recruit significant numbers of additional psychiatrists.
2) Second, as we have seen with the *Charles E. Kubly Child Psychiatry Access Project*, the legislation will create long-term, educational value for the clinicians who utilize the consultation line. This will allow these clinicians to begin independently dealing with mild to moderate mental health conditions, reducing referrals and allowing greater access for patients with the most severe mental health needs.

We believe this legislation directly speaks to the experiences and successes that MCW and the Children's Hospital of Wisconsin have seen through the *Charles E. Kubly Child Psychiatry Access Project*, and that Wisconsin would receive very similar benefits from the enactment of this bill.

Our sincere desire is for this pilot program to be enacted into law, and subsequently expanded to include statewide coverage for Wisconsin's children in future biennia. A statewide implementation would eventually begin supporting the mental health care needs of thousands of children who currently lack even the most basic access.

Thank you again for your time and attention. I am available if you have any questions.

The Charles E. Kubly Child Psychiatry Access Project

at Children's Hospital of Wisconsin / Medical College of Wisconsin Department of Psychiatry & Behavioral Medicine

The Problem: **92%** of primary care clinicians initially reported being unable to meet the needs of children with psychiatric problems.

The Need: **75%** believe that, as primary care clinicians, they should deliver basic mental health services.

Without the Charles E. Kubly Child Psychiatry Access Project, Clinicians Said...

"There's just nothing... there are no answers."

"It's extremely frustrating in Milwaukee where there are no services to refer to."

"I don't feel like we are good guides."

One Year Into the Project, Clinicians Now Say...

"I needed my hand held for a bit... [but now I'm] feeling confident."

"If I have a question, honest to goodness they will respond quickly with the appropriate information so I have the tools in hand."

"I'll be disappointed if it doesn't continue forward, it's nice to have someone I know who I can go to with these questions."

*The **Charles E. Kubly Child Psychiatry Access Project** started in 2013 due to a generous gift from Michael and Billie Kubly. The program strives to improve and expand mental health care to children by implementing a linkage intervention. Pediatricians from two Milwaukee-area clinics have access to a child psychiatrist for general case consultation, as well as a case manager for community mental health resource information. This project also provides informed curriculum for pediatricians on management of psychiatric issues in their patient population, a second opinion clinic, and access to child psychiatry for diagnostic and management dilemmas. The project is a unique endeavor, as it is only one of two existing programs in the state.*

GUNDERSEN
HEALTH SYSTEM®

Testimony Presented by
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January 9, 2014

To Chairwoman Vukmir and the Senate Committee on Health & Human Services,

Introduction

- Eric Tempelis, Director of Government Relations
- I want to extend Gundersen Health System appreciation to Members of the Legislature and the Governor for your ongoing commitment to improving mental health in Wisconsin.
- Gundersen is an integrated healthcare system headquartered in La Crosse. Our service area covers 19 largely rural counties along the Mississippi River in the tri-state region of Wisconsin, Minnesota and Iowa.
- Our health system includes hospitals, dozens of clinics, medical education, air and ground ambulance and a health plan.

Gundersen's Behavioral Health Investments

- Gundersen provides a wide range of mental health services including inpatient, outpatient and day-treatment care.
- Earlier this year Gundersen opened a new inpatient behavioral health facility in La Crosse, which is already having positive impact on access and quality of care in our region. The facility is frequently at full capacity since opening, which attests to the high demand for inpatient services in our region.
- We are pursuing National Committee for Quality Assurance (NCQA) medical home recognition to provide care coordination and "healthcare for the whole person," not segmenting mental health from other medical conditions.
- We are also engaged in regular, ongoing collaboration with nonprofit (ie. NAMI) and government agencies focused on improving care and outreach to families in need.

What can the Legislature and Governor do to improve mental healthcare in Wisconsin?

- Mental health reform is a major, multi-dimensional undertaking with many layers and complexities.
- I appear before you today to share Gundersen's support for the following bills which we believe are vehicles with great potential for improving mental health delivery in western Wisconsin:

- AB 435/SB369—Admission of Minors for Inpatient Treatment
- AB 450/SB 362—Grants for Crisis Intervention Team Training
- AB 452/SB 359—Child Psychiatry Consultation Program
- AB 453/SB360—Uses & Disclosures of Protected Health Information
- AB 454/SB 366—Creation of a Primary Care & Psychiatry Grant Program
- AB 455/SB 368—Grants to Counties to Contract for Peer-Run Respite Centers
- AB 458/SB 410—Mental Health Benefits & Medicaid Reimbursement

- We believe these bills are an admirable attempt by the Legislature to overcome this complexity with the goal of improving outcomes for all Wisconsin citizens and families who are faced with mental health challenges.

Conclusion

Thank you for allowing me the opportunity to testify today. I would be happy to answer any questions when the time is appropriate.

JOAN BALLWEG
WISCONSIN STATE REPRESENTATIVE

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41ST ASSEMBLY DISTRICT

SB 127/AB 360: Emergency detention, involuntary commitment, and privileged communications and information.
SB 126/AB 435: Admission of minors for inpatient treatment.
Testimony of State Representative Joan Ballweg
Senate Committee on Health and Human Services
January 9, 2014

Thank you, Chair Vukmir and members of the Health and Human Services Committee for hearing Senate Bills 126 and 127. Both of these bills were part of the Legislative Council Special Committee on Chapter 51, which originally began work on this topic during the 2010 interim.

Senate Bill 127/Assembly Bill 360 does the following:

- Expands the criteria for taking an individual into emergency detention to include a determination "...that detention is the least restrictive alternative appropriate to the person's needs."
- Creates a "purpose" statement for the emergency detention statute. The statement says that the purpose of emergency detention is to provide, on an emergency basis, treatment by the least restrictive means possible, to individuals who meet all of the following criteria: (a) are mentally ill, drug dependent, or developmentally disabled; (b) evidence one of the statutory standards of dangerousness; and (c) are reasonably believed to be unable or unwilling to cooperate with voluntary treatment.
- Provides that the county department may approve the detention only if the county department reasonably believes the individual will not voluntarily consent to evaluation, diagnosis, and treatment necessary to stabilize the individual and remove a substantial probability of physical harm, impairment, or injury to himself, herself, or others.
- Modifies the emergency detention statute applicable to Milwaukee County that requires the treatment director of the facility in which the person is detained, or his or her designee, to determine within 24 hours whether the person is to be detained. The bill provides that when calculating the 24 hours, any period delaying that determination that is directly attributable to evaluation or stabilizing treatment of non-psychiatric medical conditions of the individual shall be excluded from the calculation.
- Eliminates that provision in the statutes that commitments that are based on the 4th standard of dangerousness may not continue longer than 45 days in any 365-day period.

- Repeals the provision that an involuntary commitment of an inmate in a state prison or county jail or house of correction ends on the inmate's date of release on parole or extended supervision.

Senate Bill 126/Assembly Bill 435 changes these provisions:

- Eliminates the need to file a petition for review of an admission of a minor under age 14 for treatment of mental illness, alcoholism or drug abuse, or developmental disability. A petition would still be required if a parent refused to consent to treatment; if a parent with legal custody or guardian cannot be found; or if there is no parent or guardian.
- Eliminates the need to file a petition for a minor age 14 to 17 who is voluntarily participating in inpatient treatment for mental illness. A petition would still have to be filed if the minor refused to join in the application; if the parent with legal custody or the guardian could not be found; or if there were no parent with legal custody or guardian. A petition would also still be required if the minor wanted treatment but the parent refused.
- Eliminates the petition requirement at the time that a short-term admission of 12 days expires, if the admission was voluntary on the part of the minor and the parent.
- Eliminates the provision that allows for no more than one short-term (up to 12 days) voluntary admission of a minor every 120 days.

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

The Speaker's Task Force on Mental Health then reviewed the Legislative Council special committee and recommended legislation. As a member of the Speaker's task force, I can attest to how thoroughly we vetted the Chapter 51 Legislative Council bills. I ask for your support today to further this important legislation.

Thank you for your time and to the office of Senator Lazich for her work on this issue. I'm happy to answer any questions.

INTERGOVERNMENTAL RELATIONS
Milwaukee County

Testimony of Eric Peterson, on behalf of Milwaukee County

SB 127 & AB 360 – Emergency Detention & Involuntary Commitment

Senate Committee on Health

Thursday, January 9, 2014

Honorable Chairwoman Vukmir and members,

Thank you for taking testimony today on Senate Bill 127 and Assembly Bill 360, companion Joint Legislative Council bills on emergency detention, involuntary commitment and privileged communications. Milwaukee County supports this bill with particular emphasis of support for the provisions relating to tolling the 24 hour period in Sections 8 and 9 of the bill. The County Executive and Board extends their thanks to the members of the Joint Legislative Council's Special Committee on Review of Emergency Detention and Admission of Minors under Chapter 51 for their inclusion of this bill in their final report. We appreciate the bipartisan recommendation to approve this measure from the Speaker's Taskforce on Mental Health.

Too often under current law, the 24 hour period for a determination of an emergency detention is simply wasted while the patient receives medical care or other medical evaluation. Hence, the time actually allowed for determination for detention may be too short or in some cases, expire before a determination may begin. Tolling this period to begin following medical stabilization will allow for better evaluations for determinations for detention, release, or a community services placement.

This provision of the bill is of particular importance to the professionals in our county who work every day in this field. This provision will allow a thorough qualified determination for detention of a patient after they are stabilized for non-psychiatric conditions. Without this tolling of the time period, and due to the legal nature of an emergency detention, clinicians and law enforcement may never legally be able to address the mental health needs of the patient.

On behalf of Milwaukee County, I urge your support of this bill and am happy to answer questions as they arise. Thank you.

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WISCONSIN HOSPITAL ASSOCIATION, INC.

January 9, 2014

To: **Members of the Senate Committee on Health and Human Services**

From: **Matthew Stanford, WHA VP Policy & Regulatory Affairs, Associate General Counsel**
Kyle O'Brien, VP Government Relations

Re: **WHA Supports Assembly Bill 360, But Recommends that the Legislature Closely Monitor the Effect of the Two Provisions of the Bill Once Enacted**

The Wisconsin Hospital Association (WHA) was pleased that the Joint Legislative Council in 2010 formed the Special Committee on Review of Emergency Detention and Admission of Minors Under Chapter 51," (the "Study Committee"), and appreciates the work undertaken by the Study Committee on a challenging area of patient care, law, and public policy. Guided by a Mental Health Task Force formed by WHA in late 2008, WHA has been engaged in the work of the Study Committee, the Joint Legislative Council, the Speaker's Task Force on Mental Health and other efforts to identify and enact public policy that will increase the likelihood that individuals with mental health needs throughout Wisconsin consistently receive the right care, at the right time, and in the right setting. Assembly Bill 360 is one output of the Study Committee's work, and WHA offers the following comments on the bill for your consideration.

WHA supports Assembly Bill 360, but has previously expressed concerns that two provisions in the bill – the earlier start to the emergency detention "72 hour clock" and the new language requiring law enforcement to determine that an emergency detention is the "least restrictive" alternative - may unintentionally decrease the likelihood that individuals with urgent mental health needs consistently receive the right care, at the right time, and in the right setting. WHA has previously offered alternatives to those concerning provisions.

WHA and its member hospitals will monitor the practical results of those two provisions of AB360 once enacted. <u>WHA recommends that the Legislature similarly monitor the implementation of AB 360 and in the future consider additional revisions to those provisions as needed to address unintended consequences of the two provisions that arise following enactment.</u>

Area to Monitor #1 – AB 360 sets an earlier start to the emergency detention "72 hour clock," which for some patients will give mental health care providers <u>less</u> time to psychiatrically stabilize an individual in "imminent danger" and avoid a full, long-term commitment.

When an individual is brought to a hospital psychiatric unit under an emergency detention, the psychiatrist's goal is to work to stabilize the individual's condition so that an imminent danger no longer exists and the person can avoid long term commitment. Because of this care, many individuals on an emergency detention can be released without having to proceed to a probable cause hearing for a full, long-term commitment.

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If an individual is under an emergency detention, current law states that the emergency detention be ended or commitment proceedings must begin within 72 hours of the individual's arrival at "the emergency detention facility." Assembly Bill 360 amends Wisconsin law so that the "72 hour clock" starts earlier, at the time the individual is taken into custody by law enforcement. The practical result of this change is that health care providers will have less time to psychiatrically stabilize an individual that is subject to an emergency detention.

This change could be particularly problematic for individuals that may have life threatening physical injuries (such as from a suicide attempt) that require treatment before an individual can be transferred to an emergency detention facility for psychiatric stabilization. Further, this change will particularly impact the time available under an emergency detention to psychiatrically stabilize individuals in rural areas, as the change in the start of the "72 hour clock" does not take into account that significant travel may be required to transport an individual to an emergency detention facility.

Area to Monitor #2 –AB 360's new requirement that law enforcement determine if an emergency detention is the "least restrictive alternative" will likely result in inconsistent interpretation and practice.

One policy goal that the Study Committee discussed was to work to clarify in law a principle that individuals that truly agree to stabilizing treatment should not be subject to an emergency detention. WHA is supportive of that goal, but has raised concerns that the language used to achieve that goal unnecessarily uses legal jargon that will result in inconsistent application of the law and ultimately result in some individuals not getting the emergency help that they need.

Specifically the bill will require law enforcement, before they initiate an emergency detention, to determine "that taking the person into custody is the *least restrictive alternative* appropriate to the person's needs." While county crisis workers may be in a position to determine what is a "least restrictive alternative," WHA has concerns that law enforcement is not in the best position to make such determination. To ensure more consistent application of the law, WHA has previously recommended removing the proposed least restrictive jargon and instead amending law to **plainly state** that law enforcement may not take individuals that truly agree to stabilizing treatment into custody under an emergency detention.

If you have any questions, please feel free to contact Kyle O'Brien (kobrien@wha.org) or Matthew Stanford (mstanford@wha.org) at 608-274-1820.

Mental Health America of Wisconsin

Testimony to the Senate Committee on Health and Human Services
Shel Gross, Director of Public Policy

Thank you for your consideration of a number of bills addressing mental health services and related issues. Together these bills build upon unprecedented support for expanding access to mental health treatment and intervention that began during the 2013-2015 biennial budget process. Importantly, these bills build on the budget initiatives to create a stronger system of care for children and adults experiencing mental health disorders; one which supports earlier intervention and recovery.

Mental Health America of Wisconsin (MHA) did not take a position on the following bills:

- SB360, Protected Health Information: MHA recognizes the value of sharing information to improve integrated health care but has been concerned about the lack of input that consumers and family members have indicated they have had into the development of this bill. There is a strong sentiment within the mental health community that sharing of personal mental health information should remain voluntary and if there are information system limitations in exercising this right then the onus is on those information systems. Unfortunately there have been many instances where medical providers, learning about a person's mental illness, discount what are legitimate physical health complaints; often with serious medical consequences to the individual. MHA recommends that if you support this bill that you also consider support for legislation that we anticipate to fund efforts to reduce stigma and discrimination against individuals due to their mental health conditions.

- AB488, Involuntary Commitments: This bill replaced AB451 which MHA strongly opposed. While MHA is not clear that this legislation is needed we can live with the impact this bill will have.

- SB369, County Performance on Providing Core Mental Health Services.

MHA supports the following bills:

- SB362, Grants for Crisis Intervention Team Training: Crisis Intervention Training has enhanced law enforcement's ability to respond more appropriately to individuals with mental illnesses enhancing the likelihood for a positive outcome. Law enforcement officers who have taken the training report that it has greatly benefited them in dealing with often challenging situations.

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- SB359, Child Psychiatry Consultation Program: This bill is based on a program from Massachusetts which was shown to greatly increase the ability of pediatricians and primary care providers to work with youth with emotional disturbances. Given the serious shortage of child psychiatrists in most of Wisconsin this bill makes efficient use of existing resources to better meet the mental health needs of these young people. We support the bill as amended by the Assembly.

- SB366, Primary Care and Psychiatry Shortage Grant Program: This bill will address the extreme shortage of psychiatry services in many areas of Wisconsin by creating residency opportunities. We support the bill as amended by the Assembly.

- SB368: Grants to Establish Peer-Run Respite Centers: This bill will support the expansion of peer-run respite, a cost-effective alternative that can mitigate the need for emergency services. We support the bill as amended by the Assembly.

- SB409, Individual Placement and Support Program: This bill will support expansion of an evidence-based program for employment of people with serious mental illnesses, which in turn will support the recovery of these individuals. People with mental illnesses want to work but often need specialized supports in order to begin this process. We support the bill as amended by the Assembly.

- SB410, Mental Health benefits and Reimbursement for services under Medicaid: this bill addresses current prior authorization practices that are inconsistent with best practices.

- SB362, Grants for Mental Health Mobile Crisis Teams: This bill will support the development of mobile crisis in rural areas allowing a more effective intervention for someone in a mental health crisis, and often allowing for a response that does not involve incarceration.

SB127/AB360, Emergency Detention, Involuntary Commitment and SB126/AB435, Admission of Minors for Inpatient Treatment: These bills address a variety of changes to current statute developed by the Legislative Council Study Committee on Chapter 51. MHA appreciates the considerable efforts of this study committee to work through the challenging issues of balancing individual rights with timely access to treatment.