Wisconsin Legislative Council

MINUTES

STUDY COMMITTEE ON EMERGENCY DETENTION AND CIVIL COMMITMENT OF MINORS

411 South, State Capitol
Madison, WI
September 25, 2024
10:00 a.m. – 4:02 p.m.

CALL TO ORDER AND ROLL CALL

Chair James called the meeting to order and it was determined that a quorum was present.

COMMITTEE MEMBERS PRESENT:	Sen. Jesse James, Chair; Rep. Patrick Snyder, Vice Chair; Sen. LaTonya Johnson; Rep. Shelia Stubbs; and Public Members Sheila Carlson, Jill Chaffee, Cody Horlacher, Kristen Iniguez, Maryam James, Sharon McIlquham, and Tony Thrasher.
COMMITTEE MEMBER EXCUSED:	Public Member Katie York.
COUNCIL STAFF PRESENT:	Margit Kelley and David Moore, Principal Attorneys; and Kelly McGraw, Staff Attorney.
APPEARANCES:	Elizabeth Manley, LSW, Faculty and Senior Advisor for Health and Behavioral Health Policy, University of Connecticut; Kathy Markeland, Executive Director, and Emily Coddington, Associate Director, Wisconsin Association of Family and Children's Agencies (WAFCA); Megan Reis, Family Services NEW Crisis Center, Toni Maves, Journey Mental Health Crisis Unit, and Heather Hainz, Northwest Counseling & Guidance Crisis Services; and Scott Strong, RISE Wisconsin, Heather Yaeger and Kristen Fischer, Lutheran Social Services of Wisconsin and Upper Michigan (LSS), and Terri Gowey, CEO, Chileda.[1]

APPROVAL OF THE MINUTES OF THE AUGUST 21, 2024 MEETING

Sharon McIlquham moved, seconded by Representative Snyder, to approve the minutes of the August 21, 2024 meeting. The motion was approved by unanimous consent.

[1] The speakers' PowerPoint presentations and handouts are available on the committee's website.

PRESENTATION ON YOUTH BEHAVIORAL HEALTH SYSTEMS DESIGN BY ELIZABETH MANLEY, LSW, FACULTY AND SENIOR ADVISOR FOR HEALTH AND BEHAVIORAL HEALTH POLICY, UNIVERSITY OF CONNECTICUT

Elizabeth Manley presented to the committee on the design of behavioral health systems. She began by telling the committee that it is important to design a behavioral health system that quickly addresses children's behavioral health needs because many high intensity contacts with behavioral health systems are preventable. She emphasized that one of the challenges states have in designing behavioral health systems is determining how to get to a point where everyone in the state knows how and when to access care, and what care might look like.

She explained that "systems of care" help organize and design common language, common culture, and a common access point where the same questions are asked and the same considerations are made for all young people. These systems must, however, be grounded in various principles, including: shared leadership in governance; a role for young people and families in designing systems that make sense for them; cultural and linguistic competency; and a robust array of services. She also said it is important that a system address the sense of urgency that young people and their parents and caregivers have around their care, and that any system address upstream needs in addition to the most high intensity needs.

Ms. Manley then described the various components involved in system transformation. She explained that they include: understanding what services are delivered at what time and for what duration; improving youth and peer support; mobile response and stabilization (MRSS), which she defined as the customization of the crisis system in the state to address the unique needs of the kids and families who need help; intensive care coordination; access to a robust array of services, including in-home services; a single point of access for families to request help when they need it; and training and technical assistance. She emphasized that the primary objective of all of these systems is to keep kids in their own homes, schools, and communities, and that it is important to deliver the right service at the right time for the right duration.

She then offered a number of policy considerations that should be part of designing a behavioral health system. These include: a vision for public health that allows any family who feels they need care to access it when they need for the duration they need it; financing that maximizes available Medicaid, braided, and blended funding; clarity regarding who is responsible for the service array; and consideration of continuing management tools, such as data collection and transparent processes.

Ms. Manley then described the MRSS program for youth in New Jersey, which she helped implement. She explained that it involves a face-to-face response from a trained professional in the family's home within one hour. The program focuses on crisis de-escalation and is available 24 hours a day, 365 days a year. Under the program, the family defines the crisis. After the initial response, the program also includes up to eight weeks of stabilization, which involves connection to community supports and services; reconnection with community activities; and in-home clinical support for the youth and family.

Ms. Manley responded to a variety of questions from the committee members, including questions related to the following: the qualifications of the person responding to a youth in crisis under the MRSS program; the structure for the single point of access to the MRSS program, which incorporates a well-known toll-free number, 988, and child protective services; and best practices for mental health screenings and behavioral health consultations for minors. Ms. Manley also described the integration and use of psychiatric residential treatment facilities (PRTFs) in New Jersey's continuum of care.

PRESENTATION BY KATHY MARKELAND, EXECUTIVE DIRECTOR, AND EMILY CODDINGTON, ASSOCIATE DIRECTOR, WAFCA

Kathy Markeland provided background information about WAFCA. She explained that WAFCA promotes public policy, best practice, and partnerships that support member agencies, which include private, for profit, and nonprofit human service agencies, in pursuing their mission to improve the lives of individuals, children, and families.

Emily Coddington highlighted some aspects of New Jersey's system that she found instructive. In particular, she underscored the importance of the training New Jersey provides staff as well as the ability of New Jersey PRTFs to flex services to adjust to population needs.

Ms. Coddington then provided the operational context of child welfare licensed services in Wisconsin. She observed that Wisconsin has many smaller, more specialized residential centers, which creates significant variation between service providers. She said this can be beneficial because it provides options for different types of populations, but it also means that providers are only licensed for specific types of care. She also explained some differences between residential care centers (RCCs) and PRTFs. She emphasized that RCCs in Wisconsin are primarily focused on providing therapeutic "placements," not "treatment." She also clarified that kids who are placed in RCCs are primarily coming in through the child welfare or juvenile justice system, rather than through the behavioral health system.

Ms. Coddington and Ms. Markeland then identified various barriers to youth mental health service in Wisconsin, including regulatory barriers and workforce issues. With respect to regulatory barriers, Ms. Coddington recommended: allowing providers to video record in common areas of RCCs to enhance the safety of staff and residents; extending a liability limitation that currently applies to adult residential care providers to include behavioral health clinics and licensed agencies caring for children; and allowing RCCs to use locked units if needed for safety. With respect to workforce issues, Ms. Markeland suggested a variety of ways in which infrastructure and investments in childcare and healthcare could be expanded to address workforce shortage problems. Among other suggestions, she encouraged the committee to think about how the state might better utilize available Medicaid resources.

Ms. Markeland and Ms. Coddington provided the following three broad recommendations for the committee's consideration:

- Support legislation to: create a process for certifying PRTFs; allow video recording in certain areas of PRTFs; and provide a liability exemption for providers operating in behavioral health clinics and licensed agencies caring for children.
- Create a comprehensive children's mental health code to ensure children do not have to enter the child welfare or youth justice systems to receive ongoing mental health services.
- Invest state dollars to support a statewide infrastructure of prevention services, such as respite care, intensive residential care, and a high-quality workforce.

Ms. Markeland and Ms. Coddington responded to various questions related to PRTFs, Medicaid payment issues, residential care services and certification options, the Wisconsin 211 service, and the need for children to have a single point of entry to access a complicated system of services.

PRESENTATION ON EMERGENCY DETENTION ASSESSMENTS, COMMUNITY-BASED SERVICES, AND OTHER CRISIS RESPONSE SERVICES BY MEGAN REIS, FAMILY SERVICES NEW CRISIS CENTER, TONI MAVES, JOURNEY MENTAL HEALTH CRISIS UNIT, AND HEATHER HAINZ, NORTHWEST COUNSELING & GUIDANCE CRISIS SERVICES

Megan Reis described the services that Family Services provides, by contract, to Brown County. She explained that Family Services operates a 24-hour, walk-in facility and provides mobile services 24 hours a day. She then described the process and tools used for conducting assessments, the majority of which, she said, are conducted at hospitals.

Ms. Reis also shared information about crisis plans they develop for individuals. These plans include weekly check-ins with an assigned crisis counselor and assistance with continuity of care. A crisis plan lasts for up to six months, must be voluntary, and is only an option for clients who are not case-managed.

Toni Maves described the crisis services Journey provides in Dane County, and highlighted various options it can provide as less restrictive alternatives to emergency detention. She explained that these options include providing check-in calls, home visits, assessments at school, connecting with the individual's outpatient treatment team, respite care, safety planning, and coordinating voluntary hospitalization.

Ms. Maves also described how Journey determines whether to pursue the emergency detention of an individual. She emphasized that any decision to pursue emergency detention must be made both by the mobile crisis worker and law enforcement together. She explained that in the event a person is hospitalized, whether voluntarily or involuntarily, Journey monitors the individual's hospitalization and engages in discharge planning. She said that there are various discharge planning options, including returning the person to their home, placement in a shelter or juvenile center, or residential treatment.

Ms. Maves noted some preliminary recommendations for the committee, including supporting other options, such as a youth crisis stabilization facility, when it is not possible for a youth to stay with the family or caregiver, extending the time period for an emergency detention in order to have a more effective intervention, and reducing the role of law enforcement officers in making mental health care decisions.

Heather Hainz explained that Northwest Connections contracts with 34 counties to provide crisis services through telephone and mobile teams. She told the committee that while they try to keep a standard practice, there are operational differences between counties. She also explained that the counties with which they contract do not all contract for the same services; for example, some counties contract with Northwest Connections primarily for after-hours services. She said that the counties in which they provide a wider array of services to tend to be more rural.

Ms. Hainz stressed the importance of providing least restrictive interventions, both from a clinical and financial perspective. She also stressed the unique challenges rural counties face that underscore the need to provide less restrictive interventions that can be offered in the community of the individual who is in crisis. For example, there are significantly fewer facilities for accepting emergency detentions in these counties, so minors who are detained are often transported long distances in handcuffs. She also said that taking individuals to bigger cities can be stressful for the individuals who are more comfortable in smaller communities.

Ms. Hainz provided a number of recommendations to the committee, including supporting youth crisis stabilization facilities, PRTFs, in-home family therapy, and parent education. Ms. Hainz also recommended that a child should be able to consent to residential placement, even without a parent's consent, and that placement orders should not be limited to orders under the child welfare and juvenile justice systems.

In response to questions from committee members, the three presenters highlighted the difficulties in sharing information between providers and responders, and even between day and after-hours service providers. The presenters noted that counties differ on their approach to sharing information about a child's safety plan or crisis plan.

PRESENTATION ON YOUTH DIVERSION, STABILIZATION, AND RESIDENTIAL SERVICES BY SCOTT STRONG, RISE WISCONSIN, HEATHER YAEGER AND KRISTEN FISCHER, LSS, AND TERRI GOWEY, CEO, CHILEDA

Heather Yaeger and Kristen Fischer described LSS's in-home youth diversion program that is operating in five counties. They explained that the program is a voluntary service that provides emergency mental health support to families of youth up to age 18. They said that the purpose of the program is to allow youth experiencing crisis to receive services from experienced providers while remaining in their own home.

Ms. Fischer explained that individuals are referred to the in-home youth diversion program through county partners, such as county crisis workers. She told the committee that the services focus on family support, finding natural supports, and teaching basic techniques and tools that will help in future situations. She explained that after a family has been referred to the program, they will typically set up a call schedule with the family to check in with the youth and the parents, and that the program works closely with county crisis services and law enforcement to keep the youth safe. She stated that the services are covered by Medicaid.

Terri Gowey described Chileda's short-term empowerment program (STEP). She explained that the STEP program is a 6-12 month Department of Children and Families-funded program that provides intensive treatment for children with complex needs that focuses on including the family and the child in a behavioral and skill development plan. In addition to working with families to help with needs, they work with counties, law enforcement, and other stakeholders to develop a long-term plan for the child's needs after discharge.

Ms. Gowey offered various recommendations for the committee's consideration. These included making treatment available at a younger age, ensuring that supports are available for families when children remain in the home, setting up systems that allow families to get help when they first ask for it, and providing group homes or level 5 homes for individuals with severe and profound autism that need 24/7 support.

Scott Strong explained that RISE Wisconsin provides wraparound care from birth through young adulthood under the following three programming pillars: early childhood home visitation; various mental health supports; and crisis services. He explained that RISE takes a "community first" approach that looks for ways to keep an individual safe and stable in the community rather than in an institution. He emphasized the importance of the relationships they build through their wraparound approach to comprehensive community services because these relationships provide them with opportunities to divert individuals from hospitalization before they get to the point of crisis.

Mr. Strong then described that RISE Wisconsin's respite center, while not set up as a hospital diversion center, has effectively served that purpose for many of the kids with whom RISE has worked. He explained that the respite center is a safe and stable place for children to go. It is dually licensed as a child care center and a group home, so it can accommodate children, up to age 14, for several hours or overnight. Referrals can come from anywhere in the county, and last year they served 461 unduplicated children from 227 unduplicated families. Mr. Strong explained that the availability of respite care is crucial and can be instrumental in helping prevent behavioral health crises.

ROUNDTABLE ON MEMBERS' PRIORITIES FOR THE COMMITTEE

Chair James explained that his priorities for the study committee are getting law enforcement out of medical and behavioral crisis interventions, except when necessary, and providing a process for PRTFs to operate in Wisconsin. He then invited committee members to share their thoughts about how the committee should focus its work. Committee members identified a variety of additional issues, including the following:

- Reducing regulatory barriers to service.
- Investing in early mental health care for kids.
- Enhancing options throughout the continuum of care, including respite care.
- Ensuring that services are available to children and families when they seek them and before needs escalate to crises; providing the right level of care at the right time.
- Establishing central oversight and accountability for the delivery of children's behavioral health services, addressing inconsistency in procedures, and ensuring equity in care among the counties, using regionalized services.
- Improving information sharing and evaluating how to integrate children's and youth service systems.
- Examining opportunities to better utilize funding resources.
- Exploring models like New Jersey's MRSS program, with a single access point and reduced law enforcement involvement.

PLANS FOR FUTURE MEETINGS

Chair James reminded members that the committee has scheduled the next meeting for October 30, 2024, in Room 411 South, State Capitol Building.

ADJOURNMENT

The committee adjourned at 4:02 p.m.

DM:ksm