Dane County Behavioral Health Needs Assessment

October 2019

PUBLIC CONSULTING GROUP

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1. EXECUTIVE SUMMARY

Dane County Department of Human Services (DHS) contracted with Public Consulting Group, Inc. (PCG) to review the behavioral health system across providers and funders in the Dane County community and asked PCG to provide recommendations aimed at improving the availability and accessibility of behavioral health care in the County. In its request for proposals (RFP) DHS posed a series of questions to the vendor community which PCG, as the selected vendor, answers in this report. The following report share PCG's findings on the behavioral health system in Dane County and related recommendations. These recommendations are based on data analysis, stakeholder input, and research into national best practices.

Our analysis began with a population review examining factors such as Dane County's demographic profile, prevalence of mental health conditions and substance use disorders, penetration rate of services, and service utilization. Included in these findings is that most of Dane County's population self-identifies as White, Non-Hispanic, lives in urban/suburban settings, and is between the ages of 18-65 years old. Next, we scanned the continuum of care to identify how individuals access services by payer and utilization for each service type. Amongst our findings is the fact that, although crisis represents a relatively small portion of services rendered by DHS, the number of unique individuals accessing mental health crisis services paid through DHS increased 77% from 2017 to 2018.

We compared utilization for self-identified racial groupings and analyzed DHS's follow-up and readmissions rates to compare with national rates. We found that utilization does vary across racial groups and that, overall, DHS's readmission rates are similar to what is reported nationally.

Additionally, several questions surrounding mental health and the justice system are within the scope of this study. PCG reviewed Dane County law enforcement practices across jurisdictions, diversion options, and restorative justice options. PCG also compared emergency detention practices of the County and Wisconsin as a whole to those of similar states. We found that the while Madison Police Department's (PD) Crisis Intervention Team model (CIT) is a national best practice it is not replicated across the County. We also note that time spent by law enforcement during the emergency detention process, specifically due to transporting individuals, takes significant resources away from the Madison Police Department amongst our other findings.

To evaluate whether a crisis restoration center would be beneficial in Dane County, PCG compared services available throughout the County with those found at a crisis restoration center. We found that, when comparing services offered at a crisis restoration center to those available in Dane County, the County is missing 23-hour observation beds and 24/7 crisis services options and that the County has access issues with a lack of dedicated law enforcement drop-off and physical co-location of behavioral, medical, and social supports.

All of the above findings and more are detailed in the following report and include supporting data, research, and analysis. This analysis led to PCG providing seven recommendations in the report. Each recommendation includes a detailed description of the recommendation, suggestions on the parties required to fully implement it, and other key implementation considerations.

Our recommendations are as follows:

1. **Maximize capacity through better facility and provider coordination**: Capacity analysis shows that some facilities are overutilized, while others are underutilized. PCG recommends conducting a root cause analysis to determine reasons underpinning lack of utilization for certain providers. After the root cause analysis, PCG recommends Dane County collaborates with Medicaid and commercial payers to centralize resource information and educate advocates, clients, and providers about all care options with the goal of using existing capacity more effectively;

2. **Establish formal partnerships between providers and facilities**: Formal relationships can ease the administrative burden of finding placements for individuals in need of various levels of care. Ensuring that providers and facilities have formal connections with partners across the continuum of care can also help reduce facility capacity issues;
3. **Develop additional services to reduce gaps in crisis care**: One notable gap within the continuum of care is the absence of 23-hour observation beds. These extended observation beds help reduce emergency room and inpatient care for behavioral health crises. Currently, crises that occur after hours in Dane County are largely managed by hospital Emergency Departments;
4. **Improve access to care for underserved populations**: PCG recommends that Dane County work with community organizations to create and implement a strategic plan to improve access to underserved populations. This should include identifying key resources, metrics, and outreach/in-reach strategies to effectively engage individuals in need and meet people where they are in their communities;
5. **Increase diversion options**: In Dane County, there are several diversion programs available across the behavioral health and criminal justice system intercepts, however few specifically focus on mental health. PCG recommends developing diversion models that are specifically focused on mental health and/or co-occurring disorders to include both a pre-arrest and post-arrest option;
6. **Extend crisis response to rural areas**: The Madison Police Department is a national example for law enforcement response to mental health crisis. However, the same practices are not duplicated across the county, specifically in rural areas. Outside of the Madison Police Department, only the Dane County Sheriff's Office has a dedicated crisis worker, and that position is only half filled; and,
7. **Create infrastructure for cross-sector, data-driven decision making**: The current Memorandum of Understanding (MOU) Coordinated by the Criminal Justice Council (CJC) in Dane County does not include behavioral health providers. Dane County could benefit from including behavioral health providers as part of this MOU, specifically to better track frequent users of the criminal justice system who also have a mental health disorder.

Each of these recommendations is explored in more detail at the conclusion of this report.

2. PURPOSE AND SCOPE

The Dane County Department of Human Services (DHS) contracted with Public Consulting Group, Inc. (PCG) to assess the efficacy of the behavioral health system in the County and, in doing so, determine whether the residents of county would benefit from the addition of a crisis restoration center.

This report addresses the following research topics, as outlined in PCG's scope of work from DHS:

1. Service Accessibility, Effectiveness and Adequacy
    - Wait times and contractual obligations
    - Comparison to national and state outcomes
    - Outcomes disparities across population demographics
2. Impact of law enforcement practices
3. Resources in lieu of incarceration and Chapter 51
4. Restorative justice interventions

These areas are analyzed through a combination of stakeholder input, data analysis, and best practice research. Stakeholder input was received through a combination of in-person interviews, focus groups, and phone calls. Data came from both Dane County and the Wisconsin Health Information Organization (WHIO), and best practice research was performed through a variety of channels.

Through these efforts this report presents and analyzes the current behavioral health system in the County.

2.1 REPORT STRUCTURE

The report begins with a review of the current population of Dane County, including key demographics and behavioral health condition prevalence. We then describe the Care Continuum, defined as reviews of care pathways under different payers, prevention efforts underway, community-based efforts, crisis care, inpatient care, step-down & residential care, case management & transitional supports, and finally housing.

Next, we review Outcomes and Disparities with a focus on outpatient, crisis, and inpatient outcomes. Racial and ethnic disparities are analyzed in each category. We then move to a focus on law enforcement, looking at their practices as well as the state's emergency detention law as compared to other states. Finally, we assess Crisis Restoration Centers and the role one may play in Dane County.

The report concludes with PCG's recommendations. We make recommendations on improving the continuum of care, options for diversion programs, and proceeding with data-driven decision making.

Throughout the report, we reference stakeholder input received during the data collection stage of our work. To support the above research needs, PCG completed a series of focus groups and individual interviews with stakeholders identified by the County and individual referred to us by County-identified stakeholders. All stakeholders were invited to participate in one of the focus groups described in Table 1. Focus groups were scheduled based on collective participant availability and maximal representation across stakeholder groups.

Table 1. Focus Group Participant Summary.

Focus Group	Target Participants	Intent
Care Delivery	• Community, outpatient and inpatient providers • Peer support workers • Resource center representatives	Discuss service delivery across the care continuum, including known gaps, access challenges and goals for the future system.
Intersection of Behavioral Health and Public Safety	• Public safety • Resource centers • Peer support workers • Community and outpatient providers	Understand coordination of public safety and behavioral health, including successes and challenges of existing partnerships and goals for the future system.
Access and Outcomes	• Advocacy and consumer groups • Non-behavioral health community providers	Assess access to behavioral health services across populations and communities, including challenges and goals for the future system.

Individuals who were unavailable to participate in focus groups were contacted to schedule individual and/or organizational interviews. Interviews were conducted telephonically by members of the PCG project team using a standard interview guide (see Appendix A) for each stakeholder type. In total, approximately 60 percent of stakeholders recruited for this engagement were willing and able to participate in the process:

- 104 stakeholders were contacted for participation
- 50 stakeholders participated in focus groups
- 11 stakeholders participated in individual or organizational interviews

Additionally, available representatives from Medicaid HMOs serving Dane County were interviewed to determine the extent to which Medicaid supports behavioral health in the community and challenges experienced.

We additionally attempted to contact commercial insurers serving the area through two health plan associations. No insurers responded to our interview requests. References to commercial health plan coverage and utilization in this report are based on data received from WHIO as well as publicly accessible information from the System for Electronic Rates and Forms Filings (SERFF).

3. POPULATION ANALYSIS

3.1 DEMOGRAPHIC PROFILE

The following figures summarize the demographics of Dane County's 536,416 residents.[1] Over twenty percent (20.7%) of Dane's population is below the age of 18 and 13.2% are 65 years old and over. The racial ethnic breakdown of Dane County is as follows:

- African American: 5.1%
- American Indian and Alaskan Native: 0.5%
- Asian: 6.2%
- Native Hawaiian/Pacific Islander: 0.1%
- Hispanic: 6.5%
- Non-Hispanic White: 79.6%

With Madison as the major population center of the County, it is not surprising that those living in rural areas make up just 12.3 percent of the total population with 87.7 percent residing in urban settings. The median income of Dane County is $72,400 with and 11 percent living below the poverty line. Nine percent of Dane's children are below the poverty line.

In terms of health insurance coverage, commercial coverage, including employer sponsored insurance (ESI) covers the bulk of Dane's residents. Specific figures by coverage type are:

- Commercially Insured/ESI: 70%
- Medicaid: 11.5%
- Medicare: 14%
- Uninsured: 4.3%
- Tricare: >1%

3.2 CONDITION PREVALENCE

The Wisconsin Department of Health Services (WDHS) estimates 77,563 adults in Dane County have experienced a mental health illness, 18.2 percent of the adult population.[2] Serious mental illnesses (SMI) are defined as mental, behavioral, or emotional disorders that result in an impairment interfering or limiting one or more major life activities.[3] WDHS estimates 16,505 adults in Dane County have experienced SMI.[1] This accounts for 3.9 percent of Dane's population. Nearly ten percent (9.45%) of persons over 12 years of age have experienced substance use disorder, with 41 percent of those individuals experiencing a co-condition of a mental health condition.[1]

For youth, the WDHS estimates 16,557 children have experienced a mental illness, which represents 3% of total youth population.[1] Serious emotional disturbance (SED) is the youth equivalent to SMI. In Dane County, 1.6% of children (8,673 children) have experienced a SED.[1]

3.3 OVERALL PENETRATION RATE

Penetration rate is the number of unique individuals accessing services versus the estimated number of individuals living with a behavioral health condition. Penetration rates were calculated across mental health

[1] https://www.countyhealthrankings.org/app/wisconsin/2019/rankings/dane/county/outcomes/overall/snapshot
[2] https://www.dhs.wisconsin.gov/publications/p00613-17.pdf
[3] https://www.nimh.nih.gov/health/statistics/mental-illness.shtml

services and substance dependence related services either as reported to the Wisconsin Health Information Organization (WHIO) or reimbursed by DHS.

Table 6 shows the results of the penetration rate comparison between Dane County, Milwaukee and Waukesha Counties (selected as comparison counties due to their similar population size), and the state of Wisconsin as a whole. Given the lack of county payment data for all non-Dane counties, the comparison excludes county payment, though that information is provided for Dane for informational purposes.

Mental health prevalence for Dane County, comparison counties, and Wisconsin was calculated by adjusting the projected number of adults with any mental illness in each respective jurisdiction provided in the WDHS report to a prevalence percentage. The prevalence percentage reflects the number of adults with a condition as a portion of the overall adult population in each jurisdiction. This percentage was multiplied by the Census Bureau's 2017 and 2018 population estimates for adults in each jurisdiction to create the projected prevalence number. The penetration rate is the number of unique adult utilizers divided by the projected prevalence.

The main weakness in this methodology is the WDHS report acknowledges that survey data was not differentiated by county, therefore county numbers provided are approximations based off the state prevalence rate. Thus, counties likely have greater variance in prevalence than calculated.

Alcohol and other Drug Abuse (AODA) prevalence for Dane, comparison counties, and Wisconsin were provided in the WDHS report. The prevalence percentage was multiple by the Census Bureau's 2017 and 2018 population estimates to obtain projected prevalence. However, the rates provided in the WDHS report were for ages 12 and over while Census Bureau population projections include age 12 in the ages 10-14 category. PCG assumed ages 10 and 11 have similar AODA prevalence to age 12. Unique utilizers ages 10 and up are included from the WHIO dataset. In Dane County's age groupings, all of those under 18 are grouped together, therefore, only unique utilizers ages 18 and above are included in the Dane analysis. Table 2 includes asterisks that note which age grouping.

Table 2. Service Penetration Rate among WHIO and DHS Reported Services

	2017		2018*	
	MH	AODA	MH	AODA
Dane with DHS Claims (for Demonstration Purposes)**				
Dane Private, Medicaid and Medicare Utilizers (WHIO reported services only)	17,492	3,577	17,601	3,735
DHS Service Utilizers	3,898	5,086	4,609	3,892
Total Dane Utilizers	21,390	8,663	22,210	7,627
Dane Prevalence	77,578	44,903	78,577	45,444
Penetration Rate	28%	19%	28%	17%
Dane (for County & State Comparison Purposes)***				
Dane Private, Medicaid and Medicare Utilizers (WHIO reported services only)	17,492	3,577	17,601	3,735
Dane Prevalence	77,578	44,903	78,577	45,444
Penetration Rate	23%	8%	22%	8%
Milwaukee (for County & State Comparison Purposes)***				
Milwaukee Private, Medicaid and Medicare Utilizers (WHIO reported services only)	40,289	17,027	38,075	15,006
Milwaukee Prevalence	135,847	89,059	135,723	88,988
Penetration Rate	30%	19%	28%	17%
Waukesha (for County & State Comparison Purposes)***				
Waukesha Private, Medicaid and Medicare Utilizers (WHIO reported services only)	6,083	1,883	5,642	1,787
Waukesha Prevalence	57,901	31,039	58,372	31,211
Penetration Rate	11%	6%	10%	6%
Wisconsin (for County & State Comparison Purposes)***				
Wisconsin Utilizers (WHIO reported services only)	185,446	52,674	174,277	48,611
Wisconsin Prevalence	839,582	484,745	844,876	487,292
State Penetration Rate	22%	11%	21%	10%

*2018 prevalence estimated by applying the 2017 percent prevalence to the estimated 2018 population.
Data Source: DHS & WHIO
**MH claims ages 18 and above; AODA claims from WHIO ages 10 and above; AODA claims from Dane DHS ages 18 and above
***MH claims ages 18 and above; AODA claims ages 10 and above

Table 2 shows that in Dane County, 28 percent of adults with a mental illness are receiving services while roughly 18 percent of individuals with substance use disorders are receiving services. DHS connects 5 percent of adults needing mental health services and 9 percent of individuals needing AODA services to care.

Comparing only WHIO data (i.e. leaving out DHS paid claims), Dane's penetration rates for both mental health and AODA are roughly equivalent to Wisconsin's. Compared to Waukesha County, Dane County is performing better in access for adults with mental illness. Compared to Milwaukee County, Dane County has fewer individuals with mental illness and substance use disorders accessing services. Particularly, Dane County has a 10 percent lower penetration rate for AODA.

Table 3 shows the total number of unique utilizers, regardless of age, accessing mental health and AODA services.

Table 3 shows that more individuals with mental health conditions have used services than those with substance dependence. Comparing WHIO-reporting payers to County services, the County is the primary payer for substance dependence while WHIO reporting payers are the primary payers for mental health services. Nationally, Kaiser Family Foundation has reported that individuals with certain substance dependence conditions are more likely to be uninsured. The report states that 18 percent of those with opioid dependence are uninsured versus 10 percent of the total population.[4] The payer breakdown is consistent with the Kaiser Family Foundation's findings with 2017 and 2018 percentage point differences of 8% and 1%, respectively. However, while prevalence of AODA has increased, unique utilizers have not followed suit.

Table 3. Percent of MH versus SUD Services Reimbursed by County and WHIO Reporting Payers

	2017				2018*			
	MH	% MH	AODA	% AODA	MH	% MH	AODA	% AODA
Dane Private, Medicaid and Medicare Utilizers	25,684	85%	3,579	41%	25,674	83%	3,742	49%
DHS Service Utilizers	4,380	15%	5,086	59%	5,341	17%	3,892	51%
Total	30,064	100%	8,665	100%	31,015	100%	7,634	100%

Data Source: DHS & WHIO

3.4 DANE COUNTY DHS CONTRACTED SERVICE UTILIZATION

For mental health claims for County services, the proportion of claims for non-specified psychoses has declined year over year while claims specifying schizophrenia and bipolar disorder have ticked upward (Table 4).

Table 4. Top 10 Most Frequent Diagnoses for DHS Mental Health Claims for 2016-2018.

Diagnosis	2016		2017		2018	
	Count	Percent of Diagnoses	Count	Percent of Diagnoses	Count	Percent of Diagnoses
Psychoses	18,396	50%	10,298	31%	6,764	23%
Neurotic disorders, personality disorders, and other nonpsychotic	4,795	13%	2,952	9%	1,730	6%
Schizophrenia	1,707	5%	3,362	10%	3,770	13%
Schizoaffective disorders	1,176	3%	2,451	7%	2,918	10%
Bipolar disorder	1,577	4%	2,004	6%	2,487	8%
Reaction to severe stress, and adjustment disorders	1,378	4%	1,845	6%	1,806	6%
Major depressive disorder, recurrent	1,334	4%	1,957	6%	1,618	5%
Ill-defined and unknown causes of morbidity	1,790	5%	1,397	4%	1,098	4%
Major depressive disorder, single episode	1,072	3%	1,237	4%	1,644	6%

Data Source: DHS

[4] https://www.kff.org/uninsured/issue-brief/key-facts-about-uninsured-adults-with-opioid-use-disorder/

Table 5 demonstrates that alcohol related disorders continue to represent the highest proportion of diagnoses among alcohol and other drug abuse (AODA) claim for individuals accessing services through the DHS. Alcohol related disorders are also the only single diagnosis that has consistently trended upward year over year.

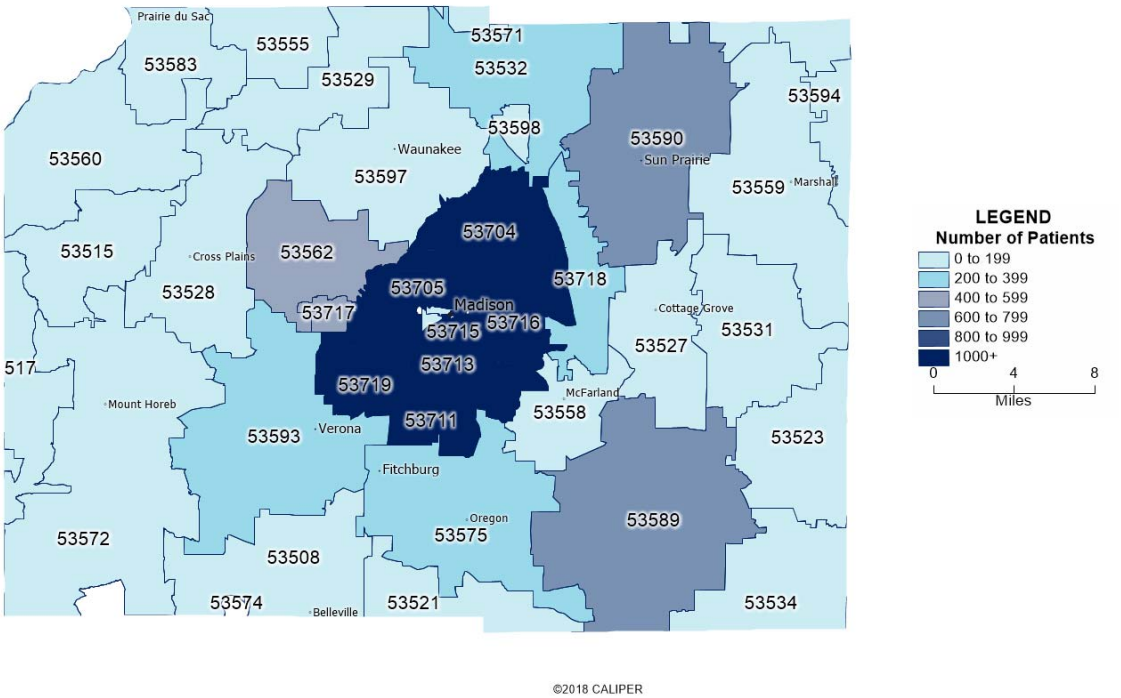
Table 5. Top 10 Most Frequent Diagnoses for Alcohol and Other Drug Abuse Claims for 2016-2018.

Diagnosis	2016		2017		2018	
	Count	Percent of Diagnoses	Count	Percent of Diagnoses	Count	Percent of Diagnoses
Alcohol related disorders	4,494	22%	1,696	26%	3,991	31%
Illness, unspecified	5,174	25%	1,499	23%	2,104	16%
Opioid related disorders	2,380	12%	1,433	22%	2,725	21%
Neurotic disorders, personality disorders, and other nonpsychotic mental disorders	3,271	16%	728	11%	490	4%
Cannabis related disorders	948	5%	268	4%	681	5%
Ill-defined and unknown causes of morbidity and mortality	1,781	9%	26	0%	8	0%
Other psychoactive substance related disorders	566	3%	132	2%	648	5%
Problems related to upbringing	483	2%	81	1%	494	4%
Transport accidents	548	3%	50	1%	311	2%

Data Source: DHS

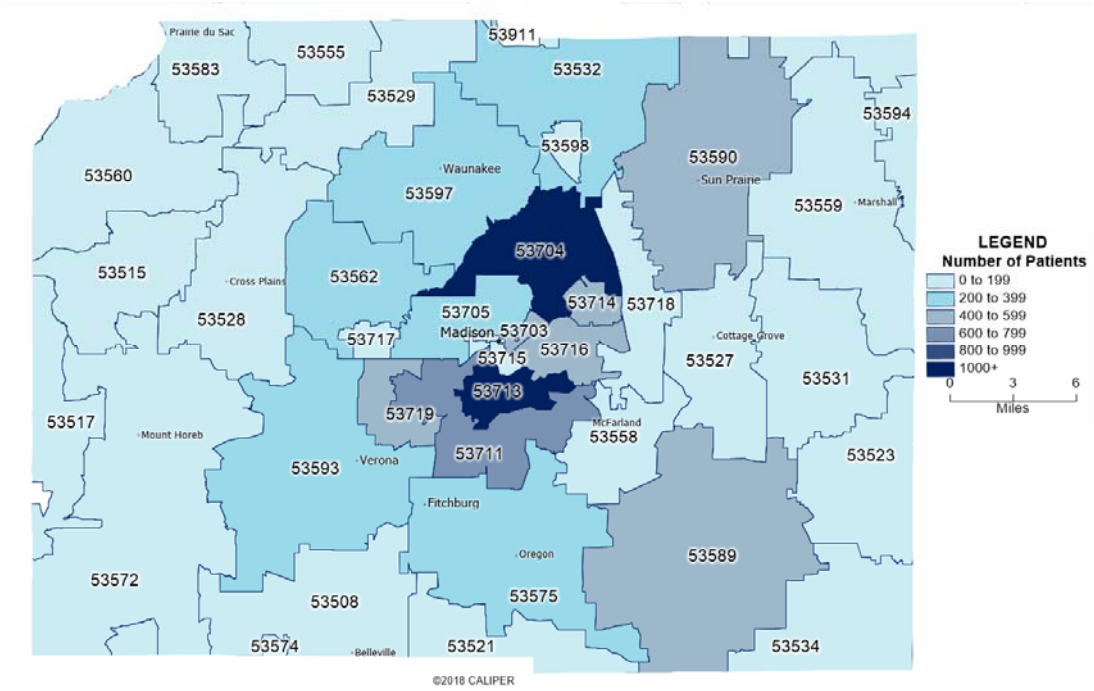
Individuals living in the 53704 and 53713 zip codes are more likely to access County services for mental health and substance dependence, as shown in Figures 1 and 2 below. Mental health utilizers are highly clustered around the Madison area, while AODA utilizers are more widespread.

Figure 1. Heat Map of 2018 Mental Health Utilizers by Zip Code.



Data Source: DHS

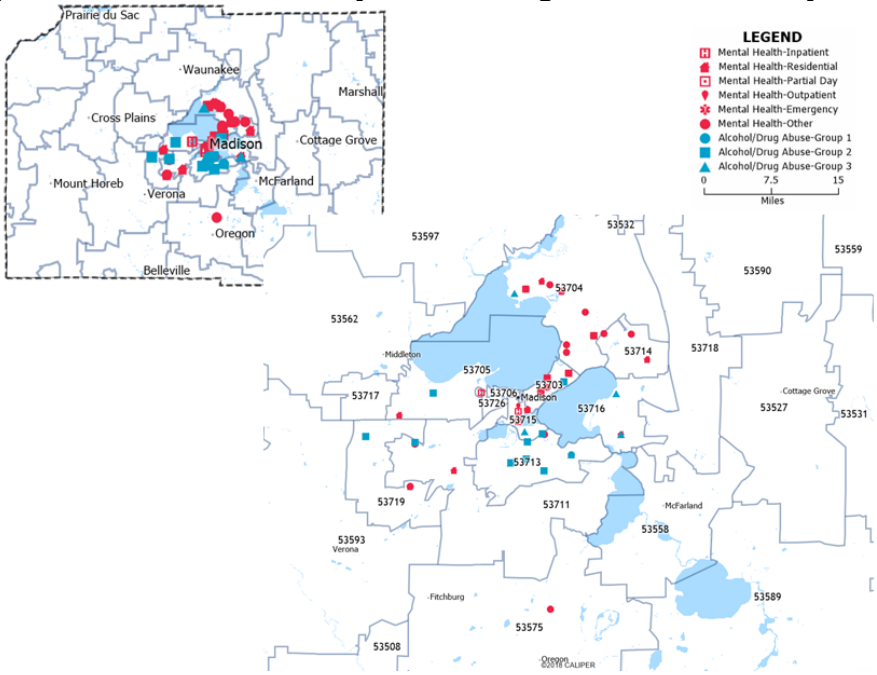
Figure 2. Heat Map of 2018 Alcohol and Other Drug Abuse Utilizers by Zip Code.



Data Source: DHS

While there are a significant number of individuals served from the North-Central and North-Eastern parts of the County, we see in Figure 3 that the majority of AODA facilities are located in the South-Central and South-Western parts of the County. Broadly, most provider facilities are located closer to the urban center of the County.

Figure 3. Map of DHS Facilities Utilized by Service Categories in Dane County.



Data Source: Dane County

4. CONTINUUM OF CARE

4.1 APPROACH

The information in this report was provided by the Dane County Department of Human Services (DHS) and the Wisconsin Health Information Organization (WHIO). WHIO information is copyrighted and requires a license for its use. Based on the crosswalk of subprogram categories (SPCs), Current Procedural Terminology (CPT), and Healthcare Common Procedure Coding System (HCPCS) codes, categories of services were generated for commercial, Medicare, and Medicaid claims based on SPC service types (The crosswalk can be found in Appendix B). DHS's datasets differentiated mental health and AODA services. For WHIO data, diagnosis code was used to differentiate whether the services were mental health or AODA related. Utilization data was generated for each care continuum category in both the DHS and WHIO datasets.

4.1.1 Limitations

There are several limitations to the dataset. As DHS uses a monthly reconciliation process for monies provided, services rendered are measured by units of service rather than a traditional claim format. This has two implications. First, exact dates of services are often unknown making it difficult to differentiate unique service visits. Second, DHS data may be inflated when comparing to WHIO units of service. For example, while DHS may have an inpatient stay as 3 units of service representing three days, there would only be one claim in the WHIO dataset representing an equivalent time frame. For the purposes of these analyses, it was assumed one unit of service in DHS's data was equivalent to one claim from the WHIO dataset. Furthermore, DHS does not receive a claim for all services individuals receive. Most notably, emergency department data is not billed through DHS. This limits the extent individuals in crisis can be tracked, especially if they present at an emergency room before accessing more appropriate crisis services. Another limitation was that DHS only had three full calendar years of data available for analysis. This limits trending capacity.

Similarly, WHIO only had two full calendar years of claim data available. Trending for WHIO data was also limited and comparisons to the DHS data are only possible in two years. Furthermore, medical coding for services may not be consistent across counties and carriers. As multiple codes exist for similar services, a degree of discretion is used for billing. This may lead to inconsistencies when trying to group service categories.

Finally, carrier wait time data is limited. PCG requested data from health plans in order to display wait times for patients seeking certain services. Data was requested from the seven largest Medicaid HMO health pans operating in Dane County. Each carrier was requested to provide data from their system on each of the service types. Of the seven carriers polled, four provided data to PCG. Given the low response to the PCG request, additional requests for wait time data were made by the Office of Commissioner of Insurance. These requests did not produce additional data. Given that the only wait time data available is self-reported and not system wide, we suggest that this data is used for information purposes only and not considered a full view of the current system.

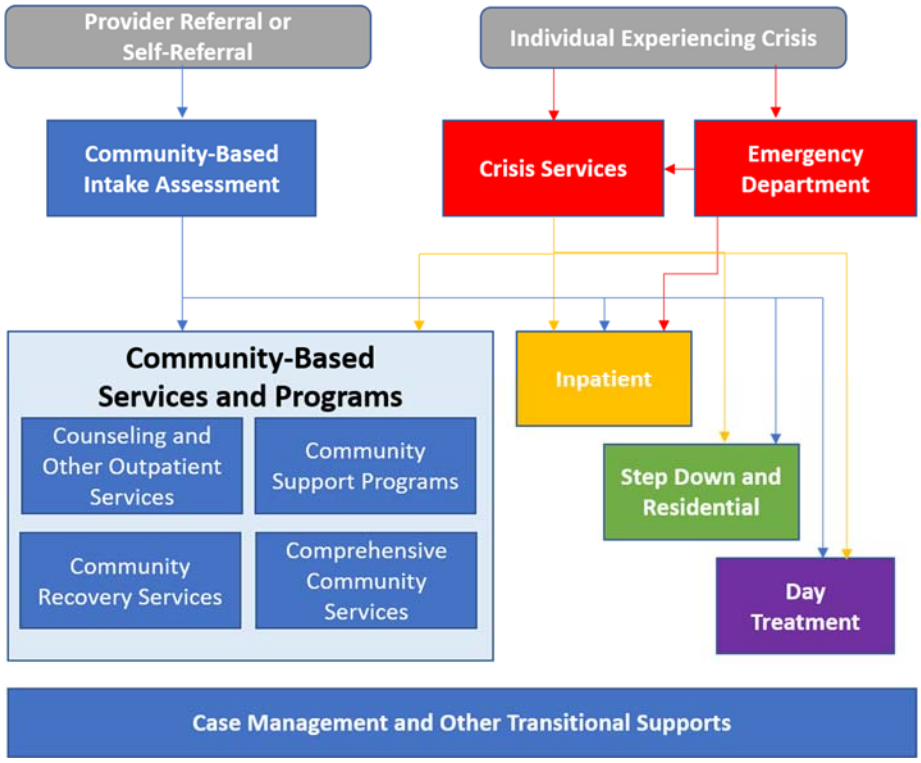
4.2 CARE PATHWAYS BY PAYER

The ways in which individuals access services – as well as the scope of services available – vary greatly by type of health coverage. Below we describe the care pathways for County services, Medicaid members, and those with private health insurance.

4.2.1 County Services

The County's main client base are those who are uninsured. At a high level, Figure 4 illustrates two potential pathways through which individuals may access various levels of care.

Figure 4. DHS Care Continuum



Across this continuum, the number of individuals using each level of service varies. Table 6 identifies the number of unique utilizers by service. Case management, outpatient counseling, and crisis care are the top three utilized service types in 2016. From 2017 to 2018, there was a large increase in crisis care utilized, as illustrated in Figure 5, which follows Table 6.

Table 6. Unique Utilizers by Service Type

Service Type	MH			AODA		
	2016	2017	2018	2016	2017	2018
Counseling and Other Outpatient	1,869	1,581	1,286	3,274	3,130	1,657
Community Support Programs	526	549	523	0	0	0
Comprehensive Community Services	468	801	1,092	0	0	0
Community Recovery Services	123	116	97	0	0	0
Intake Assessment	25	22	6	593	613	688
Crisis Care	1,621	1,502	2,656	1,161	1,267	1,224
Inpatient Care	233	215	197	0	0	0
Residential and Step-Down	530	545	516	180	195	148
Case Management and Transitional Supports	2,149	1,916	1,897	1,191	1,167	1,063

Data Source: DHS

Figure 5. Year-Over-Year Change in Unique Individuals Accessing Mental Health Services

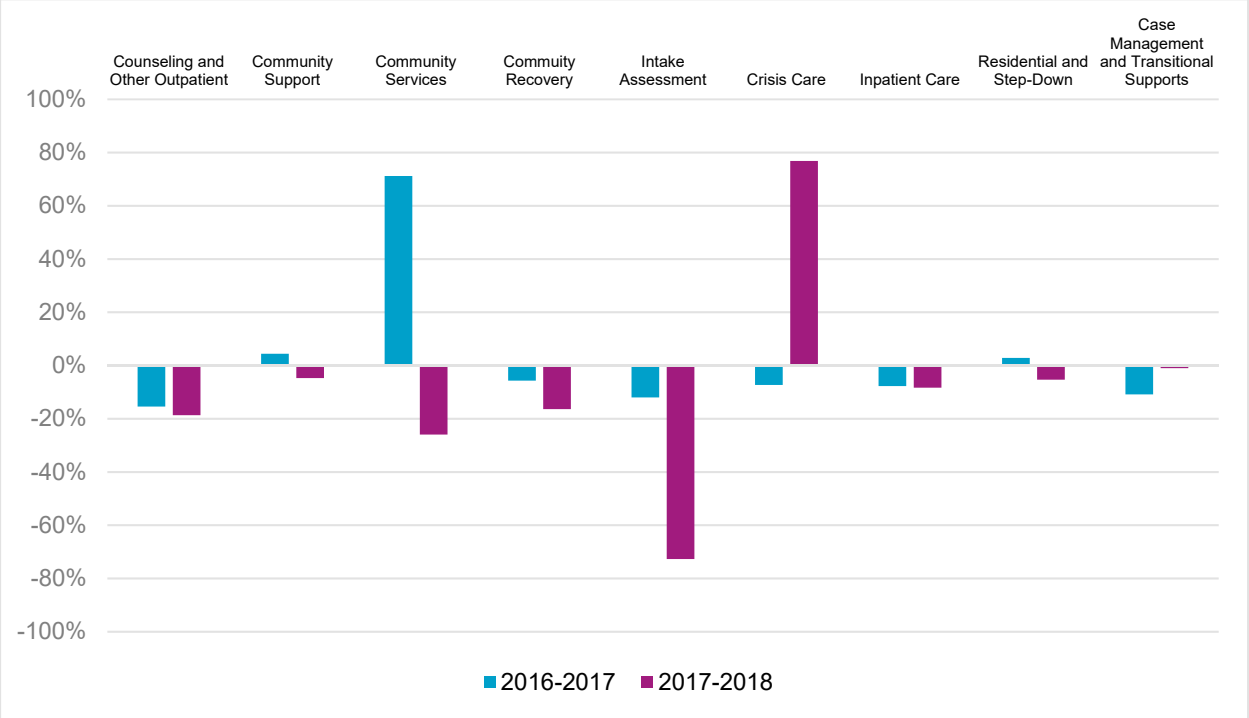
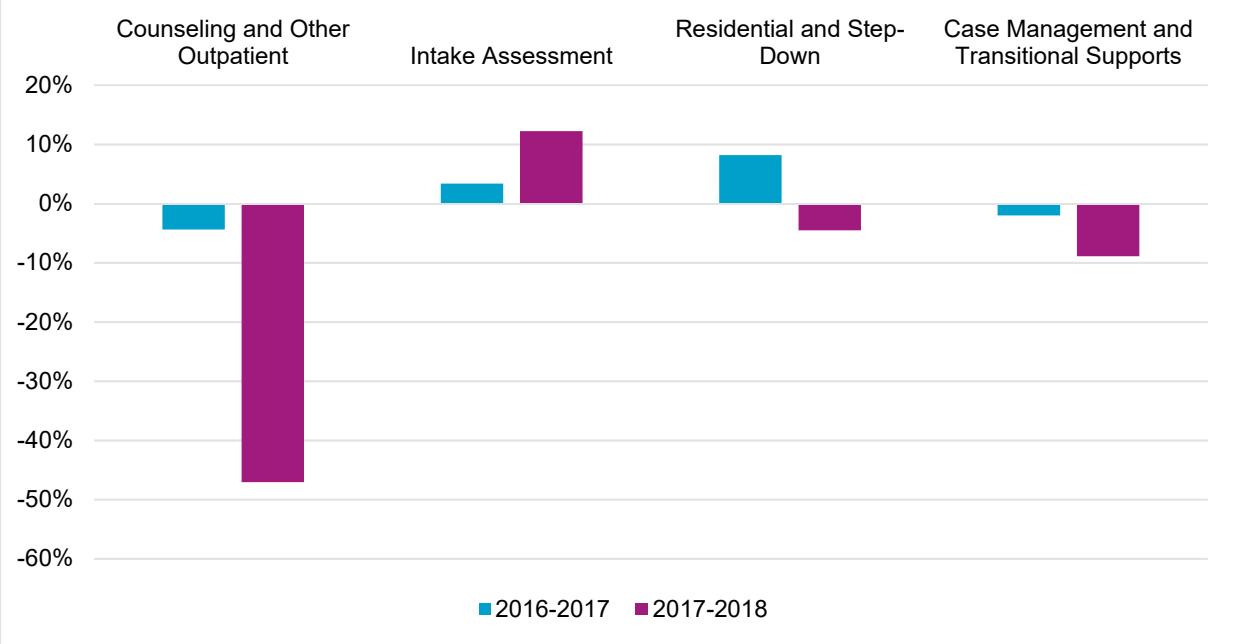


Figure 6. Year-Over-Year Change in Unique Individuals Accessing Alcohol and Other Drug Abuse Services



4.2.2 Medicaid HMO Services

Medicaid HMOs in Wisconsin are largely responsible for the provision of community-based treatment. Medicaid managed care organizations are required to comply with the federal Mental Health Parity and Addiction Equity Act, providing behavioral health services in a manner that is no more restrictive than the provision of medical/surgical care. Figure 7 illustrates how an individual covered by a Medicaid HMO might access services. Services depicted are limited to those contractually required of all HMOs. Actual plan scope and coverage may vary.

Figure 7. Medicaid HMO Required Services

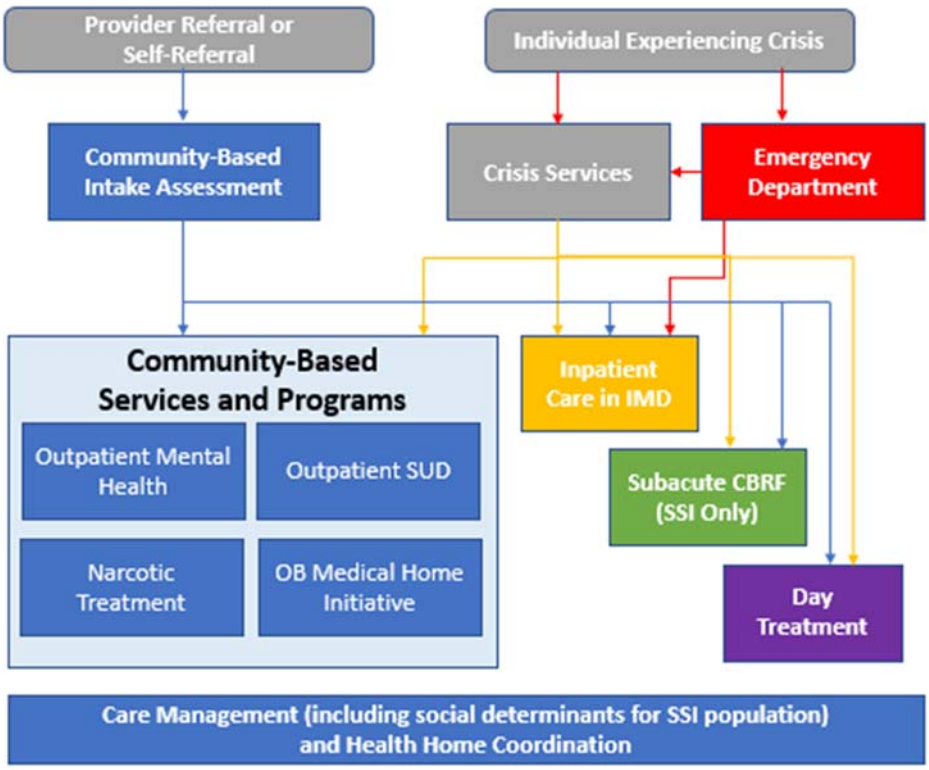


Table 7 provides the number of individuals insured by Medicaid accessing behavioral health services in Dane County. PCG cross-walked SPCs, CPTs, and HCPCS for this based on service descriptions. Counseling and other outpatient care, comprehensive community services (CCS), intake assessments, and crisis care had the highest number of unique patients accessing services.

Between 2017-2018, the number of unique patients accessing counseling and other outpatient care for mental health dropped by 6 percent while the number of unique patients accessing CCS services and case management services increased by 4 and 200 percent, respectively. Utilizers for crisis care, inpatient care, and residential care decreased by 18 percent, 3 percent, and 14 percent, respectively. For AODA, the highest increases were seen case management, crisis care, CCS, and outpatient services at 73, 9, 49, and 2 percent, respectively. Large decreases were seen for intake assessments and inpatient care at 14 and 7 percent, respectively.

Table 7. Unique Medicaid Utilizers by Service Type in Dane County

Service Type	MH		AODA	
	2017	2018	2017	2018
Counseling and Other Outpatient	15,112	14,150	2,952	3,025
Community Support Programs-like	540	500	0	2
Comprehensive Community Services	3,295	3,428	74	110
Community Recovery Services-like	122	108	0	0
Intake Assessment-like	2,874	2,279	327	281
Crisis Care	2,420	2,049	781	850
Inpatient Care	904	881	472	439
Residential and Step-Down	206	181	10	9
Case Management and Transitional Supports	550	1,112	239	413

Data Source: WHIO

4.2.3 Private Insurance Services

Individuals who have private insurance may have very different provider networks and experiences of care depending on their chosen plan. Most private insurance plans are also required to comply with federal Mental Health Parity and Addiction Equity Act regulations.

Figure 8. Private Insurance Service Map

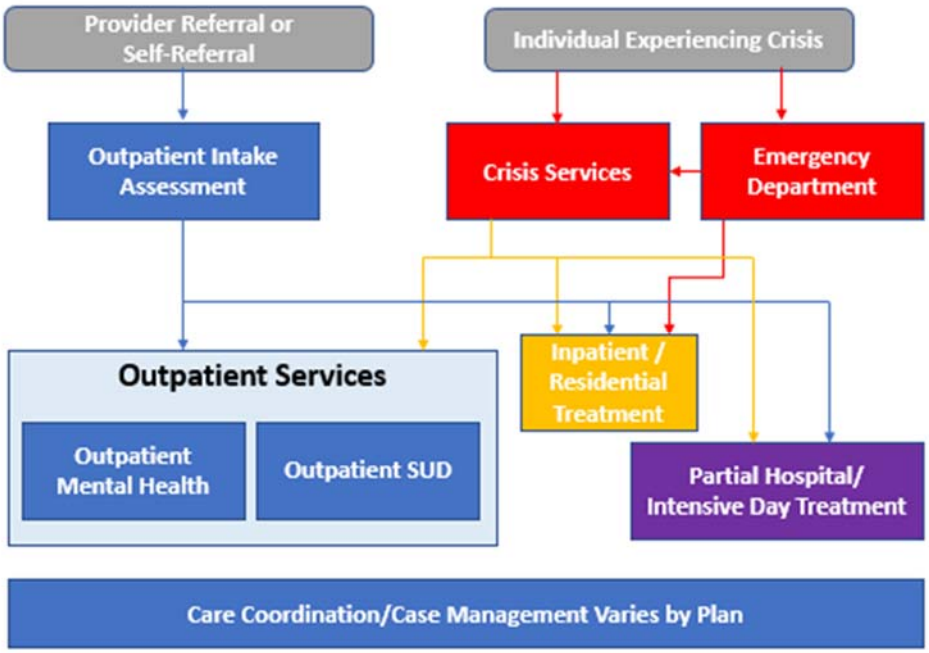


Table 8 provides the number of individuals insured by a private insurer accessing behavioral health services in Dane County. Counseling and other outpatient care, intake assessment-like, and crisis care had the highest number of unique utilizers for both mental health and AODA. Between 2017-2018, the number of unique patients accessing counseling and other outpatient care for mental health increased by 14 percent. The unique number of individuals accessing crisis care for mental health also increased by 46 percent. Persons enrolled in CCS-like services increased by 75%. For AODA, the number of unique patients

accessing counseling increased by 25 percent, while use of crisis services increased by 13 percent. Access of other service types between mental health and AODA remained relatively stagnant.

Table 8. Unique Private Insurance Utilizers by Service Type in Dane County

Service Type	MH		AODA	
	2017	2018	2017	2018
Counseling and Other Outpatient	6,594	7,495	214	267
Community Support Programs-like	3	6	0	1
Comprehensive Community Services-like	84	147	1	0
Community Recovery Services-like	0	0	0	0
Intake Assessment-like	2,086	2,460	11	10
Crisis Care	147	214	82	93
Inpatient Care	86	95	34	35
Residential and Step-Down	2	1	15	15
Case Management and Transitional Supports	1	5	0	0

Data Source: WHIO

Noted Models for Centralized Administration and Service Locators

Connections, AZ: Pima County, Arizona

San Antonio Restoration and Resource Centers: Bexar County, Texas

Charleston Mental Health Center: Charleston, South Carolina

Former WhereIsCare website and mobile application

WI Hospital Association Bed Locator

4.2.4 Stakeholder Input Regarding Access to the Continuum of Care

There is significant skepticism among stakeholders regarding the enforcement of mental health parity requirements. Inequities are common across payers and eligibility categories. Stakeholders commented that Medicaid enrollees as well as some privately insured individuals still struggle to access some services – especially medication-assisted treatment (MAT) for substance use disorder.

Providers perceive a disconnect between regulatory and insurance restrictions and evidence-based guidelines. Several participants commented broadly that beds remain empty when (1) individuals who are not covered by the associated funding stream are waiting for placement, or (2) no one is waiting for placement, but an individual is discharged before they are ready due to coverage limits. Coverage limits were specifically referenced with respect to 28-day AODA treatment programs. Participants also noted that individuals often encountered "wrong door" barriers. In such instances, individuals are discouraged from seeking services after being turned away without warm handoffs to available providers. In general, participants felt that – while community-based resources aimed at helping individuals maintain recovery are scarce – the resources that *are* available are not effectively utilized. Adjacent to resource utilization is the issue of transparency. Several providers and advocates raised concerns about the true availability of beds and other program placements for individuals whose needs are more resource intensive.

To help address this issue, several stakeholders expressed desire for more coordination and centralization. Many participants described coordination and placement processes that were directly dependent on relationships that developed among individuals over time. While trust on an individual level is essential to coordination, focus group participants acknowledged that organizational level coordination – including formal partnerships – were lacking in some areas. The Recovery Coalition of Dane County was mentioned several times as having implemented best practices with respect to successful partnerships.

Efforts to implement Collaborative Care[5] and other behavioral health integration models have also seen mixed results. One stakeholder noted that integration in their office is still happening at a personal level rather than systemic level. Advocates also expressed concerns about the current operation of crisis call centers and triage lines, noting that individuals seeking help had poor experiences (e.g. failed transfers, dropped calls, inability to provide warm handoffs).

Stakeholders expressed support for more robust, centralized models through which resources across sectors, payers and providers could be accessed (including housing, employment and support for food security). In addition to the models noted in the call-out box, stakeholders also pointed to the Homecoming Project of San Francisco as a prospective model to improve re-entry services – including housing – for Dane County's justice-involved individuals.

Sample of Prevention Programs Serving Dane County

- African-American Opiate Coalition
- Latino Council for Families and Communities
- Pride Coalition for LGBTQ+ Substance Use
- Catholic Charities Suicide Prevention
- Various school-based programs, including Building Bridges

4.3 PREVENTION

Prevention services were described as severely lacking throughout the community. School-based programs – as well as niche substance use prevention programs serving people of color, the LBGTQ+ community, and low-income populations – were cited as the only consistent examples of such programs. Stakeholders noted, however, that the impact of the above programs was hindered by the reality that these populations lacked access to services across sectors, including housing and nutrition.

4.4 COMMUNITY SUPPORT PROGRAMS

Dane County's care continuum consists of a variety of community-based programs that blend services across the care continuum. The first considered here, Community Support Programs (CSP), are coordinated care and treatment programs through provided by an interdisciplinary team. Examples of services include medications, case management, work services, counseling, activities of daily living, ongoing problem solving, and rehabilitation. To qualify, individuals must have a serious and persistent mental illness. Table 9 shows the units of CSP paid for by DHS compared to number of claims of CSP-like services covered by other payers (see Appendix B for a crosswalk of CSP-like services across payers). Only two years of data for Medicare, Medicaid, and private payers are available, ruling out the ability to perform trendline analysis.

The available data shows DHS related claims holding largely steady from 2016-2018. DHS claims account for roughly fifty percent of all claims in 2018. In 2017, Medicaid claims were higher than DHS claims, but with only two years of data it is not possible to discern if 2018 or 2017 is more typical year when it comes to the proportion of claims by payer. Private claims do not comprise any significant amount in this area.

[5] The Collaborative Care Model is an evidence-based approach to integrating physical and behavioral health that employs a primary care provider, care management team, and psychiatric consultant who advises the primary care treatment team. The model includes care coordination and management, proactive treatment monitoring using clinical rating scales, and regular psychiatric caseload reviews for individuals not showing clinical improvement.

Table 9. Number of Community Support Program and Community Support Program-like Claims by Payer

Payer	MH			AODA		
	2016	2017	2018	2016	2017	2018
DHS	61,006	66,464	66,258	0	0	0
Medicaid	N/A	87,609	68,563	N/A	0	149
Medicare	N/A	0	0	N/A	0	0
Private	N/A	181	827	N/A	0	21

Data Source: DHS and WHIO

4.5 COMPREHENSIVE COMMUNITY SERVICES

Comprehensive Community Services (CCS) is the second category of community-based services in the care continuum analyzed here. A consumer driven psycho-social rehabilitation program, CCS became available in Wisconsin in 2005 and was adopted by Dane County in 2015. Services include programs like case management, communication skills development and training, employment skills training, medication management, therapy, and substance use disorder treatment. All services are community based and often mobile depending on the consumer's need. CCS are designed for individuals who are at high risk for hospitalization during times of crisis.

CCS is funded by Medicaid. However, in Dane County, DHS is the major public provider of CCS services. Table 10 shows the number of Medicaid/DHS claims for CCS. Table 24 also includes CCS-like services that are provided by Medicare and private insurers. Once again, Medicare and private payer data is only available for 2017 and 2018. Despite this limitation the data clearly shows an update in usage of these services since 2016, with an increase in each year in all categories for which data is available. Appendix B contains the crosswalk that demonstrates the services included for all payers in the CCS category.

Table 10. Number of Comprehensive Community Service and Comprehensive Community Service-like Claims by Payer

Payer	MH			AODA		
	2016	2017	2018	2016	2017	2018
DHS/Medicaid	44,814	249,811	275,508	N/A	1,362	1,954
Medicare	N/A	15	32	N/A	0	0
Private	N/A	2,178	16,620	N/A	1	0

Data Source: DHS and WHIO

4.6 COMMUNITY RECOVERY SERVICES

The third and final category in the care continuum of community-based services considered here is community recovery services (CRS). CRS, as defined for this report, consists of three services: community living support, peer support, and supported employment. CRS is targeted towards individuals with mental illness with the goal of improving their quality of life through outcomes-based planning. Community living support teaches skills such as meal planning/preparation, hygiene, coping skills, financial management, and interpersonal skills. Peer support services connects clients to individuals who have also lived with mental illness. Supported employment assists individuals in obtaining and maintaining competitive employment.

Table 11 shows the units of service provided by DHS compared to the number of claims for similar services from Medicaid, Medicare, and private insurers. As with previous sections, Appendix B provides a crosswalk of services across payers and data is only available for 2017 and 2018 for non-DHS claims. The data in Table 11 shows relative steady usage for these services from 2016 – 2018. DHS claims show a slight up

and down tick with a slight peak in 2017. However, this appears to be on the lines of normal variation as oppose to a drastic utilization change.

Table 11. Number of Community Recovery Services and Community Recovery Services-like Claims by Payer

Payer	MH			AODA		
	2016	2017	2018	2016	2017	2018
DHS	10,615	11,349	10,470	0	0	0
Medicaid	N/A	3,903	5,790	N/A	0	0
Medicare	N/A	0	0	N/A	0	0
Private	N/A	0	0	N/A	0	0

Data Source: DHS and WHIO

4.7 INTAKE ASSESSMENT

Intake assessments are diagnostic evaluations for the community-based services analyzed in the previous three sections. Table 12 shows the units of services from DHS, Medicaid, Medicare, and private payers. As with the previous sections only DHS data is available for 2016 with all payers having data for 2017 and 2018. The number of DHS assessments decreases for mental health claims over the time period analyzed but increases for AODA claims. Medicaid data shows a similar experience.

Table 12. Number of Intake Assessment and Intake Assessment-like Claims by Payer

Payer	MH			AODA		
	2016	2017	2018	2016	2017	2018
DHS	233	214	81	3,730	4,611	4,577
Medicaid	N/A	4,261	3,502	N/A	421	396
Medicare	N/A	23	25	N/A	1	0
Private	N/A	2,368	2,824	N/A	12	10

Data Source: DHS and WHIO

4.8 OUTPATIENT

Outpatient care is an important step in the care continuum to manage chronic behavioral health issues and prevent the need for crisis, residential, or institutional care. DHS provides mental health and AODA outpatient care for uninsured individuals. Outpatient programs include things like treatment, prescriber services, and therapy. To align similar services across payers, PCG created a crosswalk of CPT and HCPS codes (Appendix B). Table 13 below identify the total claims volume by payer for various programs for mental health and AODA, respectively. Given the lack of data for non-DHS payers prior to 2016 it is not possible to identify significant trends. However, the DHS data does indicate an overall reduction in claims for both MH and AODA during the years in which data is available. Non-DHS payers do not show a similar experience in 2017 and 2018 but with only two years of data is it not possible to see any trend.

Table 13. Mental Health Outpatient Claims by Service Type and Payer

Payer	MH			AODA		
	2016	2017	2018	2016	2017	2018
DHS	78,784	37,004	12,386	30,868	26,603	19,636
Medicaid	-	255,167	191,840	-	155,283	187,626
Medicare	-	769	714	-	10	2
Private	-	39,774	42,061	-	2,591	5,916

Data Source: DHS and WHIO

Table 14 displays the percent of outpatient claims as a function of all claims by each payer. DHS claims have a lower utilization rate of outpatient services compared to Medicaid, Medicare and Private insurance. It is important to note that since 2015, DHS utilizers have been moving away from traditional outpatient care towards CCS. This accounts for some of the low utilization seen by DHS patients in Table 13 and Table 14. Those insured by Medicaid also use fewer mental health outpatient services than individuals insured by private insurance. However, for AODA, individuals insured by Medicaid utilize more outpatient services than those insured by private insurance. Compared statewide, Dane County Medicaid patients utilize less mental health outpatient services, but more AODA outpatient services.

Table 14. Outpatient Care Percent of Claims by Payer.

Payer	MH			AODA		
	2016	2017	2018	2016	2017	2018
Dane County						
DHS	27%	12%	4%	47%	43%	40%
Medicaid	-	37%	31%	-	96%	95%
Medicare	-	86%	87%	-	83%	29%
Private	-	88%	66%	-	84%	93%
Wisconsin						
Medicaid	-	43%	43%	-	92%	93%
Medicare	-	23%	23%	-	79%	30%
Private	-	88%	67%	-	78%	88%

Data Source: DHS and WHIO

Figures 9 and 10 display the percentage of mental health claims by each payer in Dane County for 2017 and 2018. Based on claims, Medicaid is the main payer for services. Figures 11 and 12 display the payer breakdown for AODA services. Medicaid also has the highest volume of outpatient AODA claims.

Figure 9. 2017 Mental Health Outpatient Claims by Payer*

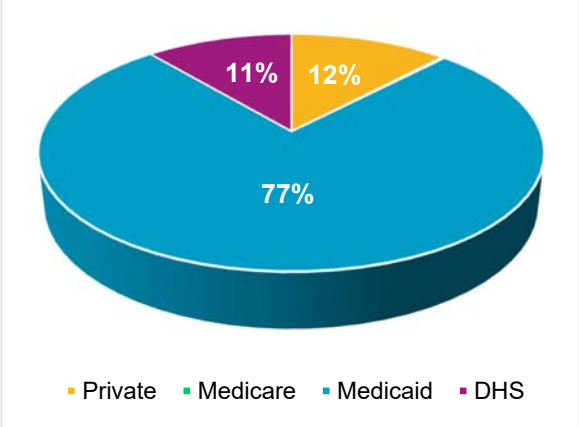


Figure 10. 2018 Mental Health Outpatient Claims by Payer*

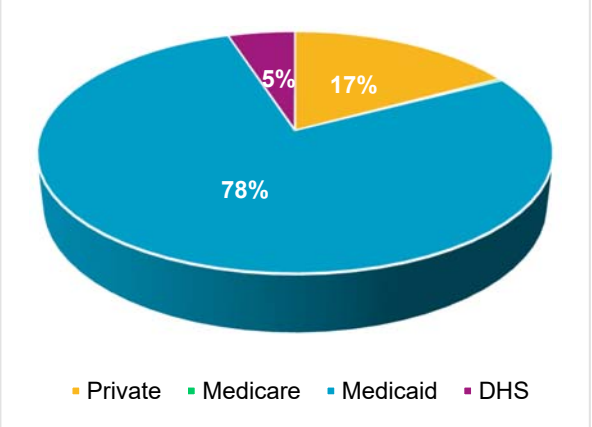


Figure 11. 2017 Alcohol and Other Drug Abuse Outpatient Claims by Payer*

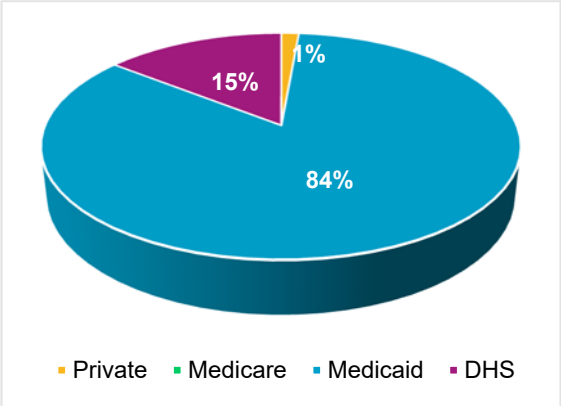
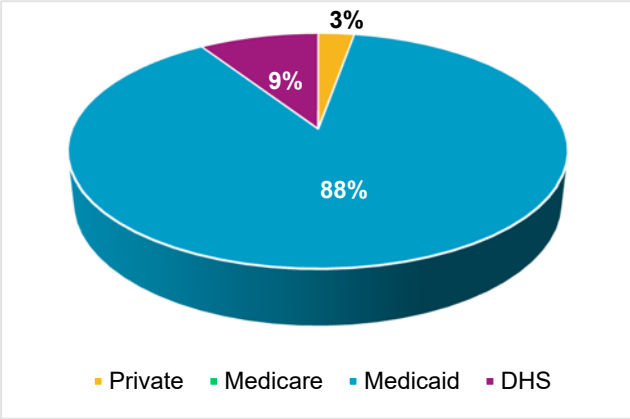


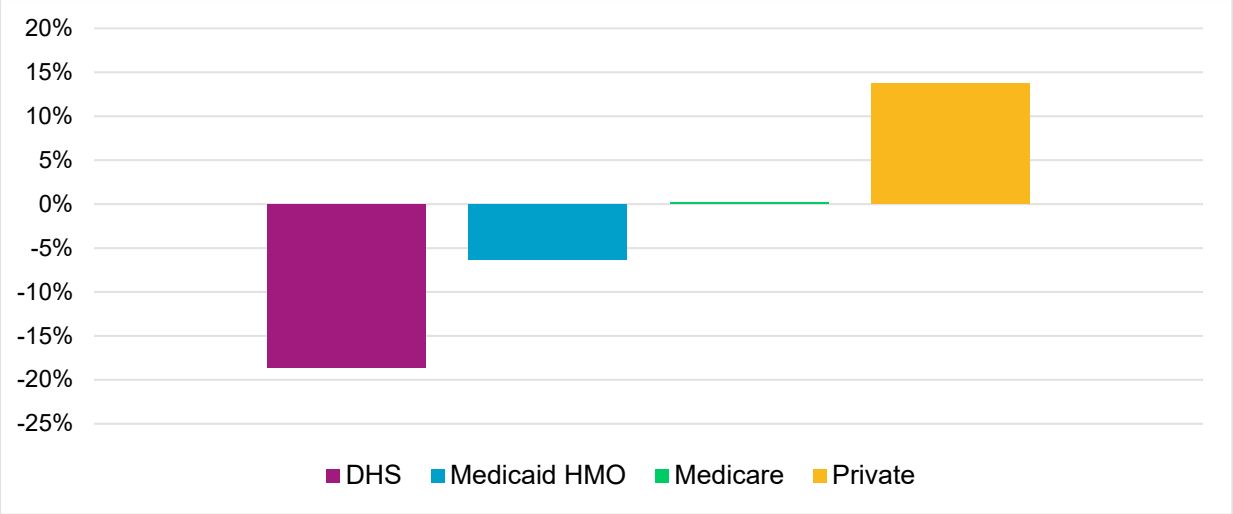
Figure 12. 2018 Alcohol and Other Drug Abuse Outpatient Claims by Payer*



*Assumes one unit of service from DHS is equivalent to one WHIO claim
Data Source: DHS and WHIO

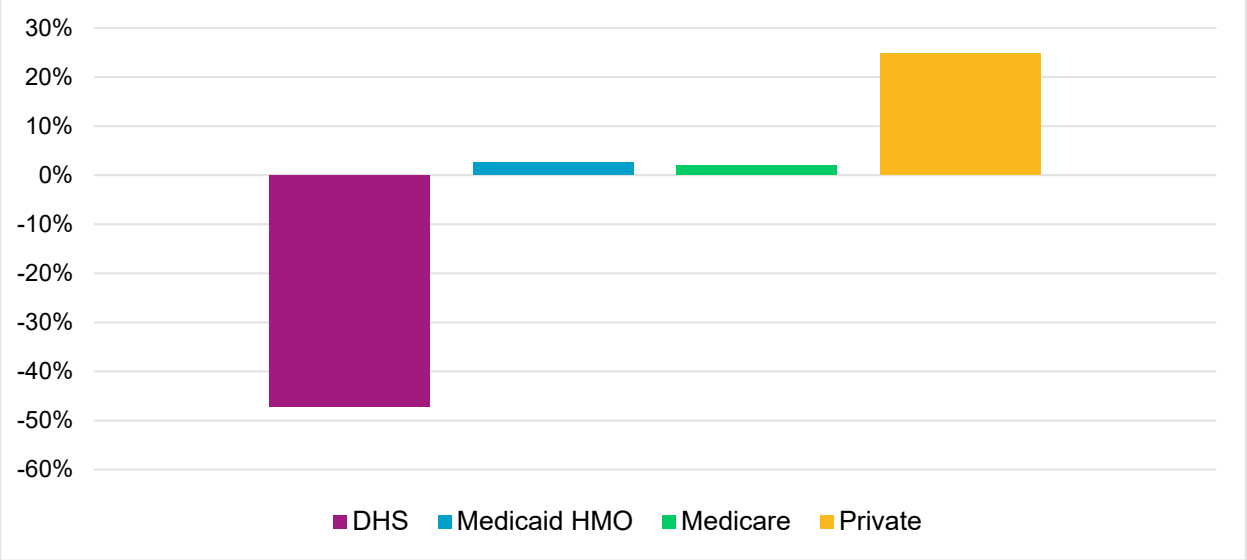
Between 2017 and 2018, there was an overall decrease in utilization of counseling and other outpatient services. For mental health, there was a 1% decrease in unique utilizers, while for AODA there was a 25% decrease. Figures 13 and 14 display the changes in unique utilizers by payer. DHS saw the largest decrease in utilizers, while private insurers saw an increase in utilizers of outpatient care.

Figure 13. 2017-2018 Change in Unique Individuals Accessing Mental Health Services by Payer



Data Source: DHS and WHIO

Figure 14. 2017-2018 Change in Unique Individuals Accessing Alcohol and Other Drug Abuse Services by Payer*



Data Source: DHS and WHIO

4.8.1 Outpatient Capacity

To measure Dane County's capacity in providing outpatient services to the most indigent populations, a utilization analysis of outpatient units of service was completed. DHS contracts with community providers and sets the amount of services to be provided by SPC. The SPCs for outpatient services can be found in Table 15. Providers provide services and go through a monthly reconciliation process, submitting the total units of services delivered per client. The utilization analysis for AODA and MH summed the units of service delivered by SPC for the year and divided the sum by the contracted units of service. The utilization rates for mental health and AODA between 2016-2018 can be found in Table 16.

Between 2016-2018, outpatient utilization for both SUD and mental health have steadily declined. In 2016, SUD outpatient contracted units of service were almost 42,000 hours. By 2018, the number of hours contracted steadily increased to 48,000 hours. However, utilization has declined with the increase in contracted hours. Utilization hovered at 62% in 2016, 2017 had 52% utilization, and 2018 had 40% utilization for services.

For mental health services, contracted units of services have steeply declined with a more gradual decline in utilization. Contracted mental health outpatient services began with roughly 60,500 hours of services in 2016, which decreased to roughly 36,000 hours in 2017, and has ended with 13,500 hours of services in 2018. In 2016, mental health outpatient services were overutilized at 125% of contracted services. In 2017, outpatient services were used at 95% of capacity while in 2018 utilization decreased to 72%.

Table 15. Outpatient SPC Codes

SPC Code	SPC Description
507	Outpatient, Regular
507.03	Counseling and Therapeutic Resources
507.1	Medication management
507.2	Individual
507.3	Group
507.4	Family (or couple)
507.5	Intensive in-home
507.6	Family support
507.9	Peer Support/Recovery Specialist
704	Day treatment-medical

Table 16. Outpatient Utilization

Year	AODA Units Contracted	AODA Units Delivered	% AODA Units Utilized	MH Units Contracted	MH Units Delivered	% MH Units Utilized	Total Contracted	Total Delivered	Total Percent Utilized
2016	41,872	25,926	62%	60,568	75,634	125%	102,440	101,560	99%
2017	42,973	22,171	52%	35,886	34,019	95%	78,859	56,190	71%
2018	46,028	18,535	40%	13,539	9,765	72%	59,567	28,300	48%

Data Source: DHS

The decrease in outpatient utilization may be attributed to a shift towards the CCS model for outpatient care. As seen in Table 10, in 2016, about 45,000 CCS claims were provided. In 2017, this increased by over 500% to over 249,000 claims. There was a 10% increase to roughly 275,000 CCS claims in 2018. Combining the units of service delivered for outpatient and CCS services 2016 had over 150,000 claims. This increased in 2017 and 2018 to over 300,000 claims. While traditional outpatient utilization is down, community-based care has increased.

4.8.2 Wait Times

PCG requested data from health plans in order to display wait times for patients seeking certain services. Data was requested from the seven largest Medicaid HMO health pans operating in Dane County. Each carrier was requested to provide data from their system on each of the service types. Of the seven carriers polled, four provided data to PCG. Given the low response to the PCG request, additional requests for wait time data were made by the Office of Commissioner of Insurance. These requests did not produce additional data. Given that the only wait time data available is self-reported and not system wide, we suggest that this data is used for information purposes only and not considered a full view of the current system. The contractual standard and results can be found in Table 17.

Table 17. Outpatient Wait Times

		Carrier 1		Carrier 2		Carrier 3		Carrier 4	
Service Type	**Contract Standard**	**Actual Adult**	**Actual Child/ Adolescent**	**Actual Adult**	**Actual Child/ Adolescent**	**Actual Adult**	**Actual Child/ Adolescent**	**Actual Adult**	**Actual Child/ Adolescent**
Outpatient Psychiatry appointment	90 days max	At least 3 months	At least 3 months	The wait for routine initial psychiatric appts is currently 7 to 10 weeks. The wait for a routine follow-up psychiatry visit is 30-45 days.	Generally, the same as adult, though wait time for routine, non-urgent psychiatry is running 8-11 weeks.	At least 30 days	At least 30 days	N/A	N/A
Outpatient Psychotherapy Services	N/A	4-6 weeks	2-4 weeks	Wait times for routine outpatient psychotherapy is 4-6 weeks.	Wait times for routine outpatient psychotherapy is 4-6 weeks.	1-2 weeks	1-2 weeks	N/A	N/A
Alcohol and Other Drug Abuse Outpatient Treatment Services (MAT)	72 hours max	unknown	unknown	Wait times can range from 1-2 days to 2 weeks	Wait times can range from 1-2 days to 2 weeks depending on the route of access, flexibility of patient regarding location, provider, scheduling time.	N/A	N/A	2 weeks	N/A

		Carrier 1		Carrier 2		Carrier 3		Carrier 4	
Service Type	**Contract Standard**	**Actual Adult**	**Actual Child/ Adolescent**	**Actual Adult**	**Actual Child/ Adolescent**	**Actual Adult**	**Actual Child/ Adolescent**	**Actual Adult**	**Actual Child/ Adolescent**
Alcohol and Other Drug Abuse Day Treatment Services (Non-Psychiatric)	30 days max	2-4 weeks	N/A	2-4 weeks	2-4 weeks	2-3 weeks	2-3 weeks	One week max	N/A
Mental Health Day Treatment or Day Hospital Services		2-4 weeks	2-4 weeks	3-4 weeks	4-5 weeks	2-3 weeks	2-3 weeks	N/A	N/A

Most carriers report meeting contractual standards related to outpatient care. However, the notable exception to carriers meeting or exceeding standards is with Alcohol and Other Drug Abuse Outpatient Treatment Services (MAT). The contract standard wait time for MAT is a maximum of 72 hours. Two carriers report not tracking this information for either adults or adolescents/children, and one only track for adults. For the carriers that did report information, a range of information is indicated, showing that wait times can be up to two weeks despite the 72-hour limit.

4.8.3 Stakeholder Input

Community-based services aimed at continuing recovery for low and moderate acuity individuals were also a noted gap among stakeholders. Several focus groups described the system as "crisis-oriented." Individuals are aware that they can only access services if their condition deteriorates. Treatment for co-occurring conditions was also noted as a significant gap in this area. Stakeholders commented that lower wages and higher credentialing standards have led many mental health providers to move out of state. One notable exception is the Comprehensive Community Services program for individuals eligible for Medical Assistance, which advocates commented had expanded access for certain populations in recent years.

4.9 CRISIS CARE

When individuals are not receiving necessary care in an outpatient setting, they may find themselves in crisis. Table 18 identifies the total volume of crisis claims identified by payer. Table 19 presents the percentage of claims crisis care accounts by payer. When compared to other payers within Dane County, Medicaid and DHS patients utilize crisis care as the greatest proportion of their mental health care. Medicaid patients in Dane County have higher utilization of mental health crisis care than other Medicaid patients in Wisconsin. Medicare and private have notable proportions of AODA crisis care, however, they are still lower than state amounts.

Table 18. Number of Crisis Care Claims by Payer

Payer	MH			AODA		
	2016	2017	2018	2016	2017	2018
DHS	18,432	20,880	21,356	2,728	2,582	2,708
Medicaid	N/A	86,777	69,444	N/A	2,319	3,443
Medicare	N/A	9	6	N/A	1	3
Private	N/A	303	473	N/A	183	195

Data Source: DHS and WHIO

Table 19. Crisis Care Percent of Claims by Payer

Payer	MH			AODA		
	2016	2017	2018	2016	2017	2018
Dane County						
DHS	6%	7%	7%	4%	4%	5%
Medicaid	N/A	12%	11%	N/A	1%	2%
Medicare	N/A	1%	1%	N/A	8%	43%
Private	N/A	1%	1%	N/A	6%	3%
Wisconsin						
Medicaid	N/A	6%	4%	N/A	2%	2%
Medicare	N/A	0%	0%	N/A	14%	50%
Private	N/A	1%	1%	N/A	8%	4%

Data Source: DHS and WHIO

Drilling into the payer breakdown for crisis services, Medicaid pays for most of the mental health and AODA services (Figures 15-18). DHS follows behind. Combined, Medicaid and DHS account for over 90 percent of crisis care claims. Private insurance accounted for 1 percent or less of mental health crisis care in 2018 and 2017. For AODA, private insurance accounts for 3 percent of crisis claims. Individuals with private insurance are less likely to go into crisis for both mental health and AODA.

Figure 15. 2017 Mental Health Crisis Care by Payer*

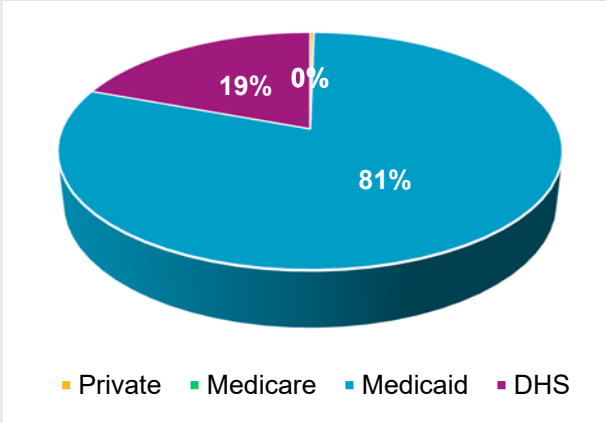


Figure 16. 2018 Mental Health Crisis Care by Payer*

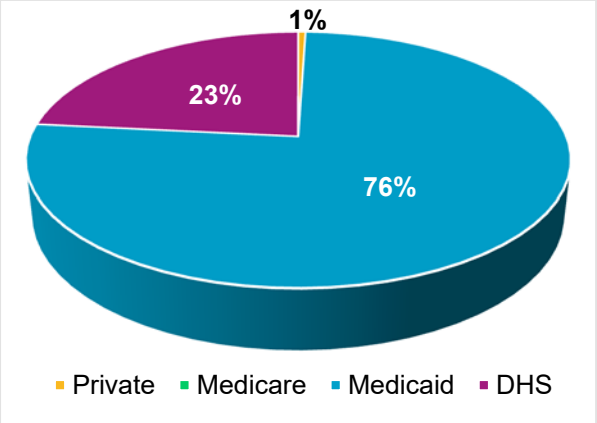


Figure 17. 2017 Alcohol and Other Drug Abuse Crisis Care by Payer*

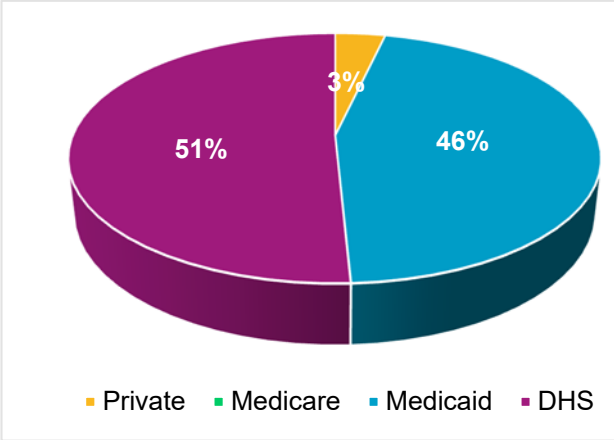
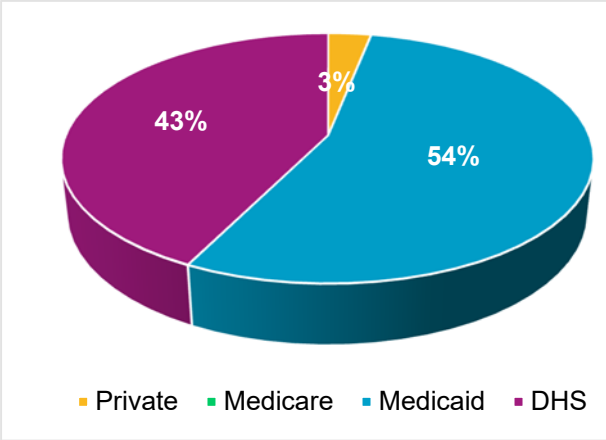


Figure 18. 2018 Alcohol and Other Drug Abuse Crisis Care by Payer*



*Assumes one unit of service from DHS is equivalent to one WHIO claim
Data Source: DHS and WHIO

4.9.1 Stakeholder Input

Further compounding crisis and Emergency Department demand is a lack of 24-hour services. Stakeholders pointed to national best practice models where crisis services are provided 24 hours a day with 23-hour crisis observation beds available to support inpatient and jail diversion. These topics are further discussed in Section 6.

4.10 INPATIENT CARE

The next level on the care continuum is inpatient care. Mental health inpatient care included in this analysis are claims labeled as inpatient, care at an institution for mental disease, and emergency detention. For AODA, claims labeled as inpatient and medically managed medical are included. Figures 19 through 22 breaks down the percent of care provided by the top 5 providers for mental health and top 3 providers for AODA. Winnebago Mental Health Institute and Mendota Mental Health Institute are state operated facilities. Mendota Mental Health Institute, St. Mary's Hospital, University Hospital, and Meriter Hospital are within Dane County limits, while Winnebago Mental Health Institute is 100 miles away. DHS patients are more

likely to use either Mendota or Winnebago, while those insured by Medicaid, Medicare, or private insurers are more likely to use Meriter, St. Mary's, and University Hospitals, or other inpatient settings nearby.

Figure 19. 2017 Provider Breakdown of Inpatient Mental Health Services*

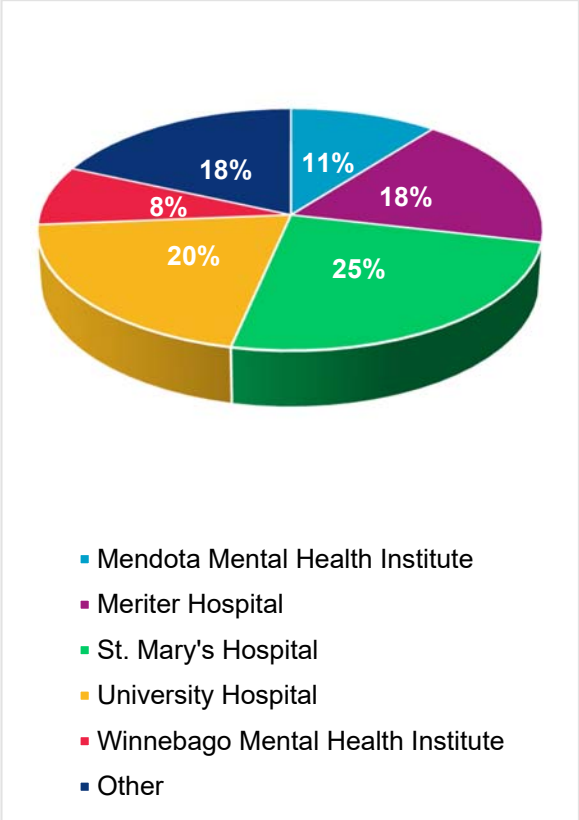


Figure 20. 2018 Provider Breakdown of Inpatient Mental Health Services*

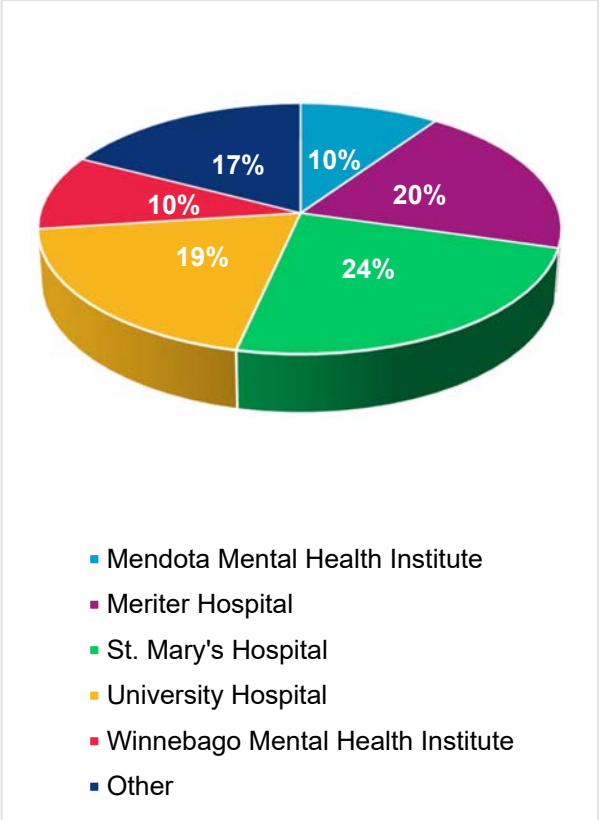


Figure 21. 2017 Provider Breakdown of Inpatient Alcohol and Other Drug Abuse Services*

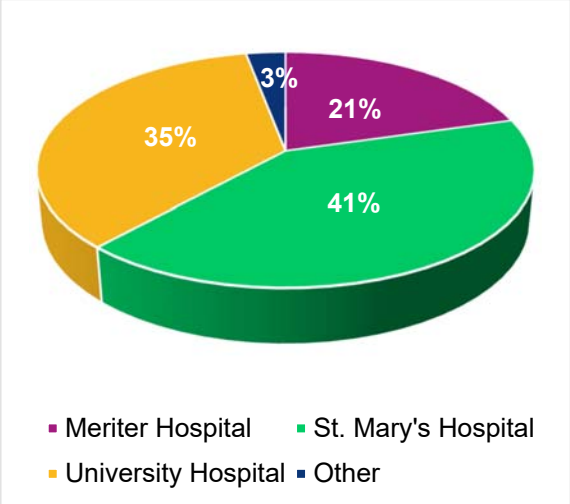
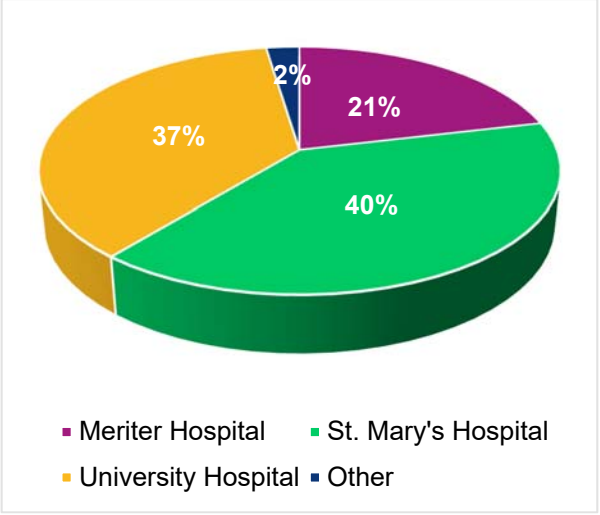


Figure 22. 2018 Provider Breakdown of Inpatient Alcohol and Other Drug Abuse Services*



*Assumes one unit of service from DHS is equivalent to one WHIO claim
Data Source: DHS and WHIO

Table 20 summarizes the volume of inpatient claims by payer for both mental health and AODA diagnoses. Table 21 shows the percent of claims by payer inpatient care accounts for. DHS has a comparable proportion of inpatient care claims for mental health compared to Medicaid and private insurers. Medicare has a higher proportion of inpatient claims than all other payers. As Medicare mainly deals with elderly populations, it is possible a higher level of care is more often necessary for those populations. Dane's Medicare population uses more inpatient care than others in the state. For AODA services, DHS has no reported claims for inpatient care. Medicaid, Medicare, and private pay have utilization proportions consistent with Wisconsin as a whole.

Table 20. Number of Inpatient Care Claims by Payer

Payer	MH			AODA		
	2016	2017	2018	2016	2017	2018
DHS	4,326	4,452	3,757	0	0	0
Medicaid	N/A	6,255	5,835	N/A	2,395	2,195
Medicare	N/A	69	30	N/A	0	2
Private	N/A	486	500	N/A	166	130

Data Source: DHS and WHIO

Table 21. Inpatient Care Percent Claims by Payer

Payer	MH			AODA		
	2016	2017	2018	2016	2017	2018
Dane County						
DHS	1%	1%	1%	N/A	N/A	N/A
Medicaid	N/A	1%	1%	N/A	1%	1%
Medicare	N/A	8%	4%	N/A	N/A	29%
Private	N/A	1%	1%	N/A	5%	2%
Wisconsin						
Medicaid	N/A	1%	1%	N/A	3%	2%
Medicare	N/A	2%	1%	N/A	0%	20%
Private	N/A	2%	1%	N/A	5%	2%

Data Source: DHS and WHIO

Figures 23 through 26 show the breakdown of inpatient units of service by payer. DHS and Medicaid are the main payer of mental health inpatient services. AODA inpatient services are mostly paid for by Medicaid.

Figure 23. 2017 Mental Health Inpatient Care by Payer*

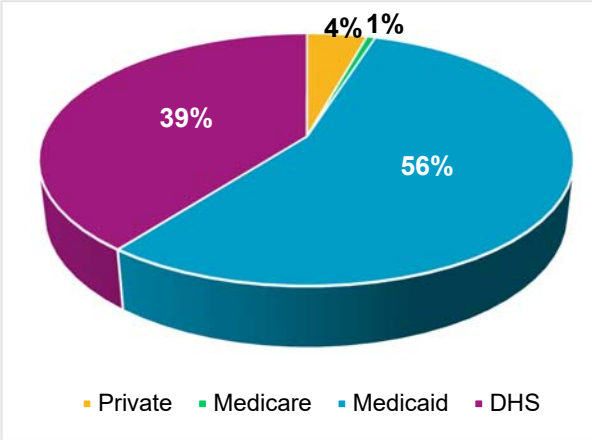


Figure 24. 2018 Mental Health Inpatient Care by Payer*

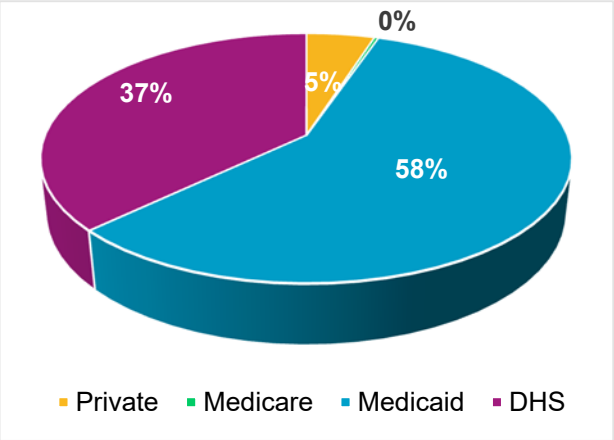


Figure 25. 2017 Alcohol and Other Drug Abuse Inpatient Care by Payer*

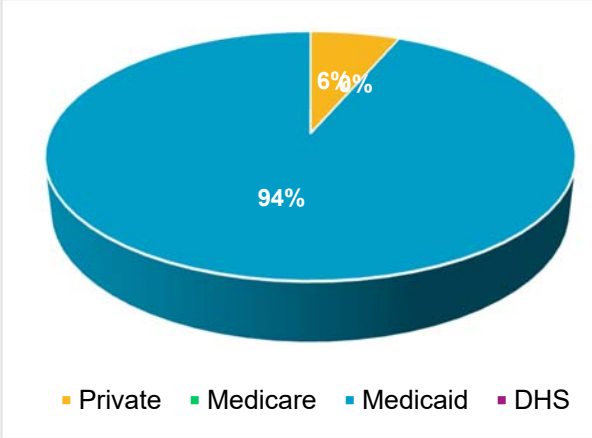
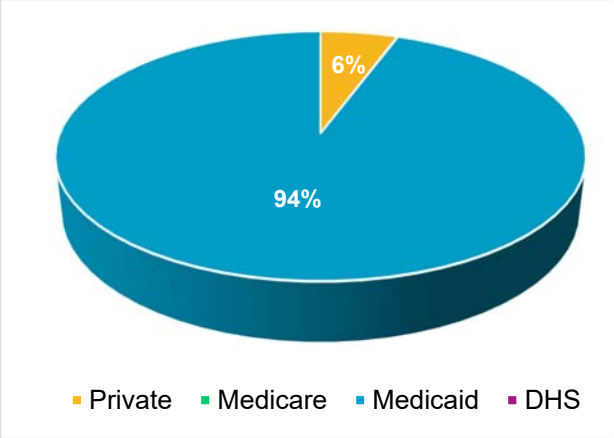


Figure 26. 2018 Alcohol and Other Drug Abuse Inpatient Care by Payer*



*Assumes one unit of service from DHS is equivalent to one WHIO claim
Data Source: DHS and WHIO

4.10.1 Wait Times

Carriers report low wait times for inpatient care, with patients typically being admitted right away. Once discharged, carriers report quick turn arounds for psychiatric follow-up appointments. Given the low response to the PCG request for wait time data from carriers, additional requests for wait time data were made by the Office of Commissioner of Insurance. These requests did not produce additional data. Given that the only wait time data available is self-reported and not system wide, we suggest that this data is used for information purposes only and not considered a full view of the current system. Carrier responses can be found in Table 22.

Table 22. Wait Times for Inpatient Care

		Carrier 1		*Carrier 2*		*Carrier 3*		*Carrier 4*	
Service Type	**Contract Standard**	**Actual Adult**	**Actual Child/ Adolescent**	**Actual Adult**	**Actual Child/ Adolescent**	**Actual Adult**	**Actual Child/ Adolescent**	**Actual Adult**	**Actual Child/ Adolescent**
Inpatient Psychiatric Care	N/A	No known wait time	No known wait time	Typically, immediate	Typically, immediate. Rarely a wait of 1 day.	N/A		1 – 3 days	
Inpatient Psychiatric Follow-up Appointment	30 days max	Within 30 days of discharge depending on the clinic and type of provider; a psychiatrist would be at least 3 months wait	Within 30 days of discharge depending on the clinic and type of provider; a psychiatrist would be at least 3 months wait.	Most often within one week.	Most often 7 days	1-2 weeks	1-2 weeks	Within 24 hours	N/A

4.11 STEP-DOWN AND RESIDENTIAL CARE

If patients do not require intensive care provided in an inpatient setting, they may be referred to a step-down facility or other residential facility for care. Table 23 displays the volume of claims by payer for step-down and residential care. Table 24 lists the percentage of total claims step-down and resident care accounts for by payer. DHS utilizes step-down and residential care for mental health more than all other payers in Dane County. While the other payers do have claims for the services, it comprises a very low proportion of their claims and overall claims. Similar findings are reported statewide. For AODA, DHS and private insurers utilize notable amounts of inpatient care. However, there is a lower proportion of residential care use by individuals privately insured when compared to the rest of the state.

Table 23. Number of Step-Down and Residential Care Claims by Payer.

Payer	MH			AODA		
	2016	2017	2018	2016	2017	2018
DHS	41,322	37,493	35,567	5,925	4,944	3,822
Medicaid	N/A	805	739	N/A	32	35
Medicare	N/A	0	1	N/A	0	0
Private	N/A	2	2	N/A	122	110

Data Source: DHS and WHIO

Table 24. Step-Down and Residential Care Percent of Claims by Payer.

Payer	MH			AODA		
	2016	2017	2018	2016	2017	2018
Dane County						
DHS	14%	12%	11%	9%	8%	8%
Medicaid	N/A	0%	0%	N/A	0%	0%
Medicare	N/A	N/A	0%	N/A	N/A	N/A
Private	N/A	0%	0%	N/A	4%	2%
Wisconsin						
Medicaid	N/A	0%	0%	N/A	0%	0%
Medicare	N/A	0%	0%	N/A	0%	0%
Private	N/A	0%	0%	N/A	10%	4%

Data Source: DHS and WHIO

When looking at all claims for step-down and residential care, DHS seems to be the sole user of these services (Figures 27-30). DHS may service higher acuity individuals that require an in between inpatient and outpatient. Furthermore, as DHS sends more individuals to out-of-county facilities such as Winnebago Mental Health Institute, having access to step-down facilities is way to have the individual return to their community once they are more stable. For AODA, the proportion of private pay may be attributed to stays in rehabilitation facilities.

Figure 27. 2017 Mental Health Step-Down and Residential Care by Payer*

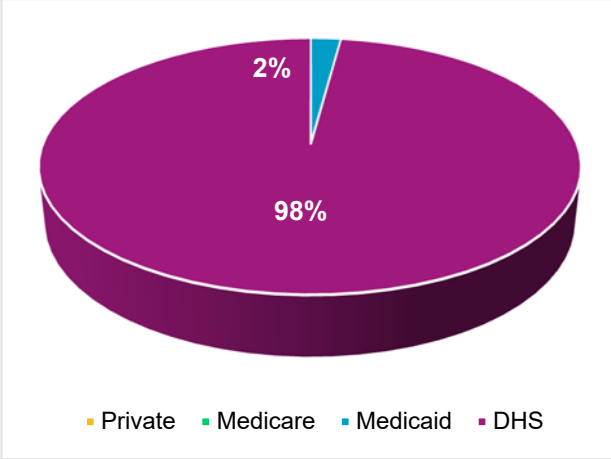


Figure 28. 2018 Mental Health Step-Down and Residential Care by Payer*

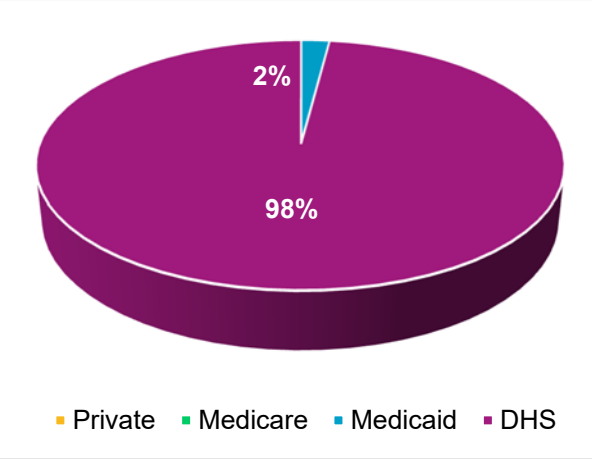


Figure 29. 2017 Alcohol and Other Drug Abuse Step-Down and Residential Care by Payer*

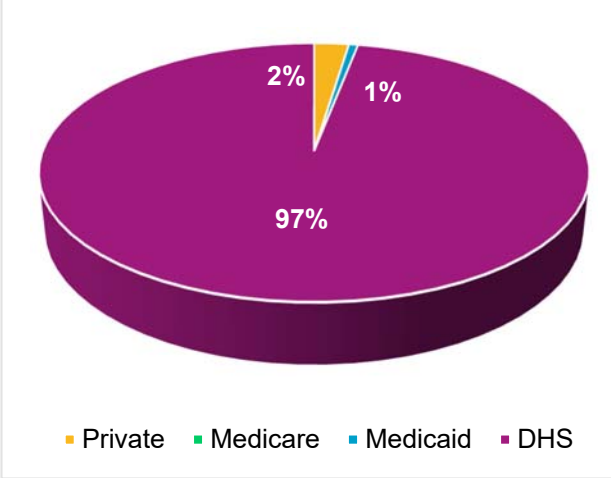
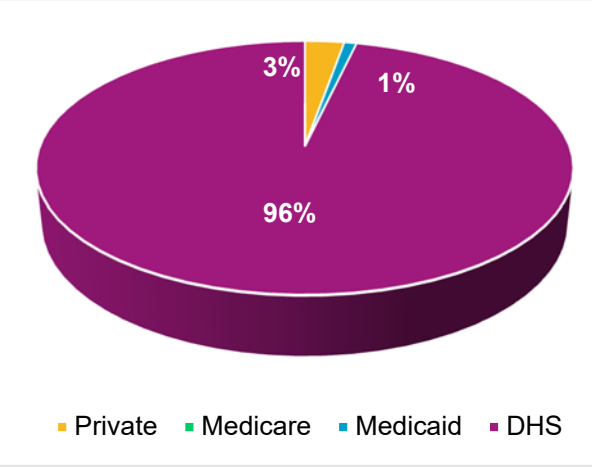


Figure 30. 2018 Alcohol and Other Drug Abuse Step-Down and Residential Care by Payer*



*Assumes one unit of service from DHS is equivalent to one WHIO claim
Data Source: DHS and WHIO

4.11.1 Stakeholder Feedback

For individuals who have stabilized in an inpatient setting, step-down, residential and supportive housing placements also fall significantly short of supply. Stakeholders noted that a lack of such intermediate care options lead to decompensation, crises, and readmissions – exacerbating the need for crisis services and inpatient beds. This issue is especially prevalent for individuals being released from jail. Stakeholders commented that release dates are not confirmed with enough notice to establish a discharge plan, widening the gap between recently released and access to community services.

4.12 CASE MANAGEMENT AND TRANSITIONAL SUPPORTS

Case management and transitional supports are analyzed as a separate category as they transcend the typical outpatient, inpatient, and residential care categories. Case management throughout the care

continuum ensures that individuals have the necessary social supports to recover. Table 25 displays the volume of claims by payer for case management and transitional supports for MH and AODA, respectively. Table 26 lists the percentage of total claims case management and transitional supports account for by payer. DHS utilizes more case management as part of the care continuum than other payers for both mental health and AODA. Medicaid also has a sizeable utilization of case management services. As populations served by DHS and Medicaid are on the lower end of the socio-economic spectrum, they may require more transitional supports to account manage varying social determinants of health. As seen in Figures 31 to 34, DHS and Medicaid are responsible for most case management claims.

Table 25. Number of Case Management and Transitional Support Claims by Payer

Payer	MH			AODA		
	2016	2017	2018	2016	2017	2018
DHS	34,709	23,734	22,311	23,106	23,454	18,550
Medicaid	N/A	2,148	2,778	N/A	780	968
Medicare	N/A	5	9	N/A	0	0
Private	N/A	8	21	N/A	0	0

Data Source: DHS and WHIO

Table 26. Case Management and Transitional Supports Percent of Claims by Payer

Payer	MH			AODA		
	2016	2017	2018	2016	2017	2018
Dane County						
DHS	12%	8%	7%	35%	38%	38%
Medicaid	N/A	0%	0%	N/A	0%	0%
Medicare	N/A	1%	1%	N/A	N/A	N/A
Private	N/A	0%	0%	N/A	N/A	N/A
Wisconsin						
Medicaid	N/A	0%	0%	N/A	0%	0%
Medicare	N/A	13%	13%	N/A	0%	0%
Private	N/A	0%	0%	N/A	0%	0%

Data Source: DHS and WHIO.

Figure 31. 2017 Mental Health Case Management and Transitional Supports by Payer*

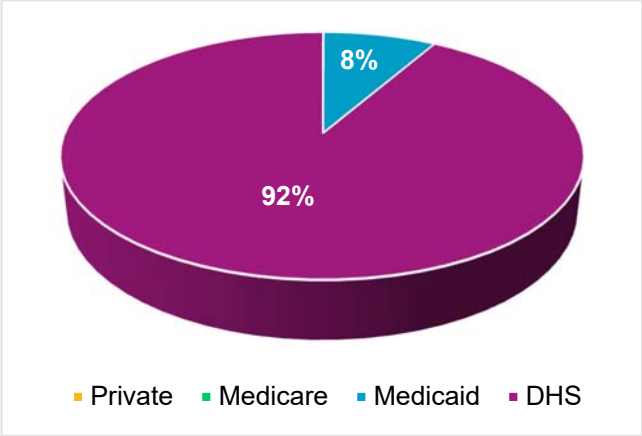


Figure 32. 2018 Mental Health Case Management and Transitional Supports by Payer*

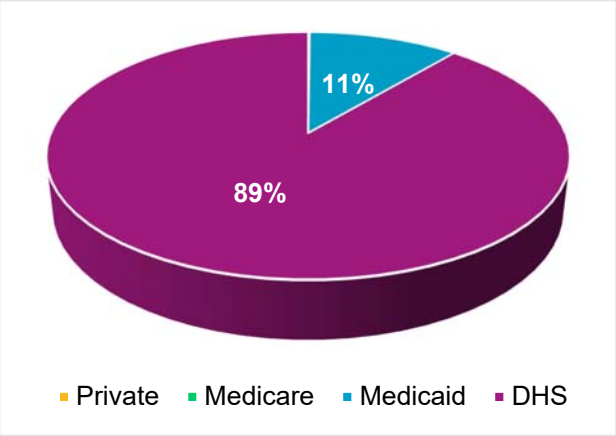


Figure 33. 2017 Alcohol and Other Drug Abuse Case Management and Transitional Supports by Payer*

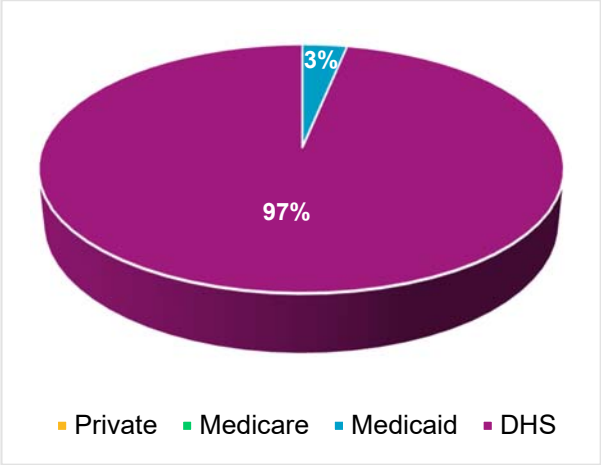
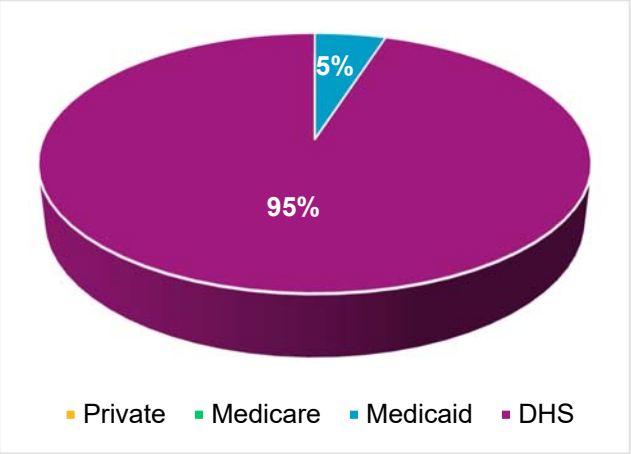


Figure 34. 2018 Alcohol and Other Drug Abuse Case Management and Transitional Supports by Payer*



*Assumes one unit of service from DHS is equivalent to one WHIO claim
Data Source: DHS and WHIO

5. OUTCOMES AND DISPARITIES

5.1 APPROACH

Regression analysis was also completed to answer questions related to racial disparities in access and utilization. Racial analysis was limited to DHS data. The WHIO dataset, which provided private, Medicaid, and Medicare claims, is deidentified and does not include race and ethnicity. It is important to remember DHS's purpose is to serve low-income individuals without other forms of insurance. There may be racial differences imbedded within the population that DHS serves. Broader comparisons on care utilization by race and payer, which proxies socio-economic status, are not possible.

DHS claims were grouped to seven racial and three ethnic categories. The racial categories were unknown race, White, Black, American Indian or Alaska Native, Asian, Native Hawaiian or Pacific Islander, and multi-racial. Ethnic categories were defined as unknown ethnicity, Non-Hispanic, and Hispanic. All races and ethnicities are self-reported by patients. White, Non-Hispanics were used as the baseline group for analysis.

Analysis of follow-up care and readmission post inpatient discharge was conducted for DHS claims. The follow-up care rate was determined by the number of unique hospitalizations and whether the patient was transferred to a step-down facility or received outpatient care within 7 and 30 days of discharge. Readmission rates were calculated by whether a patient was readmitted within 30 days of discharge or within the calendar year.

5.2 OUTPATIENT RELATED

Stakeholders stressed that people of color are less likely to be able to access culturally competent, behavioral health services. In addition to a lack of representation within the provider community, stakeholders noted that more training is needed for providers to effectively deliver culturally competent services. Advocates stressed the need for equity, particularly with respect to opioid use, noting the perception that African American individuals are more likely to be arrested than diverted to opioid treatment. Low-income individuals and families, justice-involved individuals, and at-risk youth were also identified as lacking the appropriate services and supports across the community. Broadly speaking, stakeholders stressed the need for more implicit bias training and a reduction of stigma regarding behavioral health across the community.

Regression analysis of DHS data shows persons who do not report a race or ethnicity utilize less mental health outpatient services when compared to White, Non-Hispanics (Table 27). American Indian or Alaska Natives utilize less outpatient mental health than White, Non-Hispanics. Blacks received less mental health outpatient services in 2016, but that does not extend into 2017 and 2018. For AODA, Blacks received more outpatient services than Whites. Asians receive more mental health services than Whites. Multi-racial individuals received more AODA services than Whites and more mental health services than whites in 2018. While the analysis shows some gaps in utilization, it does not speak to the quality of care and whether care is culturally competent as stakeholders have mentioned.

Table 27. Racial Analysis on DHS Outpatient Services Claims Utilization for Calendar Years 2016-2018

Race	2016 Mental Health	2017 Mental Health	2018 Mental Health	2016 AODA	2017 AODA	2018 AODA
Unknown Race	-	-	-	*	*	*
Black	-	*	*	+	+	+
American Indian or Alaska Native	-	-	-	-	-	-
Asian	+	+	+	-	*	*
Native Hawaiian or Pacific Islander	-	*	-	*	-	-
Multi-racial	*	*	+	+	+	+
Unknown Ethnicity	-	-	-	-	+	+
Hispanic	-	+	*	-	+	+

Data Source: DHS
For full regression values, please see Appendix C

*No Significant Findings
- Fewer Units of Service when Compared to White, Non-Hispanics
+ More Units of Service when Compared to White, Non-Hispanics
N/A Not enough data was available for analysis

5.3 CRISIS RELATED

Most races and ethnicities are as likely or less likely than White, Non-Hispanics to utilize crisis care. However, the two exceptions. Individuals self-identifying as Multi-Racial are more likely to utilize crisis care for mental health than White, Non-Hispanics. In 2017, Blacks were more likely to use crisis care for AODA.

There is no correlation between increased utilization of crisis care and increased utilization of outpatient services by race.

Table 28. Racial Analysis on DHS Crisis Related Claims Utilization for Calendar Years 2016-2018

Race	2016 Mental Health	2017 Mental Health	2018 Mental Health	2016 AODA	2017 AODA	2018 AODA
Unknown Race	-	-	-	N/A	-	-
Black	-	*	-	*	+	-
American Indian or Alaska Native	-	-	*	-	-	N/A
Asian	*	*	*	*	-	-
Native Hawaiian or Pacific Islander	-	*	-	*	-	*
Multi-racial	+	+	+	-	-	-
Unknown Ethnicity	-	-	-	-	-	*
Hispanic	-	-	*	-	-	-

Data Source: DHS
For full regression values, please see Appendix C

*No Significant Findings
- Fewer Units of Service when Compared to White, Non-Hispanics
+ More Units of Service when Compared to White, Non-Hispanics
N/A Not enough data was available for analysis

5.4 INPATIENT RELATED

Inpatient care was also limited to mental health claims paid for by DHS as there were no cases of inpatient claims. Regression analysis (Table 29) shows that between 2016-2018, Asians utilized more inpatient units of service than Whites. In 2016, Multi-Racial individuals also utilized more inpatient care than Whites. This may indicate failures within the continuum of care to manage mental health conditions before escalating to an acuity that requires inpatient levels of care. Although outpatient utilization is roughly on par with Whites, except for 2018, there may be greater need in the population than is currently being addressed. Greater outreach may be needed to reduce stigma and other barriers that result in lack of utilization of lower levels of care. Other races utilized less inpatient care than Whites.

Table 29. Racial Analysis on DHS Inpatient Services Claims Utilization for Calendar Years 2016-2018

Race	2016 Mental Health	2017 Mental Health	2018 Mental Health
Unknown Race	-	-	-
Black	-	-	-
American Indian or Alaska Native	N/A	N/A	N/A
Asian	+	+	+
Native Hawaiian or Pacific Islander	N/A	-	-
Multi-racial	+	-	-
Unknown Ethnicity	-	-	-
Hispanic	*	-	-

Data Source: DHS
For full regression values, please see Appendix C

*No Significant Findings
- Fewer Units of Service when Compared to White, Non-Hispanics
+ More Units of Service when Compared to White, Non-Hispanics
N/A Not enough data was available for analysis

5.4.1 Additional Inpatient Care Metrics

Additional metrics of inpatient care were also completed. The first is post-hospitalization follow-up care, comparing Dane to national metrics from the National Committee for Quality Assurance (NCQA). NCQA measures percentage of individuals with follow-up within seven and 30 days of discharge.[6] As previously mentioned, exact dates of service are sometimes unavailable in the DHS dataset though approximations can be made to allow for comparison. PCG determined that, if the month of discharge and the month post discharge had utilization, it was deemed reasonable to assume follow-up was given in the appropriate timeframe. Dane County's crisis unit also provides follow-up care post discharge. Crisis related (e.g. crisis home, gateway, and crisis home) billings were also included as follow-up care. As of 2019, a dedicated crisis follow-up code is being utilized. Table 30 compares the percentage of hospitalizations with follow-up post-discharge for Dane patients with NCQA data.

Table 30. Percent of Hospitalizations with Follow-Up Post-Discharge for 2016-2018

	DHS 2016-2018	NCQA 2016-2017 Average
Follow-Up Within 7 Days of Discharge*	28%	41%
Follow-Up Within 30 Days of Discharge*	50%	61%

Data Source: DHS
*Due to lack of exact dates across DHS data, estimated follow-up percentages may be deflated.

The NCQA reports follow-up care rates based on private insurers, Medicaid, and Medicare. While not an exact comparison, the population Dane County provides for is most like Medicaid populations. The average seven-day follow-up care rate in NCQA's dataset for 2016 and 2017 is 41%, while the average 30-day follow-up care rate is 61%.[7] Dane County's rates fall below Medicaid's. This suggests individuals are accessing follow-up care outside of DHS funded providers, there are issues accessing services, or both. While outpatient services do have capacity, individuals may have other issues accessing follow-up care such as time or transportation. Furthermore, the handoff process may need to be stronger to ensure successful case management is accomplished.

Racial analysis on follow-up care rates were also completed. Based on the regression model (Table 31), Blacks and individuals with unknown ethnic background had lower rates of follow-up care within the seven- and 30-day windows than White, Non-Hispanics. Asians, Native Hawaiian or Pacific Islands, and Multi-Racial individuals had higher 7- and 30-day follow up rates than White, Non-Hispanics.

Table 31. Racial Analysis on Follow-Up Care Rate from 2016-2018

Race	7 Day	30 Day
Unknown Race	*	*
Black	-	-
American Indian or Alaska Native	N/A	N/A
Asian	+	+
Native Hawaiian or Pacific Islander	+	+
Multi-racial	+	+
Unknown Ethnicity	-	-
Hispanic	*	*

Data Source: DHS
For full regression values, please see Appendix C

*No Significant Findings
- Fewer Units of Service when Compared to White, Non-Hispanics
+ More Units of Service when Compared to White, Non-Hispanics
Blank cells indicate not enough data was available for analysis

[6] https://www.ncqa.org/hedis/measures/follow-up-after-hospitalization-for-mental-illness/
[7] https://www.ncqa.org/hedis/measures/follow-up-after-hospitalization-for-mental-illness/

Readmission rates were also calculated for the standard 30-day period and within the calendar year of discharge. Within 30 days of discharge, 2 percent of patients were readmitted for the same diagnosis code or for a different diagnosis code (Table 32). Dane's readmission rates are similar to a 2012 study by the Healthcare Cost and Utilization Project (HCUP). HCUP reports that for individuals with mood disorders, there is a 9% readmission rate within 30 days for the same principal diagnosis, 12.6 percent readmission rate for the same principal or secondary diagnosis, and 15 percent rate for any cause.[8] For Schizophrenia, rates are much higher with a 30-day readmission rate for the same principal diagnosis at 15.7 percent, readmission rate for the same principal or secondary diagnosis at 18.6 percent, and for any cause at 22.4 percent.[9]

Table 32. Percent of Inpatients Claims with Readmissions within 30 Days of Discharge

	2016	2017	2018
	Percent Readmitted	*Percent Readmitted*	*Percent Readmitted*
Same Diagnosis Code	7%	6%	3%
Different Diagnosis Code	5%	14%	3%

Data Source: DHS

As mental health conditions are chronic, to gain a longitudinal perspective on readmissions, rates were also calculated for readmissions within the same calendar year (Table 33). This may suggest that treatment and follow-up care are improving to reduce the need for inpatient admissions. The readmission rates for the same diagnosis code have a decreasing trend. For readmissions with a different diagnosis code, no clear trend is established.

Table 33. Percent of Inpatient Claims with Readmissions within the Calendar Year of Discharge

	2016	2017	2018
	Percent Readmitted	*Percent Readmitted*	*Percent Readmitted*
Same Diagnosis Code	17%	12%	9%
Different Diagnosis Code	7%	20%	11%

Data Source: DHS

[8] https://www.hcup-us.ahrq.gov/reports/statbriefs/sb189-Hospital-Readmissions-Psychiatric-Disorders-2012.pdf

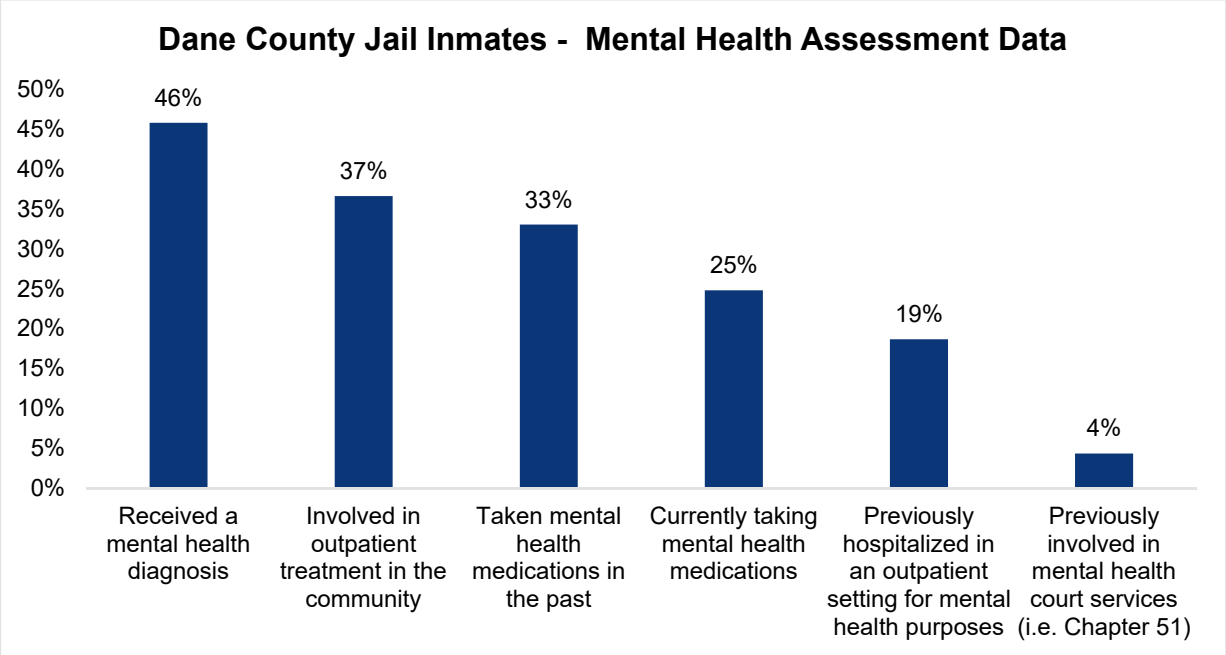
[9] https://www.hcup-us.ahrq.gov/reports/statbriefs/sb189-Hospital-Readmissions-Psychiatric-Disorders-2012.pdf

6. IMPACT OF LAW ENFORCEMENT PRACTICES AND EMERGENCY DETENTION

6.1 INTRODUCTION

Law enforcement practices and the intersection of behavioral health with law enforcement have long been studied with similar outcomes across evaluations. States and local jurisdictions continue to struggle with how to address the emergent needs of these individuals while balancing the public safety response. Nationally, jails and prisons are the largest provider of mental health services in the country. The Dane County Sheriff's Office (DCSO) maintains full-time mental health professionals, also referred to as the Mental Health Team, in the Dane County jail through a contract with Wellpath. These staff meet with every arrestee booked into the jail and complete a mental health assessment. Wellpath data from November 1, 2016 – August 31, 2017 shows there were approximately 8,700 inmates booked into Dane County jail, and of those, 46% had previously been diagnosed with a mental illness and 4% had previously been involved in court services related to their mental health issue, such as Chapter 51.

Figure 35. Wellpath Mental Health Assessment Data



Over the past several years there have been several initiatives within Dane County to help understand, address and implement interventions to reduce the reliance on jail for those individuals struggling with a mental health issue or behavioral health crisis:

- In 2016, the Diversion Work Group of the Public Protection and Judiciary Committee was charged to focus on issues related to alternatives to jail confinement, reducing the length of stay for individuals placed in jail, and concerns related to the jail confinement of and use of solitary confinement for individuals with mental health issues. The Diversion Work Group developed 22 recommendations with several recommendations focused specifically on diverting individuals with mental health issues from the Dane County jail.

- In 2016, the Dane County Criminal Justice Council began implementation of the Public Safety Assessment (PSA), a risk assessment tool developed by the Laura and John Arnold Foundation used at initial court appearances to make accurate, efficient, and evidence-based decisions on whether a defendant should be detained prior to trial or released to the community.

- In 2016 and 2017, the Dane County Criminal Justice Council worked with the National Council on Crime and Delinquency (NCCD) to initiate cross-agency data sharing and the development of a memorandum of understand (MOU) to support the initiative. The MOU was agreed upon by the Dane County Sheriff's Office, the Dane County Office of the District Attorney, the Madison Police Department, the Dane County 5-City Consortium (Middleton, Sun Prairie, Monona, Verona, and Fitchburg police departments), the Dane County Clerk of Courts, and the Dane County Circuit Court Judges.[10]

- In 2017, Dane County became one (1) of 20 jurisdictions across the country to join the Safety and Justice Challenge through the John D. and Catherine T. MacArthur Foundation, an initiative dedicated to reducing over-incarceration in local jails.

- In 2018, the Dane County Board of Supervisors with the Dane County Criminal Justice Council sought the guidance of Policy Research, Inc. to conduct Sequential Intercept Model (SIM) Mapping for Dane County. SIM Mapping is a facilitated workshop to develop a map to illustrate how individuals with behavioral health needs enter and flow through the criminal justice system. The exercise helps stakeholders identify gaps and opportunities for prevention of further penetration into the criminal justice system.[11]

- In May 2019, the Dane County Criminal Justice Council created the Behavioral Health Subcommittee to focus on the intersection of criminal justice and behavioral health.

These initiatives have resulted in many recommendations for improving the system through data sharing, collaboration, and evidence-based practice implementation. Through interviews and focus groups with key stakeholders some of these initiatives appear to have made steps in moving the system along, but there is still work to be completed across the county to address the intersection of law enforcement and behavioral health.

A common theme throughout our stakeholder discussions was the lack of diversion options designed specifically for individuals with mental health issues, specifically related to pre-arrest diversion. While there are some current programs, such as the Journey Mental Health Crisis Stabilization unit, gaps still remain in staff capacity and wages and over-night operations. Pre-arrest diversion programs divert individuals before entering the criminal justice system. Another common theme was that Madison Police Department's (PD) Crisis Intervention Team model (CIT) and dedicated Mental Health Unit officers are a great resource to the community, however, this program is only within the jurisdiction Madison and is not replicated throughout Dane County due to resource limitations and funding for additional embedded crisis workers. Furthermore, the time spent by law enforcement during the emergency detention process, specifically due to transporting individuals, takes significant resources away from the department due to the emergency detention law in Wisconsin. Lastly, it is important to note that there are data sharing efforts underway for agencies to share important data on the intersection between law enforcement and behavioral health and the Dane County Criminal Justice Council is in the process of studying the "high-utilizers" of both systems as many of these individuals experience complex conditions such as chronic health conditions, substance use disorders and mental health disorders.

There are some promising practices across the country that Dane County could further explore to help divert these individuals from coming into the system, such as pre-arrest diversion or law enforcement assisted diversion programs. Other programs, such as mental health courts, also provide resources and wraparound services to this population that aide in stabilization, housing and employment opportunities. It is important to note that although mental health courts are effective, these programs must have the resources needed to properly deal with the population, such as access to treatment providers,

[10] National Council on Crime and Delinquency. (2018). Dane County Criminal Justice Council Data-Sharing Project Progress Report. https://cjc.countyofdane.com/documents/NCCDUpdate.pdf

[11] Policy Research. (2018). *Sequential intercept model mapping report for Dane County.* Delmar, NY: Policy Research, Inc.

hospitalization as needed, housing, etc. The sections below further outline the current state within Dane County and the intersection of law enforcement and behavioral health.

6.2 PRACTICES FOR INDIVIDUALS WITH MENTAL ILLNESS AND/OR SUBSTANCE USE

While people with mental illness are not more prone to violence, it is common for law enforcement to be called when a person is experiencing a mental health crisis due to limited community health treatment options nationwide. Law enforcement agencies have reported that anywhere from five (5) to 15 percent of their annual calls involve an individual struggling with mental illness.[12] According to The Treatment Advocacy Center, people with untreated mental illness are 16 times more likely to be killed during a police encounter.[13] It is imperative for law enforcement and other first responders to have training on how to appropriately respond to a mental health crisis to help de-escalate the situation, reduce the risk of violence, and ultimately, improve outcomes for people suffering from mental illness.

There are over 20 law enforcement agencies in Dane County, and each jurisdiction has different procedures and practices for responding to individuals with mental illness. Of these jurisdictions, only Madison PD has a CIT, which is a national best practice. A CIT is a collaborative partnership between law enforcement, mental health providers, emergency service providers, and individuals with mental illness. Crisis Intervention training is a 40-hour training program led by mental health professionals to educate officers on mental health issues, including the signs and symptoms of mental illness and treatment protocol. NAMI states that at least 25% of law enforcement first responders in each jurisdiction should be trained for a minimum of 40 hours consistent with model standards for police crisis intervention training to better assure safety, appropriate de-escalation, less lethal consequences and opportunities for treatment.[14] However, currently only approximately 15% of police jurisdictions utilize CIT programs.

Madison PD has been designated a Mental Health Learning Site by the Bureau of Justice Assistance (BJA). Learning Sites represent a diverse cross-section of perspectives and program examples that are dedicated to helping other jurisdictions improve their responses to people with mental illnesses. All Madison PD officers receive approximately 100 hours of crisis management and mental health-related training during the pre-service academy, as well as ongoing in-service training. Additional CIT training is offered to officers outside of Madison PD through Dane County Sherriff's Office and through Dane County's NAMI affiliate. NAMI offers both CIT Training and Crisis Intervention Partner (CIP) Training, which is modeled after CIT training but designed for a larger audience, including emergency and hospital personnel. In 2018, NAMI conducted CIT training for 50 law enforcement officers in the county and CIP training for 95 emergency responders and other personnel.[15]

In addition, the Madison Police Department has a full-time mental health unit that provides a dedicated and specialized response to comprehensively address mental health issues within the community. This unit consists of both Mental Health Officers and Mental Health Liaisons. Mental Health Officers are dedicated, full- time, sworn officers focused on responding to people with mental illness. There are six full-time officers (one per district) and Mental Health Officers are joined by three in-house crisis workers, provided by Journey. Together, this unit takes a problem-oriented approach to address the underlying issue generating the calls for service. Mental Health Liaisons, who are sworn volunteers, also assist with crisis calls when available. Additionally, they are responsible for identifying barriers regarding access to services, coordinating services with partner agencies, serving as a point of contact for residents with mental health concerns in the community, and providing individualized follow up plans for individuals.

[12] https://www.powerdms.com/blog/policing-the-mentally-ill-tactics-best-practices/
[13] https://www.treatmentadvocacycenter.org/key-issues/criminalization-of-mental-illness/2976-people-with-untreated-mental-illness-16-times-more-likely-to-be-killed-by-law-enforcement-
[14] https://www.nami.org/About-NAMI/Policy-Platform/10-Criminal-Justice-and-Forensic-Issues
[15] https://www.namidanecounty.org/cit-cip

While Madison serves as a national example for law enforcement response to mental illness, this model is not replicated across Dane County. The Dane County Sheriff's Office (DCSO) reported they have unit of community deputies whose focus is on working with the community to make referrals for services, however, they are not a fully dedicated mental health unit. Additionally, they are currently missing the assistance of a trained crisis worker as part of the unit, as only half of the position is currently filled. Journey Mental Health reports that one reason they struggle to fill crisis positions in the county is due to low wages in comparison to other counties across the state – currently, crisis workers earn between $33,000 - $48,000 annually. Currently, there are two (2) open crisis worker positions that are waiting to be filled. First responders in Dane County have complaints that serving Madison is one thing, but the rural communities feel left out, as there are fewer services and resources available in rural parts of the counties. Of the approximately 20 smaller law enforcement agencies across Dane County, both Sun Prairie Police Department and Fitchburg Police Department report sending officers to Crisis Intervention Training. Additionally, while Deforest Police Department does specifically mention CIT, they do state that their officers work to find community-based interventions and resources for individuals when responding to mental health calls for service.

Figure 36. Overview of Madison Police Department's Mental Health Unit (2018)

Law enforcement interventions, while important, cannot successfully deliver meaningful community change without follow-up mental health services to provide further treatment and stabilization to individuals with mental illness. Law enforcement agencies should develop cross-system, collaborative partnerships with local behavioral health agencies in order to implement a comprehensive approach to mental health. These cross-system approaches, also known as police-mental health collaborations (PMHCs), build on the success of mental health training and specialized teams by layering multiple types of response models—e.g., CIT, co-responders, and mobile crisis intervention teams—and implementing one or more of these models as part of a comprehensive approach to meet their needs.[16] With these partnerships, law enforcement officers can partner with a specialized team from the behavioral health agency to divert people away from jails and into behavioral health services. Madison has worked to develop their PMHC through the development of their Mental Health Unit and the collaborative partnerships they have with behavioral health agencies, including embedded crisis workers from Journey in their Mental Health Unit, across Dane County.

Better data and information sharing between agencies is critical to tracking and improving outcomes. Information should be shared and easily accessible between law enforcement agencies, jails, behavioral health centers, and other health care providers. This concept was recently reinforced in the SIM Mapping Report for Dane County prepared by Policy Research, Inc, who stated that "creating a data match with information from local/state resources from time of arrest to pre-trial can enhance diversion opportunities before and during the arraignment process".[17] Not all agencies in Dane County that deal with mental health and criminal justice have access to one another systems, currently. However, there are existing efforts in place to improve data sharing across the county. The Dane County Criminal Justice Council (CJC) and the National Council on Crime and Delinquency (NCCD) have partnered to improve the criminal justice system through

[16] https://csgjusticecenter.org/wp-content/uploads/2019/04/Police-Mental-Health-Collaborations-Framework.pdf
[17] Policy Research. (2018). *Sequential intercept model mapping report for Dane County.* Delmar, NY: Policy Research, Inc.

data sharing and analytics. There is an MOU in place that promotes data sharing with law enforcement agencies across the county, including Dane County Sheriff's Office, the Dane County Office of the District Attorney, the Madison Police Department, the Dane County 5-City Consortium (Middleton, Sun Prairie, Monona, Verona, and Fitchburg police departments), the Dane County Clerk of Courts, the Dane County Circuit Court Judges, and the Wisconsin Department of Corrections (DOC).[18]

Many of the individuals we spoke with also mentioned racial disparity is an issue across Wisconsin and first responders need more education around racial bias and implicit bias along with training in cultural competency. Racial disparity in the criminal justice system is a noted national problem. Per the NAACP, African Americans are incarcerated at more than 5 times the rate of whites.[19] In a study of the Dane County Jail conducted in 2016 by Mead and Hunt, they noted that black inmates appear to have a total Average Length of Stay (ALOS) which is approximately 31% higher than white inmates. While performing a deep review of racial disparity in law enforcement response is outside of the purview of this study, we recommend further research on this issue.

6.3 INCARCERATION, EMERGENCY DETENTION, AND PROTECTIVE CUSTODY ALTERNATIVES

Currently, jails and prisons are the largest provider of mental health services in the country. A person suffering from mental illness is more likely to be encountered by police than to get medical help. According to NAMI, 15% of men and 30% of women booked into jails have a serious mental health condition and nearly 2 million people with mental illness are booked into jail each year.[20] While ultimately, the goal should be to provide mental health treatment to individuals outside of the criminal justice system, there are a number of strategies and programs that could be implemented to better assist people with mental illness currently in the criminal justice system. Nationally, a variety of diversion programs exist to divert people with mental illness out of the criminal justice system, including pre-booking, police-based diversion programs; pre-trail, court-based diversion programs, and alternative sentencing, or conditional release programs. However, these programs specifically targeted for individuals with mental illness are scarce.

Dane County has multiple resources for individuals experiencing mental health issues to access prior to arrest. These programs include:

- All law enforcement agencies have some number of officers that have Crisis Intervention Team (CIT) training. The Madison Police Department has three (3) Journey Mental Health crisis workers embedded within the agency to assist with mental health related calls. The Dane County Sheriff's Office also has one (1) embedded crisis worker.
- Journey Mental Health operates a dedicated 24/7 crisis hotline and Solstice House operates a warmline as additional support.
- Mobile Crisis Response Team. Journey provides mobile crisis to Dane County seven days a week between 8am-12pm. Currently there are two to three nights a week when mobile crisis is available between 11:45pm-8am. The nights in which there is no crisis worker on site, there is a crisis worker available for telephone consultation and to facilitate emergency detentions. Journey is currently in the process of hiring overnight mobile crisis workers to be able to provide mobile crisis seven days a week, 24 hours per day.
- Crisis Care Continuum. Journey offers several centers dedicated to assisting consumers at all stages throughout their care. The Bayside Care Center provides treatment in a residential facility, as an alternative to a psychiatric hospital, typically for seven (7) days. Resource Bridge provides crisis

[18] https://cjc.countyofdane.com/documents/NCCDUpdate.pdf
[19] https://www.naacp.org/criminal-justice-fact-sheet/
[20] https://www.nami.org/Learn-More/Public-Policy/Jailing-People-with-Mental-Illness

- stabilization services for up to 90 days. Recovery House provides step-down crisis care for up to 60 days.
- Tellurian Crisis Assessment, Recovery and Empowerment (CARE) Center. The CARE center provides crisis stabilization services for individuals as a diversion program and for individuals as a step-down from state hospitals through 10 contracted beds for Dane County residents.
- Comprehensive Community Services (CCS). The Dane County Department of Human Services CCS program provides a variety of psychosocial rehabilitation services to individuals with mental health and co-occurring disorders to achieve independent living and to facilitate recovery.
- Peer Support Services. Solstice House provides peer respite services where consumers stay for up to five (5) days.
- Other Services: Substance abuse services and housing services are also provided within the community.

A variety of diversion programs exist within Dane County across systems and at different intercepts; however, there a limited number of programs designed to help those specifically with mental health related issues. In addition to working with the Madison Police Department and the Dane County Sheriff's Department, Journey Mental Health Center has a Crisis Unit with over 20 crisis workers who respond to calls throughout the day without law enforcement. This unit is one of the true mental health diversion resources available in the county. The mobile crisis workers go out into the community for emergency detentions, home visits, hospital funding evaluations, risk assessments. They also complete face to face assessments at the crisis unit, as well as risk assessments on the phone. Currently, there are vacancies for the overnight mobile crisis worker positions. Table 34, below, shows the total number of crisis staff employed by Journey Mental Health across Dane County. These staff worked a total of 55,058 hours between August 1, 2018 – August 1, 2019. Journey reported 35,474 total contacts for this same time period, and of those, 3865 contacts, or 10.1%, involved law enforcement. Journey also reports that contacts involving law enforcement, especially contacts involving an emergency detention, are typically much more time consuming for crisis staff than contacts that do not involve law enforcement. Journey reported that for this time period, they were able to divert 402 individuals to Bayside and Recovery House.

Table 34. Total Journey Crisis Workers by Position

Total Journey Crisis Workers by Position	
Number of FTEs	**Position and Description**
3	Law Enforcement Liaisons (2 MPD; 1 DCSO)
9.1	Mobile Crisis Team
4.7	Emergency Telephone Workers
2	Specialized Positions (Hospital discharge coordinator; Ch 51 Program Coordinator)
1.55	Combined On-call Staff
2.5	Supervisory Staff
1	Front Desk Staff
0.75	Registered Nurse
0.3	Prescriber
25	**Total**

Table 35 below represents the variety of diversion programs in Dane County and brief description of the intervention and target population.

Table 35. Dane County Diversion Programs

Program	Description
Madison Area Recovery Initiative (MARI)	MARI is a collaborative smart policing initiative between the Madison Police Department, Connections Counseling, and the University of Wisconsin – Madison Department of Family Medicine that refers individuals who overdose or are stopped for low-level, victimless offenses and refer them to medication-assisted and behavioral drug treatment as an alternative to jail. Charges are not filed against the individual as long as all program requirements are met within six (6) months of the incident. Services include intake and assessment, case management, coordinated care with appropriate services, and a peer recovery coach.
Dane County Restorative Courts	The Dane County Restorative Court uses restorative justice national best practices and principles to utilize county and community strengths to resolve misdemeanors prior to formal charging. Misdemeanants, aged 17-25, referred by law enforcement, the District Attorney's Office, and community stakeholders, appear before a group of community members to ensure accountability, determine alternative sanctions, and to help repair the harm done to the victim. The program helps the offender with issues related to employment, relationships, basic needs, and other personal matters to help prevent future re-offending.
Tellurian CARE Center (Crisis Assessment, Recovery and Empowerment)	The Tellurian CARE Center is a community-based residential facility that assists individuals who are unnecessarily confined to an institutional setting. The program operates as a hospital diversion program and accepts referrals from law enforcement, hospitals, and from the community. Tellurian assists consumers who are in need of support, medication, symptom management, and goal-oriented treatment planning.
Mendota Mental Health Institute (MMHI)	MMHI provides forensic treatment services to male patients, including court-ordered mental health competency evaluations, treatment to competency services, and treatment for those found not guilty of criminal activity by reason of insanity. Patients are referred through the criminal court system and are provided the following services: 1) assessment of competency to stand trial, 2) treatment to competency to stand trial, and 3) treatment upon a finding of not guilty of a crime due to mental illness. MMHI also provides civil services in the Geropsychiatric Treatment Unit, including evaluation and treatment for older adults who are experiencing mental health issues.
Wellpath	Wellpath provides medical and behavioral healthcare in jails, prisons, inpatient and residential treatment facilities. Services include mental health care, suicide prevention/intervention, continuity of care and discharge planning, collaboration with community services agencies, and facility/custody/law enforcement staff training programs.
Jail Diversion Programs	The Dane County Sheriff's Office offers the following two (2) diversion programs: 1. Custody Alternative Monitoring Program (CAMP): This program allows certain offenders in the Dane County Jail with work release/Huber privileges to serve part or all of their sentence at home. 2. Volunteer Program. Unemployed inmates who volunteer may be eligible for sentence reduction credit.

Program	Description
Dane County District Attorney's Office Deferred Prosecution Unit – First Offenders Program	Eligible defendants participating in the First Offenders Program can avoid adjudication and sentencing by completing the requirements outlined in their agreement with the District Attorney's Office. The contract terms may require the defendant to participate in programs such as drug and/or alcohol treatment, abuser/generalized aggression treatment, parenting classes, and psychological/psychiatric, vocational and/or other necessary counseling. As a result of successful completion of the contract terms, the District Attorney will dismiss or amend the charges. If the defendant violates the contract, the contract will be terminated and returned to court for the entry of the adjudication and sentencing.
Dane County District Attorney's Office Deferred Prosecution Unit – Deferred Prosecution Child Physical Abuse Initiative	The Dane County Attorney's Office is launching a new diversion program that provides an opportunity for eligible caregivers to participate in an alternative to traditional criminal justice response following an incident of physical abuse of a child as the result of excessive corporal punishment.
Dane County District Attorney's Office Deferred Prosecution Unit – Deferred Prosecution Opiate Initiative	The DPU's Opiate Initiative provides wrap-around services to individuals who have pre-charge referrals to the DA's Office as a result of an arrest for Possession of Narcotic Drug and/or Possession of Opiate/Opioid Paraphernalia or individuals with post-charge referrals to the DA's Office as a result of Opiate/Opioid related crimes.
Dane County Department of Human Services Comprehensive Community Services (CCS)	The CCS program offers a variety of psychosocial rehabilitation services that support clients with mental health and/or substance use conditions. Services are provided at no cost to the client and for the duration of the client's recovery plan. Services include but are not limited to the following: screening and assessment, service planning, service facilitation, diagnostic evaluations, peer support, psychotherapy, substance abuse treatment, and employment-related skill training.
Veteran's Court	This is a voluntary diversion program where a team of criminal justice and veterans services work with veterans to address substance misuse and/or mental health. An individualized treatment plan is developed for each participant and progress is supervised by the Veterans Treatment Court judge at bi-weekly Judicial Reviews.

Program	Description
Dane County Circuit Court Drug Treatment and Diversion Court Programs	Individuals can participate in one of the following three (3) programs based on the results of screening and assessment. 1. Drug Court Treatment Program: Participants are assessed at a high risk to reoffend. This post-adjudication program is for a minimum of one year. There is potential for reduction and/or dismissal of criminal charges or a lesser sentence. This program diverts individuals from prison or jail sentences and requires individuals to meet with case managers on a weekly basis, have daily call-ins for random alcohol/drug testing, home visits, employment verification, and ongoing care planning including alcohol/drug treatment, criminality, employment/education, relationships, money management, housing, mental health, and medical issues. 2. Drug Court Diversion Program: Participants are assessed at a medium risk to reoffend. This pre-adjudication program is for a minimum of nine (9) months. This program diverts individuals from prison or jail sentences and requires individuals to meet with case managers on a weekly basis, have daily call-ins for random alcohol/drug testing, home visits, employment verification, and ongoing care planning including alcohol/drug treatment, criminality, employment/education, relationships, money management, housing, mental health, and medical issues. 3. Deferred Prosecution Unit: Participants are assessed at a low risk to reoffend and participate in one of the Dane County District Attorney's Office Deferred Prosecution Unit programs.

Even though Dane County has a variety of different diversion programs, a common theme throughout our interviews and focus groups was that more diversion programs focusing on individuals with mental health issues and the intersection with law enforcement should be offered, such as pre-arrest diversion initiatives and a mental health court. This was further reinforced in the SIM Mapping Report for Dane County by Policy Research, Inc, as a recommendation to examine the need for alternatives to detention and pre-adjudication diversion options for people with mental health disorders at Intercept 2, which is at initial detention/initial court hearing. Participants in mental health courts are typically nonviolent offenders who have been diagnosed with a mental illness or co-occurring mental health and substance abuse disorder. These courts assist the individual with improving social functioning and linking them to employment, housing, treatment, and support while providing judicial supervision.

Another common theme was that Journey Mental Health Center and Tellurian operate several crisis intervention and stabilization programs; however, coordination and communication could be improved between the organizations. Both programs also have limited bed capacity. Journey's Resource Bridge has the capacity to act as a diversion program; however, eligibility requirements would need to be expanded. Resource Bridge is a stabilization program that takes individuals who are coming out of psychiatric hospitalization and need wrap-around services. The focus of the program is to begin or continue medication, housing, transportation, insurance and then transitioning individuals to another provider after 90 days of services. In order for Resource Bridge to act as a diversion program, referral structure would need to change to allow for consumers to be referred for services prior to a crisis and expand the referral list to include more community referral sources. An increase in funding would also be critical for the expansion of services in order for the program to act as both a diversion and crisis stabilization program. Currently, Resource Bridge has two full-time clinicians, one (1) part-time RN, five (5) hours of prescribing, and one (1) part-time

program support staff and serves between 30-60 consumers concurrently in a high intensity, wrap around capacity.

Additionally, the Tellurian CARE Center provides a total of 10 beds for Dane County residents as a diversion program through referrals from law enforcement, hospitals, and the community. The program also accepts individuals transitioning from state hospitals. Referrals to the CARE Center are often initiated from the Journey Crisis Unit and Madison PD responding to the crisis in the community. The referral and communication process between Journey Crisis Unit, Madison PD and Tellurian has potential to be improved and clarified to assure that individuals not taken to jail, or the hospital, can be serviced at the CARE Center if possible. The communication process between Journey Mental Health and the CARE Center for individuals discharged from the state hospital could also be improved. Journey completes the discharge plans for these individuals and providing advanced notice to Tellurian would assist with bed availability and planning. Table 36, below, shows the number of referrals and their respective referral source from March – July 2019.

Table 36. Dane County CARE Center Referrals (March – July 2019)

Referral Source	March	April	May	June	July
ER	20	22	23	20	26
DOJ	1	1	1	1	2
WMHI	7	14	6	9	2
Community	30	31	19	20	27
WRC	0	0	0	0	1
Hospital Unit	13	20	16	13	10
MMHI	0	0	1	0	1
Detox	3	5	1	2	1
Unknown	1	0	0	1	0
Bayside	6	0	1	1	0
Total	**81**	**93**	**68**	**67**	**70**

Additionally, Table 37 shows the number of referrals not admitted to the Dane County CARE Center as well as the reason for non-admission for the same time period.

Table 37. Reason for Non-Admission to Dane County CARE Center (March – July 2019)

Reason	March	April	May	June	July
Withdrew referral	13	21	6	6	9
No show on unit	4	11	14	16	7
Not Dane County resident	0	0	0	1	2
Insurance	0	0	0	0	2
No bed	1	0	1	0	10
Referred to residential program	2	3	2	0	4
Not appropriate clinically	5	2	5	1	1
Unknown	2	9	1	3	1
Care WI refused to authorize stay	0	0	0	0	1
Total	**27**	**46**	**29**	**27**	**37**

Data sharing and communication between all agencies is another current limitation to the diversion programs in Dane County. As mentioned in the prior section, better data and information sharing between agencies is critical to tracking and improving outcomes. There is not currently a central repository for information specifically amongst law enforcement and behavioral health providers as each entity has their own data management system that do not share information. Journey Mental Health Center maintains electronic health records to track law enforcement contracts with individuals served. This data can then be used if an individual comes back into contact with law enforcement or needs further intervention at a later date. Communication and awareness of these diversion programs amongst all agencies, including law enforcement agencies outside of Madison PD and the DCSO are imperative to successful diversion efforts.

The Dane County Criminal Justice Council (CJC) has led several efforts to move criminal justice policy forward. Recently, on October 2-3, 2018, over 50 Dane County criminal justice stakeholders, advocates, researchers, mental health professionals, behavioral health directors, law enforcement and others convened in Madison to learn pre-arrest diversion/deflection (PAD) best practices. PAD, which are justice models and initiatives that divert or deflect individuals from further prosecution, jail or sentencing, and into services within the community. This approach focuses on connecting law enforcement and community partners to safely respond to individuals with mental health and substance abuse issues. Nationally, PAD programs exist to divert individuals who have committed non-violent and low-level offenses from entering the criminal justice system. Examples of these programs include the following:

- **Law Enforcement Assisted Diversion (LEAD®):** In LEAD® programs, police officers use discretion at point of contact to divert individuals to community-based harm-reduction intervention for law violations driven by unmet behavioral health needs. Rather than following the typical criminal justice path, individuals are referred to a trauma-informed intensive case management program where the individual receives wrap-around services. Prosecutors and police officers work with the case managers to ensure that the individual is provided with a service plan that helps with behavioral change.[21] Currently, there are nearly 40 LEAD® programs operating across the country and over 60 cities and counties exploring, developing, or launching this program.

- **Stop, Triage, Engage, Educate and Rehabilitate (STEER):** The STEER program of Montgomery County, Maryland is a police deflection initiative that incorporates prevention and intervention deflection to reduce crime, rebuild community relations, reduce drug use, and restore citizens' lives. STEER begins when police officers conduct a field risk-need screen to determine whether an individual has a low-moderate criminogenic risk profile and a high treatment need profile. An individual can either voluntarily accept a STEER intervention referral if charges are present or be referred into the program as a prevention contract if there are no charges. After initial contact, a case manager completes a full clinical assessment and referral to treatment resources to address underlying substance abuse and mental health challenges.[22]

- **Crisis Intervention Team (CIT) Programs.** Due to the lack of mental health crisis services, law enforcement has taken the role of the first responder in most crises. CIT programs create connections between law enforcement, mental health providers, hospital emergency services, and individuals with mental illness and their families. CIT identifies mental health resources for those in crisis and helps ensure officer and community safety. CIT programs reduce the number of arrests of people with mental illness while increasing the likelihood of being provided mental health services. In addition, CIT programs allow officers to focus on crime.[23]

[21] https://www.leadbureau.org/about-lead
[22] http://www2.centerforhealthandjustice.org/sites/www2.centerforhealthandjustice.org/files/publications/STEER-FactSheet.pdf
[23] https://www.nami.org/get-involved/law-enforcement-and-mental-health

6.4 RESTORATIVE JUSTICE OPTIONS

Restorative justice is the theory of justice that emphasizes repairing harm caused by criminal behavior by following the following principles.[24]

1. **Repairing Harm.** Justice should focus on the harm caused by the crime. Therefore, a process should occur to build relationships between all stakeholders affected by the crime, including victims and the community.
2. **Stakeholder Involvement.** The people most affected by the crime should participate in its resolution.
3. **Government Responsibility**. The government should maintain order and the community should build peace.

A variety of programs associated with restorative justice respond to and repair the harm caused by the crime, including:[25]

- **Victim-Offender Mediation.** With the assistance of a trained mediator, the victim and offender are given the opportunity to express their feelings and perceptions of the offense. The result of the meeting is to agree on steps the offender will take to repair the harm suffered by the victim.

- **Circles.** This program is similar to Victim-Offender Mediation; however, it allows additional participants to be included in the discussion, including the victim, victim's family, offender, offender's family, community members, and government representatives.

- **Conferencing.** This program is similar to the Victim-Offender Mediation program; however, in addition to the victim and offender, the discussion involves families, community support groups, police, social welfare officials, and attorneys.

- **Victim-Offender Panels.** Participants in this type of program are linked by a particular type of crime, not by the victim and offender.

- **Victims Assistance Programs.** Services are provided to victims as they recover from the crime and case moves through the criminal justice system.

- **Ex-Offender Assistance.** These types of programs provide services to offenders while they are in prison and after release.

One way to incorporate this approach is through the use of mental health courts. The first mental health court, established in 1997, sought to move defendants from jail to treatment for find long-term solutions.[26] Now with over 300 mental health courts across the country,[27] the goal is to move those with mental health issues into treatment without sacrificing safety. Mental health courts have some common features; however, they vastly vary between courts and judges.[28] Typically, mental health courts utilize a multi-disciplinary team to divert offenders from the criminal justice system by linking them to treatment and to other social

[24] http://restorativejustice.org/restorative-justice/about-restorative-justice/tutorial-intro-to-restorative-justice/lesson-1-what-is-restorative-justice/#sthash.rR6cMjF5.dpbs
[25] http://restorativejustice.org/restorative-justice/about-restorative-justice/tutorial-intro-to-restorative-justice/lesson-3-programs/#sthash.XWkxjjm9.chhUxPo4.dpbs
[26] https://www.marincounty.org/depts/gj/reports-and-responses/reports-responses/2012-13/~/media/Files/Departments/GJ/Reports%20Responses/2012/LAJ_STARCourt_-Final2.pdf
[27] https://csgjusticecenter.org/mental-health-court-project/
[28] https://www.marincounty.org/depts/gj/reports-and-responses/reports-responses/2012-13/~/media/Files/Departments/GJ/Reports%20Responses/2012/LAJ_STARCourt_-Final2.pdf

supports. Mental Health America "supports the use of mental health courts that are part of a larger effort to divert persons with mental illnesses from the criminal justice system by improving mental health services and providing diversion at the earliest possible stage."[29] Therefore, mental health courts should not be a first line of diversion, but rather should target individuals who are more frequent users of the criminal justice system. While mental health courts across the county do and should share many similarities, each court varies depending on the local climate, specifically in terms of the legal regulations, needs of the community, and treatment options available. Ultimately, the goal of mental health courts is not only to reduce recidivism among participants, but to improve mental health outcomes and reduce the length of incarceration for participants.

According to the Bureau of Justice Assistance (BJA), studies conducted on mental health courts are varied, in part due to the composition of participants and different court operational structures. However, there is consensus related to the following mental health court outcomes:

- Participants in some mental health courts have lower rates of recidivism
- Mental health courts are more effective than the traditional court system and jails at linking participants to mental health treatment
- Mental health courts have the potential to save money through reduced recidivism, and ultimately fewer time spent in jails as well as through decreased used of more expensive treatment options, such as inpatient care.[30]

Multiple studies have found that participation in a mental health court program was associated with longer time without any new criminal charges or new charges for violent crimes.[31] These findings were further reported in several local mental health court evaluations, including in mental health courts in the Bronx and Brooklyn, Allegheny County, PA, and statewide in Michigan.[32]

Restorative justice in specialty courts focuses on treatment options for an individual's issues, which promotes the restoration of the offender. Working with specialty courts allows mental health counselors to combine individual therapy with vocational counseling, oversight of community service for program participants, aftercare supervision, and mediation and arbitration with victims to emphasize accountability for the individual impacting the restorative process for all stakeholders.[33]

As an example, the Yolo County, California District Attorney's Office created a mental health court that focuses on defendants who committed a crime due to their mental illness. The Mental Health Court (MHC) is a collaboration between the Yolo County Superior Court, Probation Department, Health and Human Services Agency, Public Defender, and the District Attorney. The MHC seeks to reduce the number of mentally ill defendants entering the courts and jails. The MHC has the following four (4) goals: 1) improving treatment engagement, 2) reducing recidivism, 3) reducing jail bed days, and 4) decreasing local and state hospital bed stays.[34] The MHC provides intensive mental health/substance use treatment that addresses mental health symptoms, substance use disorder, school, volunteer, and work experience, housing, medication adherence, support systems, and criminogenic risk factors. In addition, intensive supervision and court monitoring for high-risk offenders with a serious mental illness is provided.[35]

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[29] https://www.mentalhealthamerica.net/positions/mental-health-courts

[30] https://www.bja.gov/Publications/CSG_MHC_Research.pdf

[31] McNiel and Binder. (2007). Effectiveness of Mental Health Courts in Reducing Recidivism and Violence. 164 American Journal of Psychiatry, 164, 1395.
Ray, B. (2014). Long-term Recidivism of Mental Health Court Defendants. International Journal of Law Psychology, 448.

[32] Rossman, S.B., Willison, J.B., Mallik-Kane, K., Kim, K., Debus-Sherill, S., and Downey, P.M. (2012). Criminal Justice Interventions for Offenders with Mental Illness: Evaluation of Mental Health Courts in Bronx and Brooklyn, New York.
Cissner, A.B., Kerodal, A., and Otis. K (2018). The Allegheny County Mental Health Court Evaluation: Process & Impact Findings. Center for Court Innovation.

[33] Haley, M. J. (2016). Drug Courts: The Criminal Justice System Rolls the Rock. Loyola Journal of Public Interest Law, 17, 183–214

[34] https://yoloda.org/progressive-programs/mental-health-court/

[35] https://www.fmhac.org/uploads/1/2/4/4/124447122/abbott_powerpoint.pdf

The MHC incorporates Restorative Justice into the model, which is facilitated by a licensed clinician. This allows for consideration of the offender's current and past psychiatric symptoms and for needed clinical interventions. Additionally, because many of the offender's victims are family members, Victim-Offender Conferences serves as a healing process for the family, which is aided by having a licensed clinician as the facilitator. The offender and facilitator meet for one (1) hour per week for five (5) weeks to discuss the following five (5) questions:[36]

1. **What happened?** The offender is asked to discuss the details of their crime. The goal is for the offender to acknowledge that due to the mental health symptoms there might be an alternative view of events other than their own.

2. **What are your thoughts/feelings at this time?** Using Cognitive Behavioral Therapy, the facilitator explores how the client's thoughts and feelings impacted their actions.

3. **What are your thoughts/feelings now?** Using CBT, the clinician helps the offender replace unhelpful/unhelpful thoughts from the day with neutral or positive thoughts and think about how those changes in thought would have impacted the activities of the day of the crime.

4. **What was hurt and how?** The offender is asked to identify who was hurt by their actions and whether the victim [37]was hurt physically, emotionally, mentally, spiritually, and financially.

5. **What needs to be done to make it right?** The offender is asked how to reconcile with the victims. The offender will also acknowledge how their untreated mental illness impacted the crime. Lastly, the offender will be asked to apologize to the victim in either a letter or in-person at either a Victim-Offender Conference or a Victim Impact Panel.

If the offender chooses to participate in the Victim-Offender Conference, both the victim and offender will tell their stories. Facilitated by the clinician, both parties will discuss the crime, address the impact of the crime, and determine a mutually agreed upon decision. Following resolution with the victim, the offender will write an essay to the MHC team and an aftercare plan is created.[38]

The Support and Treatment After Release (STAR) Court in Marin County, California provides an alternative to incarceration and traditional supervised probation for participants who have been diagnosed with certain mental illnesses that can be managed by medication and therapy. The goal of this court is to benefit the offender and community as a whole. By appropriately addressing the underlying mental illness, the assumption is that participants will be better able to develop a sense of personal and social responsibility and move toward self-sufficiency and integration into the community. The skills learned by the individual throughout the 18-24-month program should decrease or eliminate arrests and incarceration.[39]
The STAR Court consists of the following phases:[40]

1. **Establishing Stability.** Participants report to court on a weekly basis to demonstrate compliance with medication and avoidance with arrest of violations of probation. The participant is required to meet with their case manager and probation officer and be drug tested. The participant will also receive services regarding stable housing, Supplemental Security Income (SSI), Social Security Disability Benefits (SSDI), and achieving sobriety.

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[36] Ibid.

[38] Ibid.

[39] https://www.marincounty.org/depts/gj/reports-and-responses/reports-responses/2012-13/~/media/Files/Departments/GJ/Reports%20Responses/2012/LAJ_STARCourt_-Final2.pdf

[40] https://www.marincounty.org/depts/gj/reports-and-responses/reports-responses/2012-13/~/media/Files/Departments/GJ/Reports%20Responses/2012/LAJ_STARCourt_-Final2.pdf

2. **Growth.** Participants are required to actively seek employment or an educational program while maintaining sobriety and psychiatric stability. They must also consistently attend treatment classes. Depending on progress, participants may transition to bi-weekly court appearances.

3. **Independence.** Participants must maintain psychiatric stability, obtained and maintained housing, and be engaged in educational, vocational, or volunteer activities. Participants must be medication-compliant and not have arrests or probation violations.

4. **Graduation.** Participants do not report to court; however, they may remain in the STAR program for ongoing treatment. Misdemeanor charges may be dismissed, and a felony charge may be reduced to a misdemeanor. The District Attorney may shorten or terminate felony probation.

In addition to mental health courts, some counties also have restorative justice focused courts. Once such court is the Dane County Community Restorative Court (CRC). Although not focused specifically on individuals with mental health issues, this court offers young adults (ages 17-25) who committed misdemeanors with the opportunity to appear before a group of community members to ensure accountability, determine alternative sanctions, and help repair the harm caused to the victim. The CRC also helps the offender with issues relating to employment, healthy relationships, basic needs, and other matters that can help prevent re-offending.[41]

Another similar court, the Circuit Court of Cook County, Illinois, launched a Restorative Justice Community Court in 2017. Serving one neighborhood in northern Cook County, this court applies restorative justice practices by having defendants take accountability for their actions. Once a case is determined to be eligible for this court, both the offender and victim must agree to participate. Peace circles, consisting of the offender, victim, and relevant community members, are held to create a Repair of Harm Agreement. This agreement is a legal document that contains the requirements that the group finds necessary to repair the harm resulting from the crime. If the offender completes all of the requirements of the agreement, the case will be dismissed.[42] Participants are connected to mental health counseling, substance abuse treatment, education, job training and parenting classes.[43]

There are several methods to pay for mental health services, such as state and county general funds, Medicaid, federal grants, self-pay, and private insurance.[44] According to a 2014 SAMHSA report, *Crisis Services: Effectiveness, Cost Effectiveness, and Funding Strategies*, the following general categories of funding for crisis intervention services are often used across the country, and vary from state to state depending on Medicaid state plans and other funding priorities.

State Funding. State funding, along with Medicaid, represent the largest proportion of crisis funding as it finances services for which there are no other sources. Typically, services such as a crisis hot line or warm line, mobile services in states that do not bill Medicaid, and services for individuals with Medicare, and the uninsured are paid for by state funds. In Wisconsin, county funds are used for non-Medicaid billable services, as well match for federal revenue.

Medicaid. For some states, Medicaid managed care is often combined with state funding to pay for crisis services. In Wisconsin, crisis intervention is a county-matched benefit carved out of managed care. The Wisconsin Medicaid residential per diem rate is $139.54. The Wisconsin Medicaid Crisis Intervention Rate ranges from $47.42 per hour to $148,16 per hour based on job description and requirements.

Private Insurance. In Wisconsin, crisis programs are eligible for third-party reimbursement, but private insurance companies are not required to provide or reimburse for such services because private insurance

[41] https://www.danerestorativejustice.org/rj--criminal-justice.html
[42] http://www.njjn.org/uploads/digital-library/07.2017-RJCC%20Brochure%20FINAL%20copy.pdf
[43] http://www.cookcountycourt.org/MEDIA/ViewPressRelease/tabid/338/ArticleId/2564/Restorative-Justice-Community-Court-arrives-in-North-Lawndale.aspx
[44] https://store.samhsa.gov/system/files/sma14-4848.pdf

companies and county service providers define medical necessity differently. Insurance companies require that services are provided by individuals with a master's level or above.

Uninsured. States and local governments typically cover these costs.

6.5 NATIONAL COMPARISONS

Emergency Detention (also referred to as an emergency hold or emergency psychiatric evaluation) laws allow for involuntary admission to healthcare facilities for a person with an acute mental illness under certain circumstances. This is also referred to as Chapter 51 in Wisconsin, which is the state statute that dictates policy regarding emergency detentions. Emergency detentions can serve as a bridge for people with mental illness or in crisis to link them mental health services and treatment. The core criterion justifying an involuntary hold is mental illness that results in danger to self or others, but many states have added further specifications. While each state has an emergency detention law, these vary across states, especially in terms of who can initiate the hold, the duration of the hold, the level of court or judicial oversight, and allowable reasons for commitment, outlined in the table below.[45]

Table 38. State Comparison of Emergency Detention Laws

State		Wisconsin	Colorado	Illinois	Indiana	Iowa	Kansas	Michigan	Minnesota	Missouri	Texas
Court Order Required		Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
Duration of Hold (in hours)		72	72	24	72	48	Unspecified	24	72	72	48
Who Can Initiate	Any Interested Person		✓		✓	✓			✓	✓	✓
	Guardian										✓
	Peace Officer		✓	✓				✓			✓
	Police Officer	✓					✓			✓	
	Nurse		✓							✓	
	Physician								✓	✓	
	Advanced Practitioner Registered Nurse								✓		
	Physician Assistant								✓		
	Psychiatrist									✓	
	Psychologist								✓	✓	
	Mental Health Professional		✓						✓		
	Mental Health Program									✓	
	Social Worker		✓	✓					✓		
	Judge			✓							
Reason for Emergency Hold	Danger to self			✓							
	Danger to others			✓							

[45] https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201500205

State		Wisconsin	Colorado	Illinois	Indiana	Iowa	Kansas	Michigan	Minnesota	Missouri	Texas
	Mentally ill										
	Danger to self, due to mental illness	✓	✓		✓	✓	✓	✓	✓	✓	✓
	Danger to others, due to mental illness	✓	✓		✓	✓	✓	✓	✓	✓	✓
	Recently attempted suicide									✓	
	Gravely disabled		✓						✓		
	Unable to meet basic needs	✓					✓	✓		✓	

Initiation

Most states allow more than one initiator of emergency detention. Police in all jurisdictions have the authority to detain a person who appears to pose an imminent danger, however in only two states (Wisconsin and Kansas) police are the **only** legal initiators of emergency detention holds. The Treatment Advocacy Center also recommends that any responsible adult, but at minimum guardians and family members, should be able to petition the court to seek an emergency psychiatric evaluation as they are typically in the best position to provide information to the court on the person's current mental state. They also state, "emergency custody statutes that limit those who can initiate the process to law enforcement or mental health professionals inevitably lead to the arrest, rather than hospitalization, of those in psychiatric crisis".[46]

This practice also strains law enforcement resources across the state of Wisconsin. As stated in the Sequential Intercept Model Mapping Report for Dane County prepared by Policy Research, Inc., emergency detention can take eight hours or more, crossing between law enforcement officers' shifts, and averages 17 total officer hours per detention".[47] Emergency Detentions can be especially time consuming for law enforcement in Dane County because the subject must remain in the custody of law enforcement until they are admitted into a mental health facility. This means that officers must remain with the subject through all psychiatric testing, assessments, and labs until the facility grants admission to the subject. In 2018, the Madison Police Department reports conducting a total of 252 Emergency Detentions for the year.[48]

Duration of Hold

The Treatment Advocacy Center believes that the minimum period for an emergency detention, or emergency psychiatric evaluation, should be no less than 48 hours, but with a preference for a hold lasting 72 hours or longer.[49] This allows for a thorough evaluation to be completed, referrals to outside services, development of an appropriate discharge plan, enough time for the individual to stabilize, and adequate time to develop a long-term plan for the individual. In Dane County, Emergency Detentions last 72 hours, the process is overseen by Journey Mental Health. After the ED process has been initiated and upheld by a court, Journey begins setting up after-care services for the individual, including assisting with medication, connecting them with behavioral health, or helping to find housing or get the individual connected to insurance.

[46] https://www.documentcloud.org/documents/5001466-Grading-the-States.html
[47] Policy Research. (2018). *Sequential intercept model mapping report for Dane County.* Delmar, NY: Policy Research, Inc.
[48] https://www.cityofmadison.com/police/documents/MHOYearEndRpt2018.pdf
[49] https://www.documentcloud.org/documents/5001466-Grading-the-States.html

Reasons for Emergency Hold
In Wisconsin, a law enforcement officer can initiate an emergency detention if the officer believes the individual will meet the commitment criteria. The criteria for a civil commitment in Wisconsin is as follows:

- The person has a mental illness, and there exists a substantial likelihood that, as a result of mental illness, the person will, in the near future
    - Cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any, or
    - Suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs, and
- The person is in need of hospitalization or treatment, and,
- The person is unwilling to volunteer or incapable of volunteering for hospitalization or treatment.[50]

The matrix above shows this criterion to be in line with other state's emergency detention criteria. For instance, in Minnesota statutory language states that an emergency detention can be initiated if "the person is mentally ill, developmentally disabled, or chemically dependent, and is in danger of causing injury to self or others if not immediately detained".[51]

Involuntary Commitment
All stakeholders interviewed during focus groups mentioned that the rules under Chapter 51 mandated a very high threshold for involuntary commitment. Individuals must be on "deaths door" before they can be committed. This belief is due to the statutory language requiring the individual to be considered dangerous before a commitment can be made. Stakeholders concluded that some people need to be committed and you shouldn't have to wait until a point of no return to put the commitment in place. Perhaps the quote that best summed up the whole situation came from Judge Colas. He said there is a "A high bar for commitment and in a sense, low bar for an arrest". The Dane County NAMI affiliate believes that the interpretation of "imminent danger" included in Wisconsin's involuntary commitment statute should be interpreted more broadly to help ease the ease the process of emergency detention as the current interpretation allows for some individuals in a crisis to "needlessly deteriorate".[52]

Resources state that, in theory, emergency detention could serve as a bridge to link individuals with mental illness to services, however this has not been fully evaluated. Mental Health America states that "Voluntary admissions to treatment and services should be made more truly voluntary, and the use of advance directives should be implemented", and "involuntary treatment should only occur as a last resort and should be limited to instances where persons pose a serious risk of physical harm to themselves or others in the near future and to circumstances when no less restrictive alternative will respond adequately to the risk".[53] Though it should be pointed out that an emergency hold does not necessarily entail involuntary treatment. Emergency holds are distinct from civil inpatient or outpatient commitment, which entails the involuntary treatment of mental illness over a period of days or weeks, though an emergency hold is typically the first step in a civil commitment. By this criteria, while Wisconsin has a higher threshold for initiating an emergency detention, mental health advocacy groups across the country would agree that a high threshold is a best practice. Hospital and emergency rooms are not the ideal setting to address ongoing behavioral health issues. "When a patient isn't an immediate threat to his or her community, they're eventually discharged but left unchanged and unaided — and essentially ready to repeat the cycle".[54]

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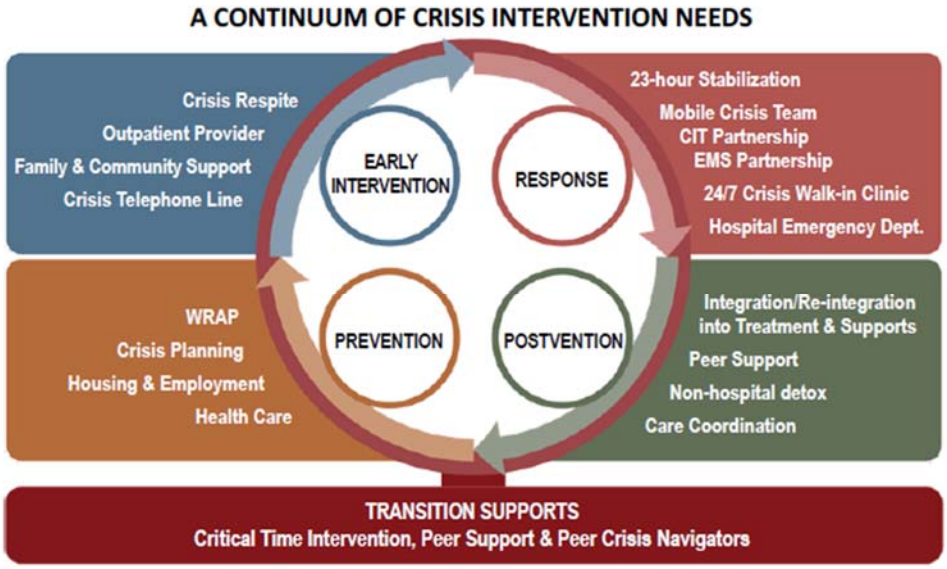
[50] https://static1.squarespace.com/static/56bbdc34a3360c65dfec8b6c/t/57fd1c8503596ef6d9b36152/1476205702001/Guide+to+civil+commitment+.pdf
[51] https://www.revisor.mn.gov/statutes/cite/253B.05
[52] https://static1.squarespace.com/static/56bbdc34a3360c65dfec8b6c/t/57ebe815e4fcb538c126ca6a/1475078165749/involuntary+commitment.pdf
[5353] https://www.mentalhealthamerica.net/positions/involuntary-treatment
[54] https://www.statnews.com/2018/10/18/mental-health-care-emergency-departments/

7. CRISIS RESTORATION CENTER ASSESSMENT

7.1 APPROACH

One of several sub-questions we aim to address within our report is how the continuum of services typically provided through centralized, crisis restoration centers compares to services that are currently available in Dane County. To organize the identified services, we reference SAMHSA's Continuum of Crisis Intervention Needs, as shown in the figure below.

Figure 37. Continuum of Crisis Intervention Needs



7.2 SERVICE COMPARISON (MATRIX)

The following chart identifies crisis-related services available to Dane County residents compared to those available through crisis restoration/resource centers (CRCs) in Pima County, AZ and Bexar County, TX. Note that the services listed for both Pima County and Bexar County are limited to those provided at the specified, central location. We include two additional categories to specifically address programs serving justice-involved individuals and racial/ethnic minorities.

Table 39. Crisis Restoration Center Comparison

SAMHSA Continuum of Crisis Intervention Needs	Dane County Crisis Continuum	Pima County (The Crisis Response Center, operated by ConnectionsAZ)	Bexar County (The Restoration Center, operated by Center for Health Care Services)
Early Intervention	• 24/7 Suicide Prevention Hotline • Individual, group and family therapy • Solstice House (peer run respite) • Psychiatry/medication management • NAMI	• 24/7 crisis hotline receiving warm transfers from 911 (call center adjacent to CRC) • Medication management • Psychiatric evaluation	• 24/7 crisis hotline • Outreach, Screening, Assessment and Referral Center (OSAR) for the Local Mental Health Authority • Co-Occurring Psychiatric and Substance Abuse Disorders Program (COPSD) • NAS Residential Treatment Program
Response	• Crisis Intervention Teams • Crisis Stabilization • Dane County Care Center and Bayside Care Center (residential crisis) • Dedicated MH Officers, Crisis Workers embedded with law enforcement, CIT/CIP training for criminal justice system • Chapter 51 civil commitment • Detox Center (Tellurian, 29 beds)	• 24/7 crisis care, including individual, group and family crisis counseling • 23-hour observation unit • Mobile crisis teams • Adjacent to Banner University Emergency Department • Short-term inpatient stays	• Crisis Care Center • Crisis Observation Unit • Mobile Crisis Outreach Team (MCOT)
Postvention	• Recovery House (step down for those who recently experienced mental health crisis) • Dane County Care Center • Treatment Readiness Center (Tellurian) • Discharge planning • Crisis Homes/Group Homes • Case management	• Ambulatory detoxification • Initiation of opiate medication-assisted treatment	• Ambulatory Detoxification Program • Residential Detoxification Program

SAMHSA Continuum of Crisis Intervention Needs	Dane County Crisis Continuum	Pima County (The Crisis Response Center, operated by ConnectionsAZ)	Bexar County (The Restoration Center, operated by Center for Health Care Services)
Prevention	• Integrated Physical Healthcare program (grant funded for individuals with SMI or other specified diagnoses and lack insurance and/or a PCP) • Substance use counseling • Medication-assisted treatment • SUD prevention programming • Zero Suicide - suicide prevention	• Co-morbid treatment for select medical conditions • Connection to outpatient and community resources • Substance use counseling • Co-occurring treatment	• Diana M. Burns-Banks Primary Care Clinic • Outpatient Substance Abuse Treatment • Mommies Specialized Female Outpatient Substance Abuse Program • Opioid Addiction Treatment Services (OATS) • In-House Recovery Program (IHRP) for homeless individuals with SUD
Transition Supports	• Resource Bridge (post crisis treatment and coordination services) • Peer support (Recovery Dane) and Recovery Coaching (Safe Communities) • Transitional Housing Program (Tellurian)	• Co-located, peer-run, post-crisis wraparound services	• Outpatient Crisis Transitional Services
Serving Justice-Involved Populations	• Law enforcement drop-off • Clinical Assessment Unit • Alternative Sanctions Program for Jail Diversion • Specialized Police Response Programs • Madison Area Recovery Initiative (MARI) • Community Treatment Alternatives (CTA) • Jail Opiate Project • Peer Support/Recovery Coaching (Safe Communities) • Jail Re-entry case management/peer support (MUM)	• Court ordered evaluation and treatment • Dedicated sally-port entrance for law enforcement (less than 10min turnaround) • Adjacent to mental health court • Supports Tucson Police Department Mental Health Support Team (MHST)	• Substance Abuse Public Sobering Unit • Injured Prisoners & Minor Medical Clinic • Drug Court Outpatient Program

7.3 COMPARING CRISIS CONTINUUM MODELS

Common elements among the Tucson and San Antonio models that differ from current services in Dane County include the types of services offered,

7.3.1 Services

Tucson and San Antonio both provide 24-hour access to crisis care for their communities. In contrast, crises that occur after hours in Dane County are largely managed by hospital Emergency Departments. The Emergency Department environment can be chaotic and is not conducive to deescalating behavioral health crises. Available staff have not necessarily been trained to respond to behavioral health crises, focusing on the individual's clinical needs and potentially contributing to the individual's trauma. Research has demonstrated that crisis centers and response teams also admit to inpatient care less often than Emergency Departments and can cost nearly 3 times less to operate.[55] Providing 24/7 crisis care offers clinically appropriate treatment settings that may reduce inpatient bed utilization and lower overall cost of care.

Both the Tucson and San Antonio models also provide 23-hour observation beds. This service provides those who are in severe distress with short term, intensive treatment in a safe environment that is less restrictive than a hospital. A limited body of research finds that observation beds can reduce the number of inpatient psychiatric days, reduce clinical severity scores and improve overall consumer satisfaction.[56,57]

7.3.2 Access

Another common theme among the above models is the co-location of services and programs. San Antonio has centralized services spanning behavioral health, primary care and social services, aiming to address the many factors that impact behavioral health outcomes across sectors. Peer-reviewed research regarding outcomes associated with co-location of social services is limited. With respect to the various models integrating physical and behavioral health, research has demonstrated that co-location of services along is not as effective as, for example, the Collaborative Care Model.[58] The Collaborative Care Model uses a team-based approach to care delivery in which primary care and behavioral health providers use shared care plans and decision-making processes to improve client outcomes. This true integration in delivery leads to significant improvement in both outcomes and engagement.

Under direction from the Pima County Regional Behavioral Health Authority, the Tucson CRC aimed to decrease preventable interactions with the criminal justice system and Emergency Departments and increase rates of community-based stabilization. Establishing law enforcement as a "preferred customer" of the CRC was an early collaborative effort toward these goals. Creating and staffing a dedicated, sally port entrance for law enforcement drop-off reduced officer turnaround times to less than ten minutes, compared to several-hour wait times at the Emergency Department. The CRC noted that, to be successful, they needed to make the CRC the path of least resistance for officers – making them more convenient than either the Emergency Department or jail.[59]

[55] Jugo, M, Smout, M, Bannister, J: A comparison in hospitalization rates between a community based mobile emergency service and a hospital-based emergency service. Aust N Z Psychiatry 2001;36:504-508.
[56] Francis E, Marchand W, Hart M, et al. Utilization and outcome in an overnight psychiatric observation program at a Veterans Affairs Medical Center. Psychiatric Services. 2000; 51(1): 92-95.
[57] Prim Care Companion CNS Disord. 2015; 17(4): 10.4088/PCC.15m01789.
[58] Blackmore, M. et al. Comparison of Collaborative Care and Colocation Treatment for Patients with Clinically Significant Depression Symptoms in Primary Care. Psychiatric Services. November 2018. Vol 69 (11) https://doi.org/10.1176/appi.ps.201700569
[59] Presentaion. Balfour, M. "More than Emergency Response: The Tucson Model's Preventive Approach to Crisis and Public Safety." National Council for Behavioral Health Annual Conference. March 2019.

7.3.3 Infrastructure

The Tucson CRC attributes their success to the County's centralized deployment of all crisis response resources. Under the umbrella of their Regional Behavioral Health Authority and in partnership with the sole Medicaid MCO serving their region, the CRC has established a robust network of real time, two-way data sharing between the CRC and MCO. CRC leadership continuously analyze clinical, claims, and member data to identify the root causes of crises in their community. Partnering with care management leaders at the MCO, they can then contribute to the design of new outreach initiatives and other early intervention programs to help prevent future crises from occurring.[60]

[60] Presentation. Balfour, M. "Data with a Soul: Leveraging crisis utilization data to drive improvement across the behavioral health network." National Council for Behavioral Health Annual Conference. April 2018.

8. RECOMMENDATIONS

PCG provides seven recommendations to improve Dane County's behavioral health care system. These recommendations are listed below and explored in more detail in the following section:

1. Maximize capacity through better facility and provider coordination,
2. Establish formal partnerships between providers and facilities,
3. Develop additional services to reduce gaps in care,
4. Improve access to care for underserved populations,
5. Increase diversion options,
6. Extend crisis care to rural areas,
7. Develop infrastructure for cross sector data-driven decision making.

Implementing elements of these recommendations may include coordination and actions by entities (e.g. Medicaid or private insurance) outside of Dane County government. With the goal of providing clarity on how recommendations can best be implemented each recommendation's description is organized into the following sections:

- Description: a summary of the recommendation itself.
- Responsible Parties: which entities are required for successful implementation of the recommendation.
- Key Implementation Considerations: areas in which we suggest specific focus as the recommendation is turned from policy suggestion to real world program.

8.1. MAXIMIZE CAPACITY THROUGH BETTER FACILITY AND PROVIDER COORDINATION

Description

Capacity analysis shows that some facilities are overutilized, while others are underutilized. PCG recommends conducting a root cause analysis to determine reasons underpinning lack of utilization for certain providers. After the root cause analysis, PCG recommends Dane County collaborates with Medicaid and commercial payers to centralize resource information and educate advocates, clients, and providers about all care options with the goal of using existing capacity more effectively.

Responsible Parties

Full implementation of this recommendation will require coordination and the work of Dane County and the Wisconsin Department of Health Services (Medicaid) and the Wisconsin Office of the Insurance Commissioner.

Key Implementation Considerations

Dane will have to select an individual or organization to perform the recommended analysis. This will require staff dedication and/or outside service fees. The participation of providers and facilities in the County will be required to complete the analysis. Once the cause(s) of variability in utilization is determined, solutions will have to be formulated. A location for sharing resources will have to be determined and made accessible to all those who will benefit from it. Implementing any proposed solutions will require collaboration between Dane County, Medicaid, and individual providers to adjust current practices and more efficiently utilize current capacity. Operation changes for current providers and facilities in Dane County will also have to take place.

8.2 ESTABLISH FORMAL PARTNERSHIPS BETWEEN PROVIDERS AND FACILITIES

Description

PCG recommends establishing formal relationships that ease the administrative burden of finding placements for individuals in need of various levels of care. Ensuring that providers and facilities have formal connections with partners across the continuum of care can also help reduce facility capacity issues. This effort may be aided by the study recommended in 8.1.1 but can also occur independent of that recommendation.

Responsible Parties

Full implementation of this recommendation will require coordination between Dane County and providers/facilities in the County. Working with Medicaid and private payers may contribute to a smooth transition, ensuring that partnerships appropriately reflect provider networks across payers.

Key Implementation Considerations

Implementation of this recommendation will require operational changes for current providers and facilities in Dane County. Providers/facilities will need to establish Memorandums of Understanding (MOUs) with referring organizations, and then update their internal policies and procedures to reflect the partnership agreements. This recommendation represents a near term change for the County that could significantly improve access and the ease of transition for individuals and families.

8.3 DEVELOP ADDITIONAL SERVICES TO REDUCE GAPS IN CARE

Description

One notable gap within the continuum of care is the absence of 23-hour observation beds. As noted in previous sections of this report, these extended observation beds help reduce emergency room and inpatient care for behavioral health crises. Crises that occur after hours in Dane County are largely managed by hospital Emergency Departments. The Emergency Department environment can be chaotic and is not conducive to deescalating behavioral health crises and those staffing EDs are not necessarily been trained to respond to behavioral health crises, focusing on the individual's clinical needs and potentially contributing to the individual's trauma. Research has demonstrated that crisis centers and response teams also admit to inpatient care less often than Emergency Departments and can cost nearly 3 times less to operate.[61] Providing 24/7 crisis care offers clinically appropriate treatment settings that may reduce inpatient bed utilization and lower overall cost of care. Centralized services spanning behavioral health, primary care and social services can also help address the many factors that impact behavioral health outcomes across sectors

Dane County may consider creating a roadmap to implement 23-hour observation beds, 24/7 crisis care, dedicated law enforcement drop off for crisis care, and programs that more fully integrate co-occurring substance use and mental health treatment.

Responsible Parties

Full implementation of this recommendation will require coordination between Dane County and facilities in the County. Location(s) for the new services will need to be determined and facilities which are willing and able to extend service hours must be identified.

[61] Jugo, M, Smout, M, Bannister, J: A comparison in hospitalization rates between a community based mobile emergency service and a hospital-based emergency service. Aust N Z Psychiatry 2001;36:504-508.

Key Implementation Considerations

Facilities that extend hours and/or services will likely face additional operational costs for extended hours. Providers who are qualified to administer the differing levels of care will also need to be found.

8.4 IMPROVE ACCESS TO CARE FOR UNDERSERVED POPULATIONS

Description

PCG recommends that Dane County work with community organizations to create and implement a strategic plan to improve access to underserved populations. This should include identifying key resources, metrics, and outreach/in-reach strategies to effectively engage individuals in need and meet people where they are in their communities. Data cited in this report notes a lack of options in some rural areas of the state as well as differing outcomes for varying races.

Responsible Parties

Full implementation of this recommendation will require coordination between Dane County and advocacy/community groups in the County. Work with providers and payers in the County is also necessary to ensure that access issues are met and funded.

Key Implementation Considerations

Final implementation of this recommendation hinges on community groups working with Dane to productively identify barriers to care and suggest solutions. Agreement with providers to engage and care for the community in a new way will also be necessary. There may be costs associated with organizing meetings and implementing solutions.

8.5 INCREASE DIVERSION OPTIONS

Description

In Dane County, there are several diversion programs available across the behavioral health and criminal justice system intercepts, however few that specifically focus on mental health. PCG recommends developing diversion models that are specifically focused on mental health and/or co-occurring disorders to include both a pre-arrest and post-arrest option. These options require unique eligibility criteria which provide different paths or options for specific individuals with mental illness through the system.

Pre-Arrest Diversion Program: Pre-arrest diversion programs, like law enforcement assisted diversion (LEAD) models, divert low-level, or misdemeanor offenders from the criminal justice system at first contact with law enforcement. These individuals are typically referred to community behavioral health treatment providers to receive a continuum of coordinated services such as treatment for mental health and substance abuse issues to housing and job training. These services are coordinated by dedicated case managers housed within an agency the county or program determines most feasible to address the needs of each individual. There are also many different options to help pay for these types of program. According to 2016 report by Community Catalyst, Medicaid, adapted Medicaid models, such as health homes & waivers, other federal funding opportunities through the Department of Justice (DOJ), Bureau of Justice Assistance (BJA) and Substance Abuse Mental Health Services Administration (SAMHSA), state and local funding, health institutions, including hospitals, and private and philanthropic funding are all methods counties across the country use to fund pre-arrest diversion initiatives.[62]

Mental Health Court Program: Mental Health Courts, modeled after drug courts, aim to divert defendants with mental illness out of the criminal justice system by linking them to mental health services and other

[62] Community Catalyst. October 2016. Financing and Sustainability Options for Pre-Arrest Diversion Programs. https://www.communitycatalyst.org/Pre-Arrest-Diversion-Report-SUD-Final-for-Web.pdf.

social supports while under the supervision of the court. Mental health courts develop strict eligibility criteria typically focused on high risk, high need populations with specific diagnoses criteria. These individuals are targeted as a specific population of individuals that need specific interventions, but also need held accountable within the criminal justice system for their crimes. Because mental health courts are composed of multi-disciplinary teams, it requires buy-in amongst several different agencies and the community including: the court system and a willing judge, prosecutor's office, public defender's office, probation department, community behavioral health and substance abuse providers, law enforcement, and other ancillary services providers to be part of the dedicated team.

Responsible Parties

Full implementation of a pre-arrest diversion program will require a Dane County agency, such as the Criminal Justice Council or Dane County Sheriff's Department, to lead the planning efforts to determine a pilot jurisdiction for this program. While Madison Police Department has a dedicated Mental Health Unit, this practice is not replicated across Dane County. Implementation of a mental health court will first require a willing judge to oversee this type of program and then buy-in from the various agencies and departments previously discussed.

Key Implementation Considerations

Pre-arrest diversion programs have been discussed within Dane County and those continued conversations with law enforcement and the treatment community could lead to opportunities for grant funding to develop capacity and start a pilot program. Mental health courts also require significant planning and partnerships with the treatment community. There must be capacity within the treatment community to be part of the mental health court team to provide the necessary treatment planning and communication with the court.

8.6 EXTEND CRISIS RESPONSE TO RURAL AREAS

Description

The Madison Police Department is a national example for law enforcement response to mental health crisis. However, the same practices are not duplicated across the county, specifically in rural areas. Outside of the Madison Police Department, only the Dane County Sheriff's Office has a dedicated crisis worker, and that position is only half filled. Journey Mental Health also does not currently have staff capacity to serve the entire county often due to turnover related to low wages for similar position in other counties across the state. Currently, there are two (2) open mobile crisis worker positions that are waiting to be filled. Furthermore, NAMI recommends at least 25% of law enforcement officers in *each* jurisdiction receive Crisis Intervention Training.

Responsible Parties

Dane County will need to work closely with Journey Mental Health to assess staff capacity issues and the best approach to reach rural areas of the county to provide continued crisis response. Dane County should continue to work with NAMI Dane County to assure Crisis Intervention Training is delivered to all law enforcement jurisdictions.

Key Implementation Considerations

Full implementation of this recommendation will require additional funding for crisis worker salaries and/or FTEs at Journey Mental Health.

8.7 CREATE INFRASTRUCTURE FOR CROSS-SECTOR, DATA-DRIVEN DECISION MAKING

Description

The current Memorandum of Understanding (MOU) Coordinated by the Criminal Justice Council (CJC) in Dane County does not include behavioral health providers. Dane County could benefit from including behavioral health providers as part of this MOU, specifically to better track frequent users of the criminal justice system who also have a mental health disorder. Tracking this data will help pinpoint individuals who have a higher need for service and help connect them to services and reduce their involvement with the criminal justice system. The CJC recently established a behavioral health subcommittee to address the issue of better data tracking, among other issues. Additionally, if an individual with mental illness is incarcerated, the jail needs to have ready access to the patient's mental health records, including a list of any medication the individual was on to ensure the individual receives appropriate and timely mental health treatment. Tracking mental health data and outcomes, such as how many mental health callouts each agency (law enforcement, crisis workers, etc.) responds to, the type of response each consumer receives on a mental health callout, and the outcome of each of those callouts, is critical to making data informed decisions on diverting consumers out of the criminal justice system.

Responsible Parties

Full implementation of this recommendation will require coordination with the CJC and likely all parties who possess applicable data. Dane may be able to use the CJC BH Subcommittee to explore additional data sharing partners as well. While the exact partners for cross sector data sharing are to be determined, partners Dane should consider working with include Medicaid, WHIO, the CJC, police forces, housing officials, the district attorney's office, the public defender's office, and provider/facilities.

Key Implementation Considerations

Final implementation of this recommendation will require an updated CJC MOU and perhaps additional MOUS with parties sharing data. Costs may be associated with any efforts to match data between systems and for the construction, operation, and maintenance of any system created to share the data.

9. APPENDIX

APPENDIX A—INTERVIEW GUIDES

Facilitator's Discussion Guide: Access and Outcomes Focus Group

Welcome and thank group for volunteering to take part. Reiterate that they were asked to join because their viewpoint is very important to the County, and we appreciate their participation because we know everyone has busy schedules.

Introduction: This focus group discussion is designed to document your current process and experience helping individuals access behavioral health care in your community. We have six main questions to guide our discussion, and those questions are largely process-oriented. For example, what steps do you take to connect people to specific services. However, during our discussion, we'll be looking for insights from each of you on common challenges, ways that coordination and access could be enhanced, etc.
Throughout our discussion, we will keep a running list of "future state" goals for the behavioral health system. These goals can represent anything from operational and technical improvements to specific outcomes or quality metrics.
The discussion will take no more than 90 minutes.

Anonymity: I would like to assure you that the discussion will be anonymous. Notes from the focus group will contain no information that would allow individuals to be linked to specific statements. You should try to answer and comment as accurately and truthfully as possible. We would appreciate it if you would refrain from discussing the comments of other group members outside the focus group. If there are any questions or discussions that you do not wish to answer or participate in, you do not have to do so.

Ground Rules
The most important rule is that only one person speaks at a time. There may be a temptation to jump in when someone is talking but please wait until they have finished.
There are no right or wrong answers
You do not have to speak in any particular order
You do not have to agree with the views of other people in the group
Does anyone have any questions?
OK, let's begin

Warm-Up
First, I'd like everyone to introduce themselves. Can you tell us your name and current role?

Introductory Question
I am just going to give you a couple of minutes to think about what you would want the future system to look like. How should individuals be able to access the system? Is anyone willing to share some high-level thoughts to get us started?
(*Facilitator*: Begin list of future state goals with any initial comments from group.)

Guiding Questions
(*Facilitator*: For each question below, ask the participants to describe their current process and then bring them back to the future state.)

What partnerships are in place across health and social services? How does the system help individuals stay connected?
How and by whom is outreach conducted across the County? What partnerships support outreach?
How do individuals you serve indicate unmet needs to you? What steps do you take to connect them with services?
How are unmet needs identified and addressed across different populations?
How are disparities identified and addressed across different populations?

What metrics are monitored across the system? What outcomes are achieved?

Concluding Question
In reviewing the future goals we've discussed,
What three steps could the community initiate in the next 12 months toward achieving those goals?
What three steps could the community initiate over the next 5 years toward achieving those goals?

Wrap-Up
Thank you for participating. This has been a very successful discussion, and we hope you have found the discussion interesting.
If you have any other thoughts or comments you'd like to share with us, please email me at:

Facilitator's Discussion Guide: Care Delivery Focus Group

Welcome and thank group for volunteering to take part. Reiterate that they were asked to join because their viewpoint is very important to the County, and we appreciate their participation because we know everyone has busy schedules.

Introduction: This focus group discussion is designed to document your current process and experience with behavioral health care delivery in your community and discuss what changes may be made to improve that experience in the future. Many of our questions are process oriented. For example, what is the first contact that an individual typically has with you as a provider. However, during our discussion, we'll be looking for insights from each of you on common challenges, ways that coordination could be enhanced, etc.
Throughout our discussion, we will keep a running list of "future state" goals for the care delivery system. These goals can represent anything from operational and technical improvements to specific clinical outcomes or quality metrics.
The discussion will take no more than two hours.

Anonymity: I would like to assure you that the discussion will be anonymous. Notes from the focus group will contain no information that would allow individuals to be linked to specific statements. You should try to answer and comment as accurately and truthfully as possible. We would appreciate it if you would refrain from discussing the comments of other group members outside the focus group. If there are any questions or discussions that you do not wish to answer or participate in, you do not have to do so.

Ground Rules
The most important rule is that only one person speaks at a time. There may be a temptation to jump in when someone is talking but please wait until they have finished.
There are no right or wrong answers
You do not have to speak in any particular order
You do not have to agree with the views of other people in the group
Does anyone have any questions?
OK, let's begin

Warm-Up
First, I'd like everyone to introduce themselves. Can you tell us your name and current role?

Introductory Question
I am just going to give you a couple of minutes to think about what you would want the future system to look like. How should behavioral health care be delivered and coordinated? Is anyone willing to share some high-level thoughts to get us started?
(*Facilitator*: Begin list of future state goals with any initial comments from group.)

Guiding Questions
(*Facilitator*: For each question below, ask the participants to describe their current process and then bring them back to the future state.)

We'll start with an "end to end" discussion of how care is provided across the system. Then we'll spend the latter part of our discussion talking specifically about crisis services.
What prevention services are available across the County? What populations are targeted for prevention services?
What is the first point of contact with the behavioral health system? How do people initially access the system?
What practices are employed during initial contact? Who (credentials, training, etc.) is working with the individual directly?
When, how and to whom is the individual referred? How are care transitions facilitated?
What partnerships are in place to support referral and follow up? What IT systems support this process?

When an individual requires inpatient care, what are the main factors taken into consideration in determining their placement? What factors determine whether an individual is ready for discharge? Who makes the determination?
How is continuity of care considered in discharge planning, such as coordination with providers that will serve the individual at discharge?
What metrics are monitored across the system? What outcomes are achieved?

Crisis Services
How do individuals experiencing crisis initially access the system? What connections/partnerships are in place across sectors?
What types of crisis services are available in the County? Who is working directly with the individual in crisis?
How is the individual supported into recovery? What partnerships are in place to support recovery? Who is accountable for follow up and monitoring?
What metrics are monitored across the crisis system? What outcomes are achieved?

Concluding Question
In reviewing the future goals we've discussed,
What three steps could the community initiate in the next 12 months toward achieving those goals?
What three steps could the community initiate over the next 5 years toward achieving those goals?

Wrap-Up
Thank you for participating. This has been a very successful discussion, and we hope you have found the discussion interesting.
If you have any other thoughts or comments you'd like to share with us, please email me at:

Facilitator's Discussion Guide: Public Safety Focus Group

Welcome and thank group for volunteering to take part. Reiterate that they were asked to join because their viewpoint is very important to the County, and we appreciate their participation because we know everyone has busy schedules.

Introduction: This focus group discussion is designed to document your current process and experience with the intersection of behavioral health and public safety in your community and discuss what changes may be made to improve that experience in the future. We have four main questions to guide our discussion, and those questions are largely process-oriented. For example, what types of jail diversion programs are in place. However, during our discussion, we'll be looking for insights from each of you on common challenges, ways that coordination could be enhanced, etc.
Throughout our discussion, we will keep a running list of "future state" goals for the behavioral health system from a public safety viewpoint. These goals can represent anything from operational and technical improvements to specific outcomes or quality metrics.
The discussion will take no more than 90 minutes.

Anonymity: I would like to assure you that the discussion will be anonymous. Notes from the focus group will contain no information that would allow individuals to be linked to specific statements. You should try to answer and comment as accurately and truthfully as possible. We would appreciate it if you would refrain from discussing the comments of other group members outside the focus group. If there are any questions or discussions that you do not wish to answer or participate in, you do not have to do so.

Ground Rules
The most important rule is that only one person speaks at a time. There may be a temptation to jump in when someone is talking but please wait until they have finished.
There are no right or wrong answers
You do not have to speak in any particular order
You do not have to agree with the views of other people in the group
Does anyone have any questions?
OK, let's begin

Warm-Up
First, I'd like everyone to introduce themselves. Can you tell us your name and current role?

Introductory Question
I am just going to give you a couple of minutes to think about what you would want the future system to look like. How should public safety and behavioral health intersect? Is anyone willing to share some high-level thoughts to get us started?
(*Facilitator*: Begin list of future state goals with any initial comments from group.)

Guiding Questions
(*Facilitator*: For each question below, ask the participants to describe their current process and then bring them back to the future state.)

What partnerships are in place to support coordination of these two sectors? How is communication facilitated?
What trainings are in place for those in the public safety sector?
What jail diversion programs are in place? How are individuals identified for jail diversion?
What metrics are monitored across the system? What outcomes are achieved?

Concluding Question
In reviewing the future goals we've discussed,
What three steps could the community initiate in the next 12 months toward achieving those goals?
What three steps could the community initiate over the next 5 years toward achieving those goals?

Wrap-Up
Thank you for participating. This has been a very successful discussion, and we hope you have found the discussion interesting.
If you have any other thoughts or comments you'd like to share with us, please email me at:

Individual Interview Guide

The interview guide will include two sections. The first section focuses on general information gathering that will be used with all participants. The second section will be tailored to specific stakeholder groups, addressing the goals for each group as identified in the communications matrix.

Participant (name, title):	
Organization/Affiliation:	
Stakeholder Group(s):	
Interview Date:	
PCG Lead Interviewer:	

Section 1: General Information

#	Question	Answer
1	What is your current role? How long have you been working in Dane County?	
2	What do you hope the community will gain from this study of the current behavioral health system?	
3	What do you see as the biggest behavioral health challenge facing your community today?	
4	Are there existing models or other counties that you wish Dane County to consider as part of this study?	

Section 2: Stakeholder Specific

#	1. Outpatient Behavioral Health Providers	Answer
1	Please describe the clients you currently serve. What is the demographic mix? How many languages are spoken?	
2	Are you able to provide timely access to services? How long does an individual typically wait for an appointment after need has been identified?	
3	What are you top staffing challenges? What recruitment/retention methods have you used?	
4	What regulatory challenges have you identified in delivering appropriate and effective care?	
5	What partnerships have you developed with other service providers and/or community-based organizations?	
#	**2. Inpatient Behavioral Health Providers**	**Answer**
1	Please describe the clients you currently serve. What is the demographic mix? How	

	many languages are spoken? Do you serve civil involuntary?	
2	Do you currently have a wait list for admission? If so, what challenges contribute to your current wait time?	
3	What are you top staffing challenges? What recruitment/retention methods have you used?	
4	What regulatory challenges have you identified in delivering appropriate and effective care?	
5	What partnerships have you developed to support transition of care? What are your top placement challenges when individuals are ready for discharge?	
#	**3. Non-Behavioral Health POS Providers**	
1	What are the most significant behavioral health needs for the populations you serve?	
2	What are the most common access issues for the populations you serve? How do those issues vary across different population demographics?	
3	Have you experienced any regulatory challenges in helping the individuals you serve receive appropriate behavioral health care?	
4	Are there any current programs or partnerships that you would identify as a best practice in the County today?	
5	What do you see as the top challenge for the system moving forward?	
#	**4. Physicians / PCPs**	
1	What are the most significant behavioral health needs for the populations you serve?	
2	Has your practice adopted any behavioral health integration models to date? If so, what successes and challenges have you experienced?	
3	Have you experienced any regulatory challenges in helping the individuals you serve receive appropriate behavioral health care?	
4	How does your practice coordinate and communicate with behavioral health providers?	

5	What do you see as the top challenge for the behavioral health system moving forward?	
#	**5. Peer Support Workers**	**Answer**
1	Please describe your average case load and the individuals you serve. What is the demographic mix? How many languages are spoken? Do you serve forensic clients?	
2	What partnerships have you developed with providers, community-based organizations, etc.? Which partnerships have proven the most valuable for your clients?	
3	What systems do you use to support your work?	
4	Have you experienced any regulatory challenges in helping the individuals you serve receive appropriate behavioral health care?	
5	What are your top challenges in effectively managing your clients today?	
#	**6. Public Safety**	**Answer**
1	How often do you interact with the behavioral health system today? Do you currently participate in any formal behavioral health partnerships or diversion programs?	
2	What practices have proven the most effective in your experience working with the behavioral health system?	
3	What are your top challenges in effectively working with the behavioral health system today?	
4	Have you experienced any regulatory challenges that impact access to behavioral health?	
5	Have you completed any trainings specific to behavioral health issues? Were they useful? What, if any, additional training do you think would be valuable?	
#	**7. Advocates and Consumer Representatives**	**Answer**
1	With respect to behavioral health services, where do you see the greatest unmet need in the County?	

2	What are the most common access issues reported to you? How do those issues vary across different population demographics?	
3	Are there any current programs or partnerships that you would identify as a best practice in the County today?	
4	Have you experienced any regulatory challenges in helping the individuals you serve receive appropriate behavioral health care?	
5	What do you see as the top challenge for the community moving forward?	
#	**8. Access Points**	**Answer**
1	What are the most significant behavioral health needs for the populations seeking care through your organization?	
2	What, if any, services do you provide directly? What are your most common referral requests?	
3	Have you experienced any regulatory challenges in helping the individuals you serve receive appropriate behavioral health care?	
4	What partnerships have you developed with providers, community-based organizations, etc.? Which partnerships have proven the most valuable for your clients?	
5	What do you see as the most significant unmet need among individuals who contact your organization?	
#	**9. Commercial Insurers**	**Answer**
1	How many of your members reside in Dane County? What portion of your total enrollment does Dane County represent?	
2	What steps have you taken to ensure timely access to behavioral health services for your members?	
3	What are your top network challenges with respect to behavioral health in Dane County?	
4	What is the feedback loop for those have trouble accessing services?	
5	Have you experienced any regulatory challenges in helping the individuals you	

	serve receive appropriate behavioral health care?	
6	Have you entered into or are you considering participating in any partnerships or other initiatives to improve behavioral health outcomes for your members?	
#	**10. Medicaid HMOs**	**Answer**
1	How many of your members reside in Dane County? What portion of your total enrollment does Dane County represent?	
2	What steps have you taken to ensure timely access to behavioral health services for your members?	
3	What are your top network challenges with respect to behavioral health in Dane County?	
4	Have you experienced any regulatory challenges in helping the individuals you serve receive appropriate behavioral health care?	
5	What is the feedback loop for those have trouble accessing services?	
6	Have you entered into or are you considering participating in any partnerships or other initiatives to improve behavioral health outcomes for your members?	

APPENDIX B—SPC, CPT, HCPCS CROSSWALK

Counseling and Other Outpatient				
Dane			WHIO	
SPC Code	SPC Name	SPC Unit	HCPCS	CPT Codes
	Mental Health		0501F	90785
507	Counseling / therapeutic resources	Hours	0503F	90791-90792
507.1	Medication management	Hours	1000F	90832-90853
507.2	Individual	Hours	1036F	90862
507.3	Group	Hours	1123F	90868
507.4	Family (or couple)	Hours	1126F	90870
507.5	Intensive in-home	Hours	1160F	90899
507.6	Family support	Hours	G0177	96101-96155
507.9	Peer Support/Recovery Specialist	Hours	G0410	97112
704	Day treatment-medical	Hours	G0463	97150
			G0467	97532
	Alcohol and Other Drug Abuse		G0470	97803
301	Court intake studies	Hours	H0001-H0005	99201-99205
507	Outpatient, regular	Hours	H0015	99211-99215
507.05	Outpatient, intensive	Hours	H0016	99243-99245
507.1	Outpatient, individual regular	Hours	H0018	99354
507.15	Outpatient, individual intensive	Hours	H0020	99509
507.2	Outpatient, family regular	Hours	H0022	99600
507.25	Outpatient, family intensive	Hours	H0033	99606
507.3	Outpatient, group regular	Hours	H0035	
507.35	Outpatient, group intensive	Hours	H0046	
507.4	Outpatient, in-home regular	Hours	H0047	
507.45	Outpatient, in-home intensive	Hours	H2012	
507.5	Outpatient, emergency regular	Hours	H2019	
507.61	Antabuse	Other	H2036	
507.62	Other medical	Other	J1230	
507.64	Urinalysis tests	Other	J3490	
507.65	Medication management	Hours	Q3014	
507.7	Methadone or narcotic detox	Hours	Q3014	
507.75	Methadone maintenance/narcotic treatment	Hours	S5125	
507.8	Buprenorphine	Hours	T1002	
507.85	Naltrexone	Hours	T1003	
507.9	Peer Support/Recovery Coach	Hours	T1015	
606	Health screening	Hours	T1019	
704.1	Day treatment	Hours	T1021	
603	Intake assessment	Hours	T1024	
			T1026	

Crisis Care				
Dane			WHIO	
SPC Code	SPC Name	SPC Unit	HCPCS	CPT Codes
Mental Health			A0422	90839-90840
501	Initial Crisis Intervention	Hours	A0427	99281-99285
501.1	Initial Crisis Intervention	Days	A0429	99291
503.2	Emergency Room	Hours	H0007	
702	Crisis Stabilization Program		H0008	
			H0009	
Alcohol and Other Drug Abuse			H0010	
501	Crisis intervention (hours)	Hours	H0012	
501.1	Crisis intervention (days)	Days	H0014	
703.1	Medically managed inpatient detox	Days	H0018	
703.2	Medically Monitored Residential Detox	Days	S9484	
703.5	Ambulatory detoxification	Hours	S9485	

Inpatient Care				
Dane			WHIO	
SPC Code	SPC Name	SPC Unit	HCPCS	CPT Codes
Mental Health			G0378	99217
503	Inpatient	Days	G0379	99219-99239
503.1	Emergency Detention	Days	G0390	99251-99256
925	IMD	Days		
Alcohol and Other Drug Abuse				
503.5	Medically managed inpatient	Days		

Residential and Step-Down				
Dane			WHIO	
SPC Code	SPC Name	SPC Unit	HCPCS	CPT Codes
Mental Health			H0011	99307-99318
102	Adult Day Care		H0019	99321-99333
202	Adult family home	Days	H2020	99335-99337
203	Foster home	Days	H2034	
204	Group Home	Days	H2036	
205	Shelter Care	Days		
504	Residential Care Center	Days		
505	DD Center/Nursing Home	Days		
506	CBRF	Days		
Alcohol and Other Drug Abuse				
102	Adult Day Care			
104	Supportive home care	Hours		
104.1	Supportive home care	Days		
202	Adult family home	Days		
203	Foster home	Days		
204	Group home	Days		
205	Shelter home	Days		
503.6	Medically monitored hospital treatment	Days		
503.7	Medically monitored CBRF treatment	Days		
504	Residential care center	Days		
506.1	Transitional residential-hospital setting	Days		
506.2	Transitional residential	Days		
703.2	Medically monitored residential detox	Days		
705.1	Residential intoxication monitoring	Days		

Case Management and Transitional Supports				
Dane			WHIO	
SPC Code	SPC Name	SPC Unit	HCPCS	CPT Codes
Mental Health			G8978	90801-90809
601	Outreach	Hours	G8979	97535
602	Information and Referral	Hours	G8987	99366-99368
604	Case Management	Hours	G8988	99490
605	Advocacy & Defense Resources		H0006	
			H0014	
Alcohol and Other Drug Abuse			S5150	
101	Child day care	Hours	S5151	
106	Housing assistance	Hours	T1017	
107	Transportation	Other		
108	Work-related services	Hours		
110	Daily living skills training	Hours		
112	Interpreter	Other		
601	Outreach	Hours		
602	Information and referral	Hours		
604	Case management	Hours		
615	Supported employment	Hours		
112.55	Specialized medical supplies	Other		
605	Advocacy & Defense Resources			

Community Support Programs				
Dane			WHIO	
SPC Code	SPC Name	SPC Unit	HCPCS	CPT Codes
Mental Health			H0039	
509	Community Support Program	Hours	H0034	
Alcohol and Other Drug Abuse				
509	Community Support Program	Hours		

Comprehensive Community Services				
Dane			WHIO	
SPC Code	SPC Name	SPC Unit	HCPCS	CPT Codes
Mental Health			0359T	92507
510.1	Comprehensive Community Services	Hours	0360T	92508
			0361T	92522
Alcohol and Other Drug Abuse			0364T	92523
510.1	Comprehensive Community Services	Hours	0365T	92526
			0366T	92567
			0367T	92579
			0368T	92609
			0369T	97110
			0370T	97116
			0371T	97140
			0372T	97161
			G0176	97162
			H2017	97165
				97166
				97530
				99199

Community Recovery Services				
Dane			WHIO	
SPC Code	SPC Name	SPC Unit	HCPCS	CPT Codes
Mental Health			H0038	
511	Community Recovery Services	Hours	H0043	
			H2023	
Alcohol and Other Drug Abuse				
511	Community Recovery Services	Hours		

Intake Assessment				
Dane			WHIO	
SPC Code	SPC Name	SPC Unit	HCPCS	CPT Codes
Mental Health				90791-90792
603	Intake Assessment	Hours		

APPENDIX C—FULL REGRESSION VALUES

Outpatient

Race	2016 MH	2017 MH	2018 MH	2016 AODA	2017 AODA	2018 AODA
Unknown Race	-26.51**	-20.07***	-5.08***	1.43	0.81	1.59
	(11.60)	(6.20)	(0.75)	(2.47)	(3.27)	(3.48)
Black	-30.36***	0.13	0.10	6.84***	9.36***	7.51***
	(4.23)	(2.10)	(0.42)	(1.01)	(1.35)	(1.52)
American Indian or Alaska Native	-54.42***	-36.52***	-5.71***	-14.19***	-6.84*	-18.80***
	(4.76)	(4.25)	(0.61)	(0.69)	(3.58)	(1.31)
Asian	12.18**	70.82***	52.36***	-3.54**	-3.24	-1.61
	(4.78)	(3.66)	(3.11)	(1.64)	(2.14)	(4.64)
Native Hawaiian or Pacific Islander	-56.88***	4.51	-2.75***	-1.47	-8.07***	-9.95***
	(4.87)	(4.23)	(1.05)	(1.46)	(1.77)	(1.52)
Multi-racial	0.18	2.76	5.40***	17.63***	15.29***	28.51***
	(11.96)	(5.63)	(1.49)	(2.66)	(2.75)	(4.15)
Unknown	-71.22***	-19.51***	-6.41***	-3.12***	32.08***	18.83***
	(2.67)	(1.35)	(1.50)	(0.65)	(3.39)	(1.92)
Hispanic	-26.08***	15.63***	0.71	-1.69**	9.20***	3.29**
	(6.54)	(4.65)	(0.76)	(0.79)	(1.36)	(1.45)
Constant	90.44***	29.14***	8.90***	17.15***	13.96***	17.21***
	(2.90)	(1.07)	(0.25)	(0.38)	(0.56)	(0.67)
Observations	10,018	7,256	4,181	10,644	9,032	4,314
R-squared	0.01	0.10	0.22	0.02	0.04	0.06

Robust standard errors in parentheses
*** p<0.01, ** p<0.05, * p<0.1

Crisis

Race	2016 MH	2017 MH	2018 MH	2016 AODA	2017 AODA	2018 AODA
Unknown Race	-23.83	-25.84	-23.84***	N/A	-1.18	-3.21
	(23.25)	(36.76)	(1.90)	N/A	(1.61)	(5.46)
Black	-5.84***	-2.19	-2.02*	-0.24	1.14***	-1.42**
	(1.48)	(1.63)	(1.04)	(0.45)	(0.28)	(0.71)
American Indian or Alaska Native	-27.36	-13.14	2.29	-2.92	-0.92	N/A
	(26.82)	(19.65)	(11.02)	(3.35)	(2.78)	N/A
Asian	-0.25	3.68	-0.57	-0.84	-1.07	-2.56
	(4.38)	(3.99)	(2.89)	(1.25)	(0.89)	(2.03)
Native Hawaiian or Pacific Islander	-6.54	-6.04	-6.27	0.49	-1.27	-0.77
	(6.36)	(7.11)	(4.63)	(1.46)	(0.91)	(2.45)
Multi-racial	16.79***	17.51***	5.12***	-2.30	-1.30	-1.60
	(2.71)	(3.04)	(1.95)	(1.68)	(0.85)	(1.84)
Unknown	-24.88***	-22.79	-17.29***	-3.10***	-2.34***	0.17
	(2.65)	(18.38)	(1.77)	(0.30)	(0.20)	(0.58)
Hispanic	-7.18***	-11.23***	-1.11	-3.02***	-1.10**	-2.23**
	(2.76)	(3.13)	(1.95)	(0.69)	(0.48)	(1.05)
Constant	30.62***	34.70***	26.68***	5.99***	4.25***	4.82***
	(0.74)	(0.82)	(0.51)	(0.24)	(0.15)	(0.29)
Observations	6,103	6,146	8,138	1,605	1,642	1,623
R-squared	0.03	0.01	0.03	0.07	0.10	0.01

Standard errors in parentheses
*** p<0.01, ** p<0.05, * p<0.1

Inpatient

Race	2016 MH	2017 MH	2018 MH
Unknown Race	-98.04***	-85.40***	-9.56***
	(22.81)	(8.15)	(3.21)
Black	-43.25***	-63.11***	-18.52**
	(6.74)	(8.39)	(8.14)
American Indian or Alaska Native	N/A	N/A	N/A
	N/A	N/A	N/A
Asian	183.51***	119.51***	138.02***
	(37.65)	(33.26)	(33.05)
Native Hawaiian or Pacific Islander		-87.40***	-37.34***
		(8.15)	(8.61)
Multi-racial	88.24***	-43.06***	-32.33***
	(31.24)	(13.47)	(5.94)
Unknown	-50.80***	-74.80***	-28.37***
	(9.24)	(10.94)	(5.81)
Hispanic	40.52*	-42.26***	-40.12***
	(23.78)	(15.06)	(6.48)
Constant	60.52***	89.40***	53.68***
	(7.16)	(8.15)	(6.30)
Observations	395	379	332
R-squared	0.23	0.14	0.19

Robust standard errors in parentheses
*** p<0.01, ** p<0.05, * p<0.1

Follow-Up Care

Race	7 Day	30 Day
Unknown Race	-0.01	-0.29
	(0.21)	(0.22)
Black	-0.05***	-0.06***
	(0.01)	(0.01)
American Indian or Alaska Native	N/A	N/A
	N/A	N/A
Asian	0.07***	0.09***
	(0.01)	(0.00)
Native Hawaiian or Pacific Islander	0.36***	0.09***
	(0.02)	(0.02)
Multi-racial	0.22***	0.09***
	(0.01)	(0.00)
Unknown	-0.47***	-0.56***
	(0.03)	(0.04)
Hispanic	-0.02*	0.01*
	(0.01)	(0.01)
Constant	0.62***	0.89***
	(0.00)	(0.00)
Observations	22,971	22,971
R-squared	0.04	0.05

Robust standard errors in parentheses
*** p<0.01, ** p<0.05, * p<0.1