Mental Health and Substance Abuse

Memorandum

DATE	August 1, 2008
TO	Joint Appropriations Interim Committee
FROM	Select Committee on Mental Health and Substance Abuse
SUBJECT	Oversight of Regionalization Funding

During the 2005 Legislative Session, the Select Committee on Mental Health and Substance Abuse Services was formed. The Select Committee met through 2005 and sought to respond effectively to many of the concerns and issues identified in both the mental health and the substance abuse treatment fields. One of the primary changes proposed by the Select Committee, and ultimately adopted by the Wyoming Legislature, was to support the development of a regionalization model for the delivery of mental health and substance abuse services.

In 2006, House Bill 91 (2006 Wyoming Session Laws, Chapter 40) was enacted to fund the development of the initial pilot projects beginning the movement toward regionalization. Then in 2007, Senate File 76 (2007 Wyoming Session Laws, Chapter 216) provided additional funding to expand the regionalization process further. In 2008, needed expansion of the crisis stabilization program (a part of the overall regionalization concept) was accomplished through additions to the budget bill, specifically 2008 Wyoming Session Laws, Chapter 48, Section 48, Paragraphs 9 and 10.

The full development of the regionalization service model will be ongoing and the Select Committee will be recommending a significant and needed appropriations request in a bill during the 2009 legislative session. These appropriations will be needed to bring regionalization closer to completion.

The process begun in 2005 was intended to develop regionalization through the financial support of pilot projects. The pilot projects would demonstrate accountability to determine if the regionalization model could address the numerous problems presented initially, such as limited community access to an appropriate level of care, reduction of unnecessary hospitalizations, and enhancements to address workforce shortages. At the present phase of the regionalization development, feedback indicates that the model is beginning to address the needs identified effectively.

The regions designated by the Department of Health are as follows:

Central Region:	Natrona, Fremont, Converse, Niobrara
Southeast Region:	Carbon, Albany, Laramie, Platte, Goshen
Northeast Region:	Campbell, Crook, Weston, Sheridan, Johnson
West Region:	Uinta, Sweetwater, Teton, Sublette, Lincoln

Basin Region: Park, Hot Springs, Big Horn, Washakie

The regionalization model was designed to treat patients locally rather in statewide institutions. In the long run, significant expenditures can be reduced because local care is more cost effective and efficacious than institutional care. This concept is proving to be correct. The first pilot project with funding for crisis stabilization beds was started in Laramie County. Because patients were being stabilized in Cheyenne rather than being sent to the State Hospital in Evanston, the State Hospital has realized a savings of $3 million.

During the 2005 interim, the Select Committee focused on identifying the primary challenges and issues and proposed solutions to the provision of mental health and substance abuse treatment services in the State. During the 2006 and 2007 interims, the Select Committee continued with expansion of the regionalization model, identifying successes and modifying approaches as necessary. During the 2008 interim, the Select Committee has continued consideration of potential expansion of the regionalization model, and it was also determined that the Select Committee should concentrate on oversight of how the appropriated funds were being spent. Accordingly, the Select Committee met on April 24 and 25 in Teton Village for a two day oversight hearing on the relevant operations of the Division of Mental Health and Substance Abuse Services. On June 17, 2008, the Select Committee requested all of the WAMHSAC providers present measurable evidence as to how each region has spent their funds and provide feedback on the impact of those expenditures. "WAMHSAC" means the Wyoming Association of Mental Health and Substance Abuse Centers. Currently the Wyoming Legislature appropriates funds to the Division of Mental Health and Substance Abuse Services. The Division then contracts with certified providers in each county to provide both mental health and substance abuse services. The providers are commonly referred to as WAMHSAC providers. For example, in Casper, the WAMHSAC provider is Central Wyoming Counseling Center, in Cheyenne it is Peak Wellness Center. All of these centers are private, non-profit corporations governed by Boards of Directors comprised of volunteers within each center's respective area of responsibility. The Division has developed best practices requirements within the contracts and monitors the providers' operations to ensure compliance.

Oversight Hearing of Division

On April 24 and 25, 2008, the Select Committee held an oversight hearing of the Division of Mental Health and Substance Abuse Services. The Division is administered by Deputy Director Rodger McDaniel. This Division is the result of a recent merger of the Mental Health and the Substance Abuse Divisions that existed prior to 2007. The merging of these Divisions has created the opportunity for more efficient policy making. The Division has two primary units. Unit #1 is named Policy and Planning and Unit #2 is named Community Services and Prevention. On April 24, the Select Committee heard a description of the duties of Unit #1, Policy and Planning. On April 25, the Select Committee heard a description of the duties of Unit #2, Community Services and Prevention. The Select Committee was able to highlight areas of needed improvement. This memorandum will highlight only those matters relevant to the concerns expressed by the Joint Appropriations Interim Committee (JAC) .

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Highlighted Issues for JAC

1. There are various tensions between the newly organized Division and WAMHSAC providers. The WAMHSAC centers provide the direct services to the clients. WAMHSAC had concerns that many of the new employees within the Division did not have the needed expertise in the mental health or substance abuse fields. Deputy Director McDaniel pointed out that he has entered into consulting contracts with experts to assist his staff. The Division appears to be taking a much more active role in the field operations of the WAMHSAC providers. This type of oversight (or as WAMHSAC describes as "micromanaging") appears to be warranted since the Division has an obligation to ensure that the funds being appropriated, especially the new funds, are being spent correctly and in the most effective manner.
2. The Division needs to be more responsive to the suggestions and concerns of the WAMHSAC providers. The WAMHSAC providers understand what actually works, rather than what may work in theory. The Division headquarters in Cheyenne could easily lose touch with the reality of field work demands and needs.
3. Considerable funds have been spent to develop a system that provides measurable evidence of outcomes to replace anecdotal evidence. There is some concern among Select Committee members that the data is not yet sufficient or adequate to make policy decisions. After several years of development, with considerable pressure from the Select Committee, the Division has developed, and is implementing, a client information database system to track both clients and their outcomes after treatment. The expectation is that the data will be providing better documentation of measurable impacts by early 2009.
4. WAMHSAC expressed concerns that the Division is creating “multiple programs” that do not fit within the current system and may actually not work within the current system. An example provided was the Screening, Brief Intervention and Referral to Treatment (SBIRT) program initiated by the Division. SBIRT is a federally funded, comprehensive integrated public health approach to the identification, early intervention and delivery of treatment services to persons with substance abuse problems. The controversy between the Division and WAMHSAC was not as significant as the questions that arose about where the Division was getting the funds to do these “extra programs.” The answer that generated the most discussion was the use of tobacco settlement funds, which generated significant additional questions from Committee members about how authority was obtained to use those funds.
5. The local communities had come together under their SPF-SIG Grants (prevention grants from the federal government) and formulated prevention marketing plans that fit the communities' unique needs. The Division created a marketing plan that was very different from the local communities’ plans. This "dual track" planning has caused some tension. The Division is using a marketing plan called “Where Do We Draw the Line”, generally referred to as the "Line" campaign. The local communities' plans were using a social norming marketing plan which focuses on positive phrases such as "95% of our kids are drug free," rather than on "5% of kids are on drugs". The Select Committee is not recommending which is the best marketing plan, but suggests there should be more coordination between the State and the Local Communities.
6. The SPF-SIG funds from the federal government were given on a pro-rata basis to all 23 counties and the Wind River Indian Reservation. There was some testimony that the money would have been spent more efficiently if the funds had been given to the top 12 counties with major problems.
7. The Children’s Mental Health Waiver has had problems getting started. Apparently, the paperwork alone was a major deterrent to the use of the waiver. Even though the implementation of the Children’s Mental Health Waiver has been difficult, how the Division is handling this issue has been very positive. The Division recognized their initial approach was not working. The Division then completely revamped its system, made the paperwork easier to understand, and

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partnered with the University of Wyoming to provide an excellent training course for potential providers. It was very gratifying to see the Division able to recognize when something was not going well, to back up and re-evaluate, and then execute a new strategy for implementation.

8. The high costs of Title 25 (involuntary commitment) patients continue to be a problem. The Select Committee suggested that the Division consider contracts with local holding hospitals that would cap the costs incurred by the State. There are many communities that hold the patients in other hospitals until the patient can be transferred to a treating hospital (e.g., the State Hospital, Pineridge Hospital in Lander, or Wyoming Behavioral Institute in Casper). These costs incurred by the State at holding hospitals are high. The Division continues to resist the suggestion to enter into cap contracts. The Select Committee suggests that the Division attempt to bring down its costs through cap contracts with the holding hospitals.
9. Overall, the Division appears to be working successfully with the implementation of regionalization. The Division is attempting to work better with the WAMHSAC providers.

Oversight of WAMHSAC Implementation of Regionalization

On June 17, 2008, the Select Committee met in Evanston and heard from each region as to how the implementation of regionalization was being accomplished. Overall, all of the regions are doing a superb job of implementation. One of the best comments heard at the meeting was from the Northeast Region, when one of the providers stated that if nothing else, the process has created the opportunity for the different WAMHSAC providers within a region to talk to each other. Previous to the requirement for consensus building among providers within a region, the agency director had never had any conversations with another provider in the region. Some regions are doing better than others, but overall the regions are all progressing well. Some identified concerns include:

1. A major concern for WAMHSAC providers was that, in some communities, the providers have run up against community opposition to the establishment of group homes for the mentally ill. The community opposition through zoning and covenants, conditions and restrictions (CCR's) has slowed the progress of building some group homes.
2. The Legislature is not providing funds for brick and mortar for the WAMHSAC providers. The building costs are prohibitive and are slowing the implementation of certain aspects of regionalization.
3. Last year the Legislature passed legislation that specifically allowed funds to be used for start-up costs. The Division and WAMHSAC have disagreed with respect to what constitutes reimbursable start-up costs. This issue appears to have slowed the implementation of certain projects.
4. Since the beginning of the formation of the Select Committee, the Basin Region has been an area of concern, since it has the least amount of resources available for its citizens. The Basin has greatly expanded their services through the regionalization process. The successes in the Basin Region have brought providers closer to achieving parity with the other regions was very positive news.
5. The Central Region, especially Fremont County, appears to continue to struggle to provide services.

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Conclusion

Implementation of regionalization is proceeding well. Both the Division and the WAMHSAC providers have done a good job of implementing the process. There have been some transition challenges, but overall the process is going well. The Legislature should consider numerous issues, including full implementation of regionalization through the appropriations process in the 2009 session. Among the issues the Select Committee recommends for consideration are:

1. Fully funding crisis stabilization beds in every region ($3 million). The Legislature has provided funding for such facilities in 3 regions, and there are 2 regions (Central and Northeast) yet to be appropriately funded.
2. Completing the full regionalization of co-occurring disorders programs ($3.6 million) and the adult acute psychiatric care programs ($3.5 million) in every region. Presently, only the Southeast Region has these programs and the other four regions need funding.
3. Re-structuring the manner in which drug courts are funded. Presently, the funding is $200,000 per court, regardless of how big or little the program is, thus a court serving 40 clients gets the same funding as a court serving 10 persons. Also, because there is not enough money to fund all 24 courts at the $200,000 level, it is distributed on a pro-rata basis. A new formula should be implemented that gives a base amount plus a certain amount per client served.
4. Funding for the family treatment courts should be provided separately from the drug courts, such as through their respective district court budgets. Presently there are 3 family treatment courts.
5. Funding for the juvenile drug courts should be provided through a different funding source than the adult drug courts. The juvenile drug courts have different needs and higher costs than the adult drug courts.
6. Careful review of the use of tobacco settlement funds to evaluate the manner in which those funds are being distributed. The initial payment was placed in a trust fund and every year thereafter the payments are given to the Department of Corrections, the Department of Family Services, and the Department of Health for a myriad of different programs. One suggestion was to take the yearly payment and place it directly into the trust fund and in the future the State only spend the interest earned from the investment of the trust fund. The earned interest would satisfy the needs of tobacco cessation programs, but not the other substance abuse programs that are funded with these funds, including ½ of the funding for drug courts. There is a concern that at some point the tobacco settlement payments from manufacturers will end and the State will have relied too heavily on the those funds to prop up the entire substance abuse treatment system. It would be more efficient to fund the successful substance abuse programs out of the standard budget to avoid a potential emergency funding situation when the payments start decreasing from the tobacco companies.
7. Funding existing infrastructure needs at the State Hospital. The first priority should be to get a working HVAC system in the Karns Building. There was testimony before the Select Committee that the temperature at the nurses station approaches 90 degrees in the summer. The Select Committee walked through the building in the summer of 2007 and

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it was uncomfortably hot. Persons with mental illnesses should be housed in a building with a better HVAC system. This request may be proceeding through the State Building Commission as a major maintenance issue. The second priority is the State Hospital needs to consider seriously building a geriatric psychiatric facility on the grounds of the State Hospital. The number of elderly persons with psychiatric needs is increasing with the aging of Wyoming citizens, and nursing homes in the State are not capable of housing elderly patients with special needs. Building a geriatric psychiatric facility at the State Hospital would free up beds for additional Title 25 patients in the main hospital, thereby shortening the waiting list for admissions. The Division has completed a study that recommends that the emphasis be on treating the geriatric patients in nursing homes in their own communities. While agreeing with the recommendations of the Division, the Select Committee nevertheless believes that there are some geriatric patients that can not be adequately served in nursing homes and the number of those persons will continue to increase, thereby posing a risk to those patients and to other patients in nursing homes. Therefore, the Select Committee strongly recommends that the Legislature authorize the building of a facility at the State Hospital to house and treat geriatric patients who can not otherwise be adequately served in nursing homes.

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