Behavioral Health Redesign Steering Committee (BHRSC)
November 19, 2015

Call to Order. Chair Flanagan called the meeting of the Behavioral Health Redesign Steering Committee to order at 12:03 P.M. in Rooms N1-N2, Fifth Floor, Rock County Courthouse-East.

Committee Members Present: Chair Kate Flanagan, Supervisor Billy Bob Grahn, Tricia King, Rebecca Rudolph (alt. for Linda Scott-Hoag), Lance Horozewski, Dr. Ken Robbins, Tim Perry, Pastor Mike Jackson, Tami Lalor, Verlene Orr, Michelle Rose-Barajas, and Deputy Chief John Olsen.

Committee Members Absent: Laura Neece, Lindsay Stevens, Sheila DeForest, Ian Hedges, Brian Gies, Judge R. Alan Bates, Neil Deupree, Emily Pelz, Cmdr. Erik Chellevold, Samantha Palan, and Ian Hedges.

Staff Members Present: Greg Winkler, HSD Outpatient Services and Melissa Meboe, HSD Crisis Services.

Others Present: Supervisor Lou Peer, Steve Howland, Ethel Below, Lynda Owens, Diane Hadsell (NAMI-Rock County), and Representative Debra Kolste.

Approval of the Agenda. Supervisor Grahn moved approval of the agenda as presented, second by Pastor Jackson. ADOPTED.

Approval of the Minutes of October 20, 2015. Pastor Jackson moved approval of the minutes as presented, second by Dr. Robins. ADOPTED.

Workgroup Updates

Data Workgroup: Chair Flanagan said this group met at the beginning of November. They will meet again right after Christmas. They discussed how to utilize the Spillman to interface between law enforcement/jail and behavioral health.

AODA Steering Committee: This is the highlighted group for the month.

CCRG: Ms. Meboe said this group met yesterday and worked on their MOU and discussed transport responsibilities. There is an additional meeting for this group on December 21st. Ms. Meboe added that there is a new detox contract in the works, as a second detox option in Milwaukee.

Cultural Competency: Mr. Deupree will report on this at the next meeting.

Kids Continuum of Care: Mr. Horozewski said this group met last Friday. He said they continue to make progress and the goal for 2016 is to enhance the system of care. They are also looking at barrier associated with insurance not paying for portions of trauma treatment.

Adult Continuum of Care: Chair Flanagan said efforts continue to focus on the HSD Intake process.

Consumer/Family: Ms. Hadsell said they have taken a break since the Wellness Fair and will meet again in December.

AODA Workgroup Presentation and Heroin/Opiate Recommendations. Ms. Rudolph passed out a report from the AODA Steering Committee outlining recommendations for the opiate problem. Mr. Horozewski suggested more time be sent at the next BHRSC meeting to discuss these recommendations. The group agreed.

Discussion regarding Mental Health and Violence. Dr. Robbins handed out a document about mental health and violence. The group went over the document with him. Pastor Jackson said he was interested in continuing this discussion at the next BHRSC meeting. The group agreed.

Review of Strategic Plan Outcome Dates & Data Dashboard and Discussion regarding Next Steps. Due to time constraints, this item will be on the next BHRSC agenda.

Update on Justice and Mental Health Collaboration Grant Activities. Due to time constraints, this item will be on the next BHRSC agenda.

Success Stories/Positive Outcomes Related to Strategic Plan Goals. Due to time constraints, this item will be on the next BHRSC agenda.

Citizen Participation and Announcements. Ms. Pohlman McQuillen announced the retirement party for Pastor Jackson on November 29th.

Ms. Hadsell said NAMI-Rock County will be offering Family to Family Classes. More information will be forthcoming.

Ms. Orr announced International Survivors of Suicide Day. More information will be sent via email to BHRSC members.

Future Meeting Date and Time. Thursday, January 21, 2016, at Noon, in N1-N2, 5th Floor Courthouse East.

Adjournment. The meeting adjourned at 1:00 p.m. by acclamation.

Respectfully submitted,
Elizabeth Pohlman McQuillen
Criminal Justice System Planner/Analyst

NOT OFFICIAL UNTIL APPROVED BY COMMITTEE.

Rock County AODA Steering Committee Report on the State of Opiate Treatment in Rock County

Since its release in July 2014, the summary of recommendations from the heroin workgroup of the Wisconsin State Council on Alcohol and Other Drug Abuse has provided guidance for Rock County's AODA Steering Committee goals and strategic plan.

We, the community partners representing AODA treatment in Rock County, wish to present the following report on the status of opiate treatment in our area.

The information outlined below discusses steps that have been taken in Rock County to address the recommendations within the Treatment Pillar of the SCAODA report, as well as observed trends, ongoing barriers to meeting these goals, and additional recommendations from the Rock County AODA partners:

WI SCAODA Heroin Workgroup Recommendations

Treatment Pillar

Recommendation 25: Establish in-patient stabilization centers/ facilities throughout Wisconsin to allow patients time to detox as well as coordinate follow-up services such as continuing treatment options, stabilized housing, or community recovery support.

Trends in Rock County: There has been an observed decrease in the past year in opiate detox services available to Rock County residents. Locally, opiate detoxification services that were previously available through Mercy Hospital have been discontinued. Contracted partner services through Genesis detox in Milwaukee have been terminated. Contracted services with Tellurian in Madison continue to be accessible to Rock County residents, however, opiate detox tends to be utilized on a limited basis due to overdose risks, as well as the inefficacy of detox as a standalone treatment for opiate dependence. This service is primarily used as a point of entry for individuals who will immediately enroll in residential or IOP programming. In addition, the Rock county contract with Tellurian only covers two beds. When these beds are both being used we are unable to access this resource.

There continues to be a lack of residential treatment services available to Rock County residents for opiate dependence, although outcome studies of residential treatment do not demonstrate any greater efficacy than intensive outpatient services for opiate dependence. Despite an observed increase in Rock County residents able to obtain insurance through the public healthcare system, Wisconsin Medicaid currently does not provide for residential level of care under any of the Badgercare plans. Rock County AODA services currently maintains contracts with Hope Haven and Tellurian in Madison for residential treatment, at an approximate cost of $5,000 to $9,000 per patient per month.

One significant barrier to accessing residential treatment for opiate dependence is that these facilities require patients to be stabilized on an opiate treatment medication or detoxed from opiates prior to admission. The substantial lack of medication-assisted treatment providers in Rock County will be addressed under Recommendation 27, but this gap in treatment presents a problem for patients seeking residential level of care as well.

Rock County has reached out to sober living and community support providers as one way to bridge this gap in services. Rock County clients have been able to receive housing supports through GIFTS Men's

Shelter, who have been active partners in the AODA Steering Committee, and also Ruth's House, as a sober living option for women.

The Department of Corrections has also expanded funding for emergency housing needs and has increased the number of inpatient halfway house beds available for individuals following incarceration.

Recommendation 26: Provide treatment for persons while incarcerated.

Trends in Rock County: Rock County offers limited jail re-entry case management services to individuals who are dually-diagnosed. Rock County jail also provides AODA treatment groups to eligible inmates through the RECAP program. Individuals who have been sentenced in the jail are able to attend AA meetings, however individuals who are pending sentencing are not able to attend.

One area of concern is the current policy that incarcerated individuals are unable to continue physician-prescribed medication-assisted treatment, even if they have been in a stabilized treatment program and their physician provides appropriate prescription information to the jail. This gap in care may contribute to increased overdose risks for individuals upon release from incarceration.

Recommendation 27: Provide accessible Medication Assisted Treatment (MAT) throughout Wisconsin for all populations through multiple services providers and delivery systems.

Trends in Rock County: Since the start of the opiate crisis, there has been a shortage of Medication Assisted Treatment providers in Rock County, and this provider shortage continues to present one of the greatest challenges to individuals seeking services in our area. Currently in Rock County, Janesville Psychiatric Center is the only partner agency offering Medication Assisted Treatment. Because of the high level of need for these services, there are often lengthy wait times for admission to this program. Mercy Health System is also accepting a small number of patients who meet specific criteria for Medication Assisted Treatment through their Addiction Day Treatment program. Methadone services continue to be available through Comprehensive Treatment Center (formerly QAM) in Beloit, however an individual must have Title 19 insurance coverage or be able to self-pay for this service, at an approximate cost of $110 per month.

Increasing numbers of Rock County residents have been able to apply for public insurance coverage for services, however navigating Badgercare HMO systems that provide Medication Assisted Treatment in our area often presents a barrier for those seeking care. Rock County AODA services continues to offer assistance with treatment linkage as well as AODA block grant funding for uninsured and underinsured individuals, at an approximate cost of $1000- $1800 per individual per month.

Rock County treatment courts offer limited Medication Assisted Treatment for individuals enrolled in Drug Court and OWI Court programs.

The Veteran's Administration offers Medication Assisted Treatment services for Veteran's Court clients and other eligible veterans.

Additionally, while Vivitrol/ Naltrexone medications can be prescribed by any physician, there continues to be a reluctance on the part of providers to utilize these interventions in treating patients with a history of opiate dependence.

Recommendation 28: Provide accessible Non-MAT throughout Wisconsin for all populations through multiple service providers and delivery systems.

Trends in Rock County: Within the scope of treatment services, Rock County has an abundance of providers and partner agencies offering Level 1 Outpatient and Intensive Outpatient treatment, including Beloit Health System, Lutheran Social Services, Crossroads, and Mercy Options. These programs typically have little to no wait times for admission and provide for individual and group therapy. These services are available through many private and public insurers, as well as Rock County AODA block grant funding for most programs. Typical costs for outpatient services that are funded through Rock County block grant are $600- $1,000 per month. Opiate dependent patients tend to struggle in outpatient treatment programs, however, with outcomes showing poor treatment retention and high relapse rates.

The Department of Corrections also offers heroin-specific treatment groups in Rock County for individuals on probation, and has a process in place to "fast-track" admission to outpatient services for clients with opioid addiction.

Recommendation 29: Establish adolescent treatment options throughout the state.

Trends in Rock County: Rock County Human Services began offering Level 1 Outpatient AODA treatment services to youth involved with the juvenile justice system in March 2015. There continues to be a need for expanded services for youth at other levels of care, including Intensive Outpatient services, Early Intervention services, and residential treatment, which are currently not available or available only on a very limited basis to Rock County residents.

Recommendation 30: Provide positive proactive supportive services for pregnant women and people with SUD's with dependent children.

Trends in Rock County: In response to the needs of pregnant women and women with dependent children in need of opiate treatment services in our area, Rock County developed a consultation and referral service for Child Protective Services staff and clients. Rock County also established contracted services with Meta House in Milwaukee for residential treatment for pregnant women and women with dependent children. Pregnant women also continue to receive priority admission for services with Rock County partner agencies.

Overall Trends:

- Increasing numbers of clients obtaining insurance through WI Medicaid system.
- Shortage of medication-assisted treatment, with wait times ranging from 6 weeks to 5 months for admission to services.
- Ongoing stigma related to opiate dependence treatment, with some partners and providers reducing and/ or declining to provide services for opiate dependent clients.
- Even for clients with insurance or who are eligible for insurance, there continue to be barriers to accessing care due to HMO limitations, waiting times, and under-insured coverage.
- Lack of housing, sober living, and other supports for related socio-economic needs.

Additional steps Rock County and partners have taken to address needs related to opiate treatment:

- Lack of funding to meet the substantial need related to opiate dependence. RESOLVED- Rock County Board approved additional AODA block grant funding for 2015 to meet treatment needs.
- Rock County held a series of Heroin Town Hall Meetings to promote education and advocacy around the areas of opiate dependence, overdose, and treatment resources.
- Janesville Mobilizing 4 Change began offering a monthly Naloxone training in partnership with AIDS Resource Center to reduce and prevent overdose deaths in Rock County.

AODA Steering Committee Recommendations:

1. Increase training regarding evidence-based treatment practices for opiate dependence for provider agencies and partners to reduce stigma surrounding opiate dependent population and medication assisted treatment.

    a. Send partner agencies and providers to training events related to EBP's in the field.

    b. Bring in a physician educator to provide training to local psychiatric providers.

2. Partner agencies will continue to train front-line staff on being welcoming and responsive to patients seeking opiate treatment.

3. Request the presence of Child Protective Services representative at monthly AODA Steering Committee meetings.

4. Secure commitments from partner agencies to increase capacity for evidence-based opiate treatment, including medication assisted treatment with Naltrexone or Buprenorphine.

5. Identify ways to increase community-based awareness campaigns and support group events (i.e. overdose awareness and parents' groups).

6. Create a Heroin Task Force that includes representation from Prevention, Harm Reduction, Law Enforcement and Treatment providers. This will allow a coordinated, comprehensive approach that balances public order and health in order to create a safer, healthier community.

Mental Illness and Gun Violence
Dr. Ken Robbins
Rock County Mental Health Steering Committee
November 19, 2015

1. Data on mental illness and gun violence
2. Risk Factors for violence amongst those with mental illnesses
3. Duty to Warn
4. Policy implications

There are several types of violence for which the connection to mental disorders is unquestioned and substantial. People with mental disorders are about 10 times more likely to be victims of violent crime than the general population. Suicide is also disproportionately associated with mental illness. According to 2009 data from the CDC, age adjusted mortality from suicide for the overall US population was 11.8 per 100,00 people, and 80% of those had a serious psychiatric illness. The rest of this talk, however, will focus on violence committed by those with mental illnesses.

Data on mental illness and gun violence

1. In 1990, the first large epidemiologic study was published that reported the prevalence of any minor or serious violent behavior in adults with and without diagnosable psychiatric disorders in randomly selected community household sample irrespective of treatment. The National Institute of Mental Health Epidemiologic Catchment Area (ECA) study measured violence using an index of survey questions that asked about the occurrences of specific physical assaultive behaviors such as hitting with a fist, pushing, shoving, kicking or throwing things at another person, or using a weapon to harm or threaten another person.

Analysis from 3 sites (Baltimore, St. Louis and LA) with a combined total of 10,024 participants showed a statistically significant association between violence and mental illness. The 12 month prevalence of any minor or serious violence among people with schizophrenia, bipolar disorder or major depression was about 12% overall, and 7% in the subgroup with these disorders alone and no substance abuse comorbidity. That was compared with a general population prevalence of about 2% in persons without mental illness or substance abuse disorders, for an adjusted relative risk of 3:1 for mental illness alone. Lifetime prevalence rates were estimated at 15% for the population without mental illness, 33% in those with serious mental illness only, and 55% for those with serious mental illness and substance abuse combined.

The ECA, using data that included the prevalence of mental illness, concluded if the elevated risk of violence in people with mental illness were reduced to the average risk in those without mental illness, an estimated 96% of the violence that currently occurs in the general population would continue to occur. So, even if mental illness

were eliminated as a risk factor for violence, it would only stop 4% of violent acts overall.

4 factors were statistically predictive of violence in people with or without mental illness. These included age below 25, male gender, those of lower SES, and those having problems involving alcohol or illicit drug use.

2. The MacArthur Violence Risk Assessment Study (MVRAS) followed a cohort of more than 1000 discharged psychiatric inpatients over 1 year in the mid-1990's and used self and family reporting to measure violent outcomes. The MVRAS found that substance abuse comorbidity was responsible for much of the violence in discharged psychiatric patients. Patients who had only mental illness without substance abuse, did not have a higher risk of violent behaviors than their neighbors in the community, persons selected at random from the same census tracts in which the patients lived. However, many of these were disadvantaged, high crime neighborhoods in the inner city where base rates of violence were higher than in the ECA study. So, one could interpret these findings as suggesting the social-environmental influences on violence are stronger than the effects of psychopathology.

3. Van Dorn in 2012 confirmed the basic pattern of the ECA community findings with an analysis of the association between violence and mental illness using data from the National Epidemiologic Survey on Alcohol and Related Conditions, a national household survey of 32, 653 person in the United States. This study reported similar patterns, though lower overall rates of violence than the ECA study did because of sampling and methodological differences between the studies (in part having to do with a higher standard in the definition of violence). They found 2.9% of people with serious mental illnesses alone committed violent acts in a year, compared with .8% of people with no mental disorder or substance abuse. Those with co-occurring serious mental illness and substance abuse had a rate of violence of 10%.

4. Studies that have examined the prevalence of violence amongst psychiatric patients vary largely based on the clinical settings in which the studies were conducted. Based on meta-analytic studies, the rates of violence among psychiatric outpatients in treatment is about 8%; discharged hospital patients about 13%; those who present in psychiatric emergency settings 23%; involuntarily committed patients 36% and studies of people with their 1st episode of psychosis 37% in the year leading up to their first treatment encounter.

5. In meta-analytic studies from Nordic Countries and Australia, attributable risk for violence in people with psychotic disorders was about 10%, for those with personality disorders (including antisocial PD) was about 20%, and was between 20 and 24% for those with substance use disorders.

Risk Factors

Risk factors for violence amongst people with mental illnesses can be divided into 3 clusters.

1. Cluster 1 are social and economic risk factors. These include poverty, crime victimization, early life trauma, ambient neighborhood crime, education level, age, social supports and unemployment.

2. Cluster 2 are psychiatric symptoms. Paranoia, command hallucinations, mania, severe anger/ feelings of humiliation, treatment nonadherence, and substance abuse are the most significant risk factors.

3. Cluster 3 are other important issues. These include a history of violence and past circumstances around any violence (provoked? by what? associated with substance use? and how does that compare with current circumstance?), and what are the most significant recent stressors.

Duty to Warn

1. Tarasoff v. Regent of the University of California. Supreme Court of California held that mental health professionals have a duty to protect individuals who are being threatened with bodily harm by a patient. The original 1974 decision mandated warning the threatened individual, but a 1976 rehearing of the case by the California Supreme Court called for a "duty to protect" the intended victim. The professional may discharge the duty in several ways, including notifying police, warning the intended victim, and/or taking other reasonable steps to protect the threatened individual.

2. Schuster v. Altenberg Case before the Wisconsin Supreme Court in 1988. This is the only Wisconsin case to get beyond a circuit court and involved a psychiatrist, Dr. Barry Altenberg. In this case, the psychiatrist's outpatient (Ms. Schuster) was involved in an automobile accident while driving, killing herself and seriously injuring her daughter who was one of the plaintiffs. The patient's family sued the psychiatrist, alleging that he causally contributed to the accident through negligent diagnosis and treatment, as well as through negligent failure to protect others either by warning the family of the patient's condition and its implications or by seeking civil commitment. Even though there was no readily identifiable victim, the Supreme Court opined that Dr. Altenberg had a duty to protect. They believed that reasonable people in the position of the defendant would have foreseen the risk to other parties. The duty to warn, according to this decision extends to all potential people in the "zone of

danger." They rejected the notion that it must be a specific threat to an identifiable victim.

Policy Implications

1. Is this a time to consider changes to the involuntary commitment criteria? If more people were committed, do we have the resources to adequately care for them?

2. In 2013, the Consortium for Risk-Based Firearm Policy, a group of the nation's leading researchers, practitioners, and advocates in gun violence prevention and mental health, convened to review the relevant research evidence and formulate policy recommendations. The groups' recommendations, based on epidemiologic evidence included the following:

Recommendation 1: The federal government should clarify and refine existing mental health firearm disqualification criteria relating to involuntary commitment, and state laws should be strengthened to temporarily prohibit individuals from purchasing or possessing firearms after a short-term involuntary hospitalization. Concurrently, the process for restoring firearm rights should be modified to better protect the public while being fair to individuals who seek to regain their rights.

Recommendation 2: Congress and state legislatures should enact new restrictions on purchase and possession of firearms by individuals whose behavior presents evidence-based risk factors for violence. Categories of persons prohibited from firearms on a temporary basis should be expanded to include individuals convicted of a violent misdemeanor, subject to a temporary domestic violence restraining order, convicted of two or more offenses for driving while intoxicated or driving under the influence of alcohol or drugs in a 5 year period, or convicted of two or more misdemeanor crimes involving a controlled substance in a period of 5 years.

Recommendation 3: States should develop a mechanism to authorize law enforcement officers to remove firearms when they identify someone who poses an immediate threat of harm to self or others. States should also create a new civil restraining order process to allow family members and intimate partners to petition the court to authorize removal of firearms and to prohibit firearm purchase and possession temporarily based on a credible risk of physical harm to self or others, even when domestic violence is not an issue.