

WISCONSIN

DEPARTMENT OF HEALTH SERVICES

**DIVISION OF MENTAL HEALTH AND
SUBSTANCE ABUSE SERVICES**

**COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT MONITORING REPORT**

May 19–21, 2009

EXECUTIVE SUMMARY

The Community Mental Health Services Block Grant (also known as the Mental Health Block Grant (MHBG)) monitoring visit of the Wisconsin Department of Health Services (DHS), Division of Mental Health and Substance Abuse Services (DMHSAS) occurred from May 19 to 21, 2009. The monitoring team was given the opportunity to review materials and speak with agency leadership, advocates, members of the Wisconsin Council on Mental Health (WCMH) (also known as the Planning Council), and other stakeholders.

The Division is staffed by individuals with in-depth knowledge of the State's mental health system. Having employees with inpatient and community services experience contributes to the effective and efficient resolution of mental health service delivery system issues.

A major concern at the time of the monitoring visit was the next budget that begins in July 2009. The State was projecting a \$7 billion deficit expected to result in reductions to inpatient and community programs, as well as staff furloughs.

The Wisconsin Public Mental Health and Substance Abuse Infrastructure Study, which began recently, will review the State-supervised, county-based system of financing and providing publicly funded services. The study's findings will be used to develop potential models/pathways for financing the public mental health and substance abuse services system and result in recommended strategies for improvements to be considered during the 2011–2013 biennial budget and policy-making processes.

The major strategic steps highlighted during the monitoring team's meeting with the Division Director and leadership as most important for realizing DMHSAS's vision for the delivery of mental health services for adults and/or children are Wisconsin's movement toward recovery and DHS's emphasis on addressing health disparities through broad-based collaborative partnerships with mental health advocacy groups such as the WCMH, State and County Coordinating Councils, Wisconsin Family Ties (WFT), Wisconsin Council on Children and Families, the National Alliance on Mental Illness Wisconsin, and Mental Health America of Wisconsin. Maintaining and strengthening its partnership with counties was also viewed as critically important in realizing DMHSAS's vision of a transformed mental health system.

It should be noted that the WCMH views its task as being the voice for consumers and family members. The Planning Council's perception is that the State is shifting financial responsibility to the counties, and the Council believes this will result in a decrease in services.

The use of evidence-based practices, such as Assertive Community Treatment, Integrated Dual Diagnosis Treatment, Wellness Recovery Action Plans, Illness Management and Recovery, Supported Employment, Supported Housing, and Family Psychosocial Education, and the contributions of Peer Support Specialists are system strengths. In addition, Medicaid coverage for mental health services has improved, and the State's Medicaid policy facilitates access to a wide range of adult mental health services, including Community Support Programs and Comprehensive Community Services (CCS).

Wisconsin is addressing stigma, which has been identified in research, survey data, and Healthiest Wisconsin 2010 (the State Public Health Plan) as an issue to be addressed. Moreover, the Wisconsin United for Mental Health Coalition is dedicated to educating the public and increasing awareness regarding mental illness as it promotes treatment and recovery. The State has also invested in Aging and Disability Resource Centers to provide information and assistance regarding disability benefits counseling. These centers are the single point of entry for information and assistance for older adults.

The whole health approach of the Integration of Physical Health, Mental Health, Substance Use, and Addiction Initiative is key to improving health access and treatment for adults and children with serious mental and emotional healthcare needs. In addition, the Maternal and Child Health Advisory Committee is a partnership with State and local agencies and groups that represents a much-needed shift toward health promotion, prevention, and early intervention to capitalize on systemic partnerships across the lifespan.

The WFT is a major strength of the children's mental health system. Family surveys indicate a high degree of satisfaction with both mental health services received and WFT's services and supports.

The use of nearly 100 percent of MHBG funds for innovative services, system improvement projects, and transformation is exemplary and has positively impacted service system outcomes. For example, MHBG funds were used to develop the Integrated Services Project (ISP)/Coordinated Services Team (CST) initiatives to expand children's services to underserved areas. The Division's collaboration with the child welfare, juvenile justice, substance abuse, and education systems is noteworthy and builds on the incorporation of the principles and values of recovery and resilience into wraparound services for children and their families. These blended funding services have assisted DMHSAS in reducing out-of-home placements, treating the family as a unit, and fostering family participation in the decision making process at all levels and auspices of the children's service systems. The writing of the CCS initiative into the State's administrative rules has also strengthened children's services. These three initiatives, ISP, CST, and CCS, as well as the Long-Term Support Waiver, Children Come First, and Wraparound Milwaukee, address the needs of children with multisystem involvement through a coordinated wraparound and systemic service delivery approach.

Although the county-based system is a strength, it also presents system improvement opportunities in that its essential funding is derived from a tax levy sustained by property taxes. Due to current economic conditions and the State law that places a cap on levy increases, those tax revenues have diminished, creating a \$7 billion shortfall in the State budget. Other issues confronting Wisconsin include the need to improve service access in underserved areas, a shortage of psychiatrists, the need for updated technology, and funding for Medicaid 1915(i) expansion.

The MHBG has presented Wisconsin with opportunities to provide new services and support transformation. It is important to assure that these funds are obligated, expended, and reported in a timely manner. The fiscal data in the MHBG Application and Implementation Report require ongoing oversight and documentation in addressing the maintenance of effort (MOE)

requirement. Establishing a review and management process with key Division staff to facilitate review of State, county, and Medicaid expenditure data to ensure future compliance with the MOE requirement is essential.

The increasing demand on fiscal resources which support mental health services requires increased attention to accountability and documentation of patients, services, and cost in the community system. All levels of government (county, State, and Federal) must make decisions regarding what services will continue to be funded. The Division's contracting process is critical to the delivery of effective community mental health services. A contract is a vehicle through which expectations for both the contractor and provider are communicated. The precision of the document is critical to defining the services to be delivered, fiscal/service reporting requirements, and designated due dates.

The monitoring team greatly appreciates the time and effort that DMHSAS and Jefferson County Behavioral Health Division staff and other system stakeholders put into the monitoring visit. The team members were impressed with the preparation of those with whom we met and by the commitment of both State and county public mental health system staff to improving mental health services for Wisconsin adults, children, and their families.

Technical Assistance (TA) Recommendations

The DMHSAS has played a leadership role in transforming the State's mental health system. It has also targeted dollars to Wisconsin's 11 Native-American tribes and used MHBG funds to support cultural competency training and TA. There is, however, the need to review these accomplishments to ensure that services are optimally responsive to the ethnic, racial, and cultural diversity and special needs of all users of the public mental health system. It is critical as well for DMHSAS and other mental health system staff and members of State-sponsored boards, such as the WCMH, to reflect the cultural, ethnic, and racial diversity of the State's population. The public mental health system would also benefit from DMHSAS's completing the updating of its cultural competency development and improvement plan and establishing minimum standards for staff cultural competency.

Other TA from which Wisconsin could benefit is as follows:

- Further identification of funding models and system redesign to assist the State in its infrastructure study.
- Information regarding the MOE waiver to help identify how the State may pay for services and be able to show from where those dollars come.
- Information technology to assist Wisconsin in combining county data and financial information.

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CHAPTER I: INTRODUCTION

Mental Health Services Block Grant Monitoring

The passage of Public Law (P.L.) 102-321 afforded States the opportunity to receive Federal grants for the purpose of establishing or expanding comprehensive community mental health services to adults with serious mental illness (SMI) and children with serious emotional disturbance (SED). Under the statute, each State must submit a State Plan for Comprehensive Community Mental Health Services for the fiscal year involved. Each Federal grant can be used for the purpose of planning, administration, education, and evaluation activities related to carrying out and providing services under the State Plan.

The State Planning and Systems Development Branch, Division of State and Community Systems Development, within the Center for Mental Health Services (CMHS), is organizationally responsible for ensuring each State's compliance with the array of administrative and programmatic requirements under the law. P.L. 102-321, and as amended by P.L. 106-310, requires that "the Secretary [of DHHS] shall in fiscal year 1994 and each subsequent fiscal year, conduct not less than 10 State investigations of the expenditures of grants received by the States under section 1911 . . . in order to evaluate compliance with the agreements required under the program involved" (Subpart III, Section 1945 (g)). The CMHS conducts these investigations in partnership with the States under the term "monitoring visit" to:

- Monitor the expenditures of Federal Block Grant funds.
- Assess compliance with the funding agreements and assurances required under the program.
- Identify strengths (e.g., best practices, exemplary efforts) of the State and local mental health systems.
- Focus on opportunities for improvement, i.e., ascertain/recommend priority needs for technical assistance, identify issues that need to be addressed, as well as policy challenges related to the mental health program and service delivery at the State and local levels.

The Monitoring Visit Process

The CMHS conducts the monitoring visits with the assistance of a team of three consultants with fiscal, management, and/or clinical expertise in providing services to adults with SMI and children with SED. One member of the team is designated as the Team Leader/Writer. A Federal Project Officer makes the final selection of the members and accompanies the team. The onsite visit of the State mental health system is usually 3 days in duration. The monitoring visit includes an assessment of the State Mental Health Agency, along with interviews with Mental Health Planning Council members, consumers, and family members, and a visit to a local

program (urban, rural, or suburban) that serves adults with SMI and/or children with SED and receives some portion of Federal Block Grant funds.

In addition to monitoring the Block Grant expenditures and compliance with the funding agreements and assurances, the monitoring process involves the assessment and analysis of a range of planning, management, clinical, and fiscal issues as they relate to the implementation of the five criteria. Guidelines have been developed to assist each consultant in reviewing related materials and in conducting focused interviews to obtain necessary information to prepare the report.

Before the monitoring visit, the State Mental Health Director and the Block Grant liaison receive notification of the visit. The liaison is also contacted to:

- Discuss the purpose of the monitoring visit.
- Identify materials to be reviewed before and during the monitoring visit.
- Request the selection of a local program to be visited by the monitoring team.
- Assist in identifying key personnel to be interviewed by the consultants.
- Develop the monitoring schedule.

General Limitations

The fiscal observations contained in this report do not constitute audit findings. The fiscal information included in the report is based on the data provided by the agencies visited. Although the fiscal consultant attempts to verify key information during the visit, the fiscal interview is not conducted according to generally accepted auditing standards issued by the American Institute of Certified Public Accountants or Government Auditing Standards issued by the Comptroller General of the United States. Other limitations of the monitoring report are: (1) the limited time spent onsite, (2) the process of selecting staff interviewed and the program visited, (3) the process used to collect and review documents, (4) the sampling nature of the monitoring visit, and (5) the inherent limitations and biases of the team of consultants.

Exhibit 1: Monitoring Visit Data Sheet

Agency: Division of Mental Health and Substance Abuse Services

Director: John Easterday

Date of the Visit: May 19-21

Monitoring Team: Mike Hammond, Adult Monitor
Gloria Logsdon, Child Monitor and Team Leader
Larry Sobeck, Fiscal Monitor
Gloria Walker, Adult Monitor Trainee

Federal Project Officer: Eugene Hayes

Entrance Conference

Participants: Federal Project Officer and Monitoring Team
Peg Algar, DMHSAS
Joyce Allen, DMHSAS
Mike Bachhuber, Wisconsin Council on Mental Health
Tim Conner, DHS
Marie Danforth, DMHSAS
John Easterday, DMHSAS
Morgan Groves, DMHSAS
Mark Hale, DHS, Division of Quality Assurance
George Hulick, DMHSAS
Dan Naylor, consultant
Gary Nelson, DHS

Exit Conference

Participants: Federal Project Officer and Monitoring Team
Peg Algar, DMHSAS
Joyce Allen, DMHSAS
Mike Bachhuber, Wisconsin Council on Mental Health
Rebecca Cohen, DMHSAS
John Easterday, DMHSAS
Melanie Foxcroft, DMHSAS

CHAPTER II: STATE AGENCY SERVICE AND SYSTEM ASSESSMENT

State Mental Health Agency and Administration of Mental Health Services

The Division of Mental Health and Substance Abuse Services (DMHSAS) is part of the Department of Health Services (DHS) and is Wisconsin's State Mental Health Authority (SMHA). The Department is a cabinet-level agency, part of the Executive Branch, and the Secretary of DHS is appointed by the Governor. The DHS has five other divisions: Public Health (DPH), Health Care Access and Accountability (DHCAA), Quality Assurance (DQA), Long Term Care (DLTC), and Enterprise Services (DES). The DMHSAS administers client services in the community and at State institutions; develops regulations for care and treatment providers; and also supervises and consults with local, county, and tribal public and voluntary agencies.

The SMHA comprises the Bureau of Prevention, Treatment, and Recovery (BPTR) and the Mendota and Winnebago Mental Health Institutes, which provide inpatient care to both adults and children. The SMHA also includes the Wisconsin Resource Center, which serves prisoners who have mental illness, and Sand Ridge Secure Treatment Center, which provides evaluations and treatment as specified by State statute.

The BPTR includes Mental Health Services and Contracts (MHSC), Substance Abuse Services (SAS), and the Integrated Systems Development Section (ISDS). The MHSC is responsible for the Community Mental Health Services Block Grant (MHBG) and staffing for the Wisconsin Council on Mental Health (WCMH). Other responsibilities include some of the integrated mental health and substance abuse functions, mental health and substance abuse programming for the deaf and hard of hearing, Pre-Admission Screening and Resident Review (PASRR), and monitoring Community Support Programs (CSPs) for adults with severe and persistent mental illness (SPMI), as well as programs that target housing and staff coordination with the Department of Commerce on homeless issues. The MHSC is also responsible for all evaluation and contract processing activities for mental health and substance abuse services.

The SAS focuses on services and programs primarily for consumers of substance abuse services. Other substance abuse and prevention programs have been consolidated from across the bureau and are now the responsibility of SAS. The Substance Abuse Prevention and Treatment Block Grant (SAPTBG) is administered from the SAS section. The Substance Abuse Prevention and Treatment State Plan (SAPTBG application) is created and monitored by this section; SAS staff provide general oversight of the implementation of the plan. Staffing for the State Council on Alcohol and Other Drug Abuse (SCAODA) is provided from this section.

The ISDS's responsibilities include mental health and substance abuse programs and services at the system and client levels. The ISDS comprises the Children, Youth and Families Unit (CYFU) and the Systems Transformation Unit (STU). The CYFU's focus is the special needs of children and families with substance abuse and/or mental health disorders. One of the primary functions of the CYFU is to address the needs of children with serious emotional disturbance (SED) and their families and of other children who may not meet the criteria of SED but are

involved in two or more systems of care. An example of a program that serves children with SED and their families is the Integrated Services Program (ISP). It provides a wraparound approach through comprehensive systems case management for children and their families. The Coordinated Service Team (CST) Program for children and their families also provides a comprehensive systems approach to case management for children who are involved with more than one system of care but may not meet the definition of SED. All children's mental health and substance abuse programs and services are consolidated in this unit.

The STU is responsible for the implementation and monitoring of systems-level initiatives for adult mental health and substance abuse service systems. Most initiatives in this unit focus on systems development and training for local administrators and providers on substance abuse and mental health treatment. Unit staff focus on the implementation of evidence-based practices (EBPs) within the system of care across Wisconsin for adults with serious mental health disorders. Unit staff will implement and monitor the Mental Health/Substance Abuse Transformation Initiative with a focus on integrated mental health/substance abuse screening and treatment, managed care, quality improvement, and promotion of recovery-focused services and systems. Monitoring the implementation and development of recovery-based outcomes is conducted through contracts and support to the Recovery Implementation Task Force (RITF).

The ISDS Section Chief provides direct supervision to ISDS staff in both the CYFU and the STU who are responsible for implementing and monitoring initiatives for adult mental health and substance abuse services. Most initiatives focus on systems development and training of local administrators and service providers. The BPTR is also responsible for implementing child and adult EBPs, as well as implementing and monitoring the Mental Health/Substance Abuse Transformation Initiative. Monitoring the development and implementation of recovery-based outcomes is accomplished through contracts with county mental health programs and through support of the RITF. Other responsibilities include preparing counties for human service system disaster response and preparedness and monitoring Comprehensive Community Services (CCS) for adults and children.

State-level coordination between children's and adult services occurs within BPTR. Staff responsible for adult and children's services are housed in the bureau and report directly or indirectly to the Bureau Chief. Some bureau staff have the lead for developing and implementing (at the State level) services and programs that are used by both populations, and adult and children's staff interact on an ongoing basis to coordinate child and adult services and resolve issues as they arise. The staff also collaborate in bureau and Division workgroups and committees that are convened to address systemic as well as service- and program-specific issues in the development, implementation, and delivery of public mental health system services.

In Wisconsin, the public mental health system is administered through 67 county/regional program boards that cover all 72 counties and have statutory authority and responsibility for the delivery of mental health services as delineated in Chapter 51 of the Wisconsin State statutes. Many Medicaid programs for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED) are funded with the county providing the non-Federal share of program costs. Counties are required to establish a county department of community programs to administer a community mental health program and appropriate funds for program operations.

The county department of community programs authorizes inpatient care provided by State, county, or private providers, as well as services provided by other residential facilities through contract; if an individual is sent out of the county for inpatient treatment, the county is responsible for authorizing and paying for the treatment. According to Section 51.42 of Wisconsin's State statutes, county mental health departments are responsible for the following:

- Prevention services in collaboration with public health and other human service agencies
- Comprehensive diagnostic and evaluation services
- Inpatient and residential treatment
- Outpatient care and treatment
- Partial hospitalization
- Emergency care
- Supportive transitional services
- Staff in-service training, including periodic training on emergency detention procedures
- Continuous planning, development, and evaluation of programs for all population groups

The DES links DHS and local county human service agencies in a broad range of program areas. Staff are located in five DHS regional offices, work with personnel throughout DHS on an ongoing basis, and coordinate with other State departments. Area administrator duties include administration of the Annual State/County and Family Care Contracts; oversight and monitoring of local human service programs; consultation and technical assistance (TA) to counties; identification of local issues or concerns, and helping DHS management to resolve them; facilitation of communication and coordination between counties and DHS; and representation for DHS on statewide, regional, and local workgroups and committees.

Mental health, Medicaid-supported community services are available in all counties. These services form the base of community mental health services in Wisconsin. As county government is responsible for the delivery of mental health services to its citizens, the State has determined that counties are responsible for providing the non-Federal share for Medicaid mental health psychosocial services in the community. This requirement has been in place since the mid-1980s and was implemented when the State was giving the counties Community Aids Funds, which were an incentive to counties to provide the Medicaid non-Federal share. In the late 1990s, the growth of Community Aids Funds stopped, and counties had to use more of their own funds to pay the Medicaid non-Federal share as Medicaid services increased. As a result, increasing county tax dollars were needed to support the non-Federal share for Federal Medicaid funds. This stress on county funds has continued over the last decade and may impact the availability of community mental health Medicaid services in the future.

The State began focusing on recovery when the Governor appointed the Blue Ribbon Commission on Mental Health in May 1996. The Governor's charge was to examine the mental health delivery system and the principle of a State/county partnership; mental health services for children, adults, and older adults; and the impact of stigma on community perceptions and current mental health policies. The Commission adopted the concept of recovery, that is, the successful integration of mental disorder into a consumer's life, as the key tenet of the redesigned mental health system. One outcome was consumers as partners.

Transformation efforts include transforming the State's administrative rules. In addition, Wisconsin is focused on delivering consumer-centered services and on consumer and family involvement as guiding principles while new services are developed. The DMHSAS created the consumer-run statewide RITF to help plan strategic changes to transform service delivery across the State. With funding from the Medicaid Infrastructure Grant given to DHS by the Centers for Medicare and Medicaid Services (CMS), the Division has been able to give a contract to a local Independent Living Center to hire a mental health consumer. This consumer assists the Department in developing a system to ensure that Peer Specialists meet CMS standards for Medicaid billing in the major community programs in Wisconsin. Capacity and authority to hire Peer Specialists already exists for the Crisis Programs, CCS and CSP. What was lacking was a job description, competencies, and approved training to ensure quality Peer Specialists in Wisconsin programs. In 2007, a consumer/advocate committee of the RITF was created to develop the Peer Specialist program. To date, a job description and competencies have been developed and approved, a draft State examination for Peer Specialists is in progress, an examination is being developed, and a statewide database of trained and certified Peer Specialists will be created.

Long-term care reform is focusing on mental health treatment and on ensuring the availability of an array of recovery-oriented services.

Consumers and parents are actively involved at the State level. For example, they were represented on the Governor's Blue Ribbon Commission; sit on the RITF, serve on the WCMH (also known as the Planning Council); and participate on the Crisis Planning Committee. More than 20 consumers are being trained to train other consumers on trauma-informed care and person-centered planning.

In January this year, the Secretary of DHS announced steps to connect illness prevention and management with health promotion, as well as public education and awareness efforts to better address service delivery approaches to mental and physical health, substance use, and addictive disorders. The goal is to improve life expectancy and health outcomes for individuals with these conditions and strengthen statewide momentum for an integrated framework. Administrative rules are integrating efforts to address physical and mental health in Wisconsin's public health approach.

Assertive Community Treatment (ACT) was first developed and implemented in Wisconsin and was later implemented in other States. In addition to ACT, the State is also implementing other EBPs, such as Supported Employment, Supported Housing, Illness Management and Recovery, Integrated Dual Diagnosis Treatment, Peer Support Specialists (PSSs), and Family Psychosocial Education.

Consistent with the goal of making infrastructure changes in the areas of policy, financing, information technology (IT), and workforce development designed to facilitate/support transformation of the children's mental health system, Wisconsin has proposed or implemented a number of changes. Examples include the piloting of Mental Health Consultation Models for Early Childhood Providers, Families, and Programs; the development and implementation of trauma-informed care; a Child Welfare Screening Pilot; and improved quality of services for infants and young children. Another development underway is an initiative to increase access to

child and adolescent psychiatrists and other children's mental health professionals. The objective is to enhance the State's capacity to grow and retain its local workforce, especially in rural areas.

Prior to the current budget crisis, the Division contracted for the Wisconsin Public Mental Health and Substance Abuse Infrastructure Study to review its State-supervised, county-based system of funding and service delivery. This study will review current funding and delivery of public mental health and substance abuse services in Wisconsin, review alternative funding and delivery systems in other States, and recommend strategies for improvement to be considered during the 2011–2013 biennial budget and policy-making processes.

Benchmarks will measure the strengths and weaknesses of Wisconsin's and other States' systems in order to inform the review of service delivery models and financing options. The DHS has identified four benchmark categories; the study will include individual indicators as measures in these categories. The four broad benchmark categories are as follows:

- Equitable access to services across the State.
- Accountability for outcomes (including the availability of EBPs and IT to evaluate outcomes).
- Equitable and affordable funding for services.
- Efficiency of service delivery.

The State uses a wraparound approach for the delivery of mental health services to children and their families. The CSTs are being expanded annually with the intent of making them available to all counties and tribes. The DMHSAS has developed its first intertribal contract, which staff described as a participatory process in which 8 of the 11 Wisconsin tribes were actively engaged. The guiding principles of the CST program are consistent with those of the New Freedom Commission (NFC), including those of delivering consumer- and family-driven services, conducting individualized treatment planning with child and family involvement in the treatment process, and offering services that are culturally competent. Other CST service delivery strategies that reflect the values of the NFC include screening for co-occurring disorders, as well as focusing on partnering with the education, juvenile justice, child welfare, and primary healthcare systems. This approach to service delivery for children and their families uses some of the best available practices, and the State has committed itself to continuing to expand and promote the use of telehealth technology to enhance access to child psychiatrists in rural areas.

The SMHA uses its administrative rule and contracting processes to ensure that services are responsive to the cultural diversity and special needs of both adult and child consumers and family members. Wisconsin's assessment process and individualized, person-centered, consumer- and family-focused approach to service delivery also strengthen the delivery system's capacity to provide culturally appropriate services. The DMHSAS funds cultural competency training and TA for service providers, and interpreter services are available at community mental health agencies. In addition, several programs, including the CST, provide targeted grants for

the State's 11 tribes. A cultural competency plan was developed in 2000, and a new cultural competency action plan was under development at the time of the monitoring visit. Wisconsin does not, however, have minimum standards for staff cultural competency.

There is also a Minority Health Officer in the DHS's DPH. That Division has the lead for addressing disparities in healthcare access; this issue is one of 11 priorities of the State's public health plan. Although Wisconsin is and has engaged in other efforts as well to develop a more responsive service delivery system, staff and other mental health system stakeholders, including the WCMH, with whom the monitoring team met did not reflect the ethnic and racial diversity of the State.

State Agency Leadership Perspective

The monitoring team met with the DMHSAS Director and leadership. The Director stated that the major strategic steps that he saw as most important for realizing DMHSAS's vision for the delivery of mental health services for children and adults are managing the facilities and expanding and strengthening community-based services. Staffing issues at the facilities are problematic, and mandated budget cuts require staff and overtime reductions to stay within budget. His concern is how to provide these services with even less funding in light of anticipated additional State budget cuts. He indicated the Sexually Violent Persons Program (SVPP) is also problematic as it is currently at 350 beds, reducing the amount of resources available for individuals with mental illness accessing inpatient care. In addition, other major issues with community-based services that were identified include funding cuts, the State's \$7 billion deficit, the need to enhance service access, improve program quality throughout the State, sustain service improvements, integrate services (primary care, education, and others), and focus on prevention services. The Director also indicated that health IT is a significant issue because there is no core platform for providers and counties to communicate.

Mental Health Planning Council

The purpose of the WCMH as outlined in its bylaws is, "...to assist the State in the development and implementation of a comprehensive mental health system with a coordinated array of services and other assistance for adults and children with mental illness or who have other mental health problems." Its committees are Executive, Children and Youth (C and Y), Legislative and Policy, Criminal Justice, Adult Quality, and Nominating.

The WCMH's perspective on its involvement in systems change initiatives and processes that influence the future direction of the system is one of providing input to impact how all the various systems of services interrelate. Members also see their role as assuring that systems are recovery oriented and provide trauma-informed and client-determined care.

The Planning Council members view their task and relationship with the State agency as collaborative and cooperative, but recognize that, as advocates, there will be times when they are in disagreement with the State. Members also view their task as one in which they must be the voice for consumers and family members and, as such, express their concerns about State policies and actions. For example, the Planning Council's perception is that the State is shifting

financial responsibilities to the counties, and the Council believes this will result in a decrease in services.

The most critical mental-health-related issues facing the State, as identified by the WCMH, are the budget shortfall; access to appropriate, effective mental healthcare; and recent trends in three major funding sources (Medicaid, Community Aids Funds, and the county tax levy) as putting increased strain on local levies. Also identified were waiting list elimination, more consumer-run services, long-term-care system reform, parity, and unequal services.

The State ensures public comment during development of the MHBG Plan by inviting the comment in several ways. The MHBG Plan is posted on the WCMH Web page for the public to access and review a week before the public hearing. Mental health consumers, advocates, policy makers, and private citizens are encouraged to attend the public hearing and provide feedback on the Plan. Meetings and notices of MHBG activities are posted on the State's Web site. The Plan is also sent out as an e-mail attachment to county networks, CCS, providers, and WCMH members and their networks, as well as all members of advocacy, State and local family and consumer organizations, and other mental health system stakeholders and groups. Individuals were to be able to call in to the July WCMH meeting to comment; all public comments are taken seriously and incorporated into the Plan when appropriate.

Madison, where WCMH meetings are held, is located in the southern part of the State. The middle and northern parts of Wisconsin are mostly rural, and that is where most tribal communities are located. Some discussion is occurring about the use of video conferencing to include potential members in the remote, mostly rural areas.

The composition of the WCMH now meets MHBG guidance for membership requirements. At the meeting that the monitoring team observed, there was some discussion about dual representation, such as individuals initially appointed as family members of children who subsequently aged out of the children's system and adult consumers who have children currently served by the public mental health system. Membership is authorized at 21 to 25 members. There is a vacancy from the Medicaid agency. There are 15 full voting members plus ex officio members.

There is no separate budget for the WCMH, but the State provides resources for members to fulfill their duties. The Council holds planning meetings a few times a year for strategic planning. State staff provide support to the WCMH. Other State staff provide support to WCMH committees, and members' expenses associated with attending meetings are reimbursed by the State. The Planning Council meets every other month. The WCMH membership is not representative of the service area population, and it is a continuing challenge for the Council to meet the requirements with respect to the need for racial and ethnic diversity as well as the inclusion of youth consumers.

Review of the State Plan starts in May and lasts through July. A Council committee helps put the Plan together. The Adult Quality and C and Y Committees work with the Planner. A draft of the plan is in hand by the end of May. It is then circulated to WCMH members; Council committees go through it section by section and modifications are made. A new draft is received

by the WCMH in July. At the July meeting, members spend 2 to 4 hours reviewing the final draft.

Planning Council advocacy efforts have included a legislative briefing paper on funding of the public mental health system. The WCMH, moreover, has identified public sector mental health funding among its legislative priorities. Attempts to enhance funding through the budget process or through separate legislation, however, were not successful. As a result, the WCMH, in collaboration with the Wisconsin Counties Human Services Association, developed a briefing paper documenting the current status of public sector funding, the implications for various stakeholders, and suggested solutions. It was presented to DHS, the legislature, and the Governor. Council members attend a variety of meetings to raise public mental health service delivery issues on an ongoing basis. In addition, the WCMH Chair also testifies before the legislature and has provided written testimony on issues of concern to the membership.

During the WCMH meeting attended by the monitoring team, Council members indicated that their efforts to monitor, evaluate, and review the allocation and adequacy of mental health services in the State were not being systematically and consistently carried out. They see these tasks as being accomplished at the committee rather than the full Council level and believe that monitoring, evaluating, and reviewing the allocation and adequacy of Wisconsin mental health services are primarily accomplished as part of the Council’s review of the MHBG Plan implementation process. The Council confirmed that it receives State mental health service system data for review from the State on an annual basis. The WCMH also makes visits to facilities and community providers. Most of the review activity is conducted by the Council’s committees and is related to specific areas of concern.

A review of the minutes of past WCMH meetings confirms the major role that parents and family members of children play on the Planning Council. At the time of the monitoring visit the C and Y Committee was in the process of updating its Strategic Plan, and its list of priorities, issues, and areas of concern complemented those of the Division. At other meetings attended by the child monitor during the course of the monitoring visit, it was clear that members of the committee have formed productive and respectful partnerships with Division staff and leadership, advocacy groups, the statewide family organization, and representatives of other systems with which children’s mental health system stakeholders collaborate to ensure that children with SED and their families receive needed services and supports.

Exhibit 2: Planning Council Composition by Type of Member

Type of Membership	Number	Percentage of Total Membership
TOTAL MEMBERSHIP	23	
Consumers/Survivors/Ex-patients (C/S/X)	6	
Family Members of Children Diagnosed with SED	2	
Family Members of Adults Diagnosed with SMI	1	
Vacancies (C/S/X and family members)	2	
Others (not State employees or providers)	2	
TOTAL C/S/X, Family Members, and Others	13	57

Type of Membership	Number	Percentage of Total Membership
State Employees	6	
Providers	2	
Vacancies	2	
TOTAL State Employees and Providers	10	43
Number of Planning Council meetings during the past year	6	100

Guidance for Membership:

- 1) The ratio of parents of children with SED to other members of the Council must be sufficient to provide adequate representation of such children in the deliberations of the Council.
- 2) Other representatives may include individuals with interest in children with SED or adults with SMI.
- 3) State employees and providers shall constitute no more than 50 percent of the total membership.

Quality Improvement and Decision Support

Wisconsin uses both program monitoring and peer review quality management processes to oversee and improve services for its target populations. The State's quality standards are defined by administrative rule, and performance and outcome measures are linked to quality standards. The DMHSAS is responsible for developing standards which govern the care and treatment of adults and children served by the State's mental health system.

The DMHSAS is in the process of rewriting Wisconsin's outpatient mental health rule and has convened an Outpatient Mental Health Rule Stakeholder Group from across the State. It includes public and private providers, consumers, advocates, and other State agency staff. The DQA, Division of Health Care Access and Accountability (DHCAA), and the Department of Regulation and Licensing (DRL) are also involved in this process.

Peer reviews are used by DMHSAS to monitor MHBG-funded services as well as programs supported by other funding streams. Review teams include consumers and parents of children served by the public mental health system, as well as central and regional office Division staff and other providers of the peer-reviewed services and programs.

The DQA is responsible for enforcing standards and monitoring programs through certifying a wide array of care and treatment providers, including those offering inpatient and community mental health and substance abuse services. Onsite monitoring of mental health services and programs occurs every 2 years, and desk reviews are conducted in alternate years. Staff of DQA perform both the onsite and desk review monitoring processes with DMHSAS regional office staff. Consumers and family members are not involved in these onsite certification visits and desk reviews.

The DMHSAS collects mental health system data when Wisconsin counties submit data to the Human Service Reporting System (HSRS), a primary data source. The HSRS captures services provided as well as revenues and expenditures for community services. Additional reports

developed by BPTR address State inpatient services. The Division is currently in the process of developing a new data recovery system which will utilize electronic data input from the counties and interface with the State's Medicaid data system. The new system will provide data in a timely manner and enhance service system decision-making.

The DMHSAS is collecting National Outcome Measures (NOMs) data; however, the current data systems are not designed to address all of the performance data. The new data system under development will more effectively capture data required in NOMs. As it is implemented, increased oversight of NOMs information will be accomplished.

In discussions with staff responsible for the collection of Uniform Reporting System (URS)/NOMs data, staff indicated that it is difficult to collect data on EBPs. The new data system being developed may address some of the State's concerns.

Consumer and Family Member Involvement

Consumer and family involvement in areas of service delivery and system change has a rich history in the State. Consumers and families were members of the Governor's Blue Ribbon Commission on Mental Health. Currently, DMHSAS contracts with the major consumer and family organizations for the provision of education, support services, and advocacy. To ensure successful and meaningful involvement of consumers and families, support is provided so that barriers encountered, such as timing of meetings, childcare, transportation, and training, are addressed.

The DMHSAS currently supports the following consumer and family organizations:

- Wisconsin Family Ties (WFT)
- National Alliance on Mental Illness (NAMI) Wisconsin
- Wisconsin Coalition for Advocacy
- Wisconsin United for Mental Health
- The Grassroots Empowerment Project
- Recovery Implementation Task Force (RITF)
- Stable Life, Incorporated
- Ten Peer-Run Support/Recovery Sites
- Mental Health America (MHA) of Wisconsin

The State has developed a strong consumer database to ensure consumer participation at the State level from all Wisconsin regions. The monitoring team had an opportunity to meet with representatives of consumer and family advocacy groups; what was reported was a strong desire to be more involved in the policy-making process. Stakeholders wish to sit down with the State to develop a strategic plan. A few commented that it sometimes feels like an afterthought to have consumers and families at the table. In addition, their perception is that the consumer and family voice is sometimes marginalized. Consumers and families noted that that the RITF and the Trauma-Informed Care initiative are both inclusive of consumers and families. The stakeholders also noted that consumer and family involvement is extensive at the county level. One additional concern shared was that there is no youth involvement of which the stakeholders

with whom the monitoring team met are aware. Comments indicate that the perception is there is no specific outreach effort to include consumers and families who are members of cultural, ethnic, or linguistic minorities at the State level. It is noteworthy that there is language in State contracts with respect to the expectation for vendors to reach out to engage cultural, ethnic, and linguistic minorities, but the perception of consumer and family advocacy groups is that this practice is not modeled by the State. System stakeholders noted, however, that Wisconsin's population is not as diverse as that of some other States.

Some advocates also indicated that State resources allocated to consumer- and family-run organizations and initiatives, such as peer assistance, recovery support, and self-directed care, are insufficient. The State enhances meaningful contributions of consumer and family members regarding policies and services by enlisting NAMI Wisconsin and consumers' help in writing the Partnership Agreement. The State also provides scholarships to conferences and trainings for consumers and families to have the knowledge, skill development, access, resources, support, and time to contribute meaningfully to systems change. Examples of State efforts include the following:

- 2009 Mental Health Consumer Conference (June 29–30, 2009) “United We Stand ... Creating Our Future in Mental Health” – a conference by and for consumers of mental health services to create a new and inclusive statewide consumer network for all.
- Mental Health America's Centennial Conference (June 10–13, 2009) “Celebrating the Legacy, Forging the Future”.
- Thirteenth Annual Crisis Intervention Conference, “Making Connections to Create Solutions,” in September 2009.
- Fifth Annual Mental Health and Substance Abuse Services Training Conference, “Celebrating Strengths During Challenging Times,” in October 2009.

The WFT, which has been operating since 1987, is the statewide organization run by and for families of children with emotional, behavioral, and mental disorders. It is the State affiliate of the Federation of Families for Children's Mental Health and last year served 1,100 families. In addition to receiving \$250,000 in MHBG funds, it is also supported financially by individuals, corporations, Community Shares of Wisconsin, and other grants. Its staff of 15, some of whom are part time, include an Executive Director and Family Advocates. Services include advocacy at the individual child and family level as well as at the local system and statewide levels. Support groups, information and referral, and educational workshops are some of the other services provided, and WFT will be holding its 20th Annual Children Come First Conference in November 2009. To assist parents in gaining a broader perspective and provide opportunities for them to bring back valuable information to share with other families, WFT gives scholarships for parents to attend State and national conferences. It also publishes a statewide newsletter and has a certification process for Family Advocates. In addition, WFT will also sponsor its 14th annual Family Fun Day this summer at a water and theme park. Last year, 900 children attended this event. Children and Families staff at the Jefferson County Human Services Department (JCHSD), the site of the local program visit, were already organizing fundraising activities so

that participating Jefferson County children and families would be able to attend this year's Family Fun Day at no cost.

The organization also conducts the Family Satisfaction Survey for DMHSAS. In 2008, on a scale of 1 to 5, average satisfaction scores ranged from 4.2 to 4.5 for 10 of the survey items and averaged 3.6 and 3.9 on the other 2. The two highest-ranked items related to parents feeling that they were treated as important members of their child and family team and that the team schedules services and meetings at times that are convenient for families. Items that averaged the lowest related to whether families thought they were getting better at coping with life and its daily challenges and to whether the team already had a plan for services for children 14 and older for the time when they reach 18.

The State has undertaken other efforts to enhance the meaningful contributions of parents and family members of children regarding policies and services. These actions have been instrumental in ensuring that the parents of children served by the Wisconsin public mental health system have the knowledge, skill development, access, resources, support, and time to contribute meaningfully to system change.

One example is that the CST program provides opportunities for parents, family members, and consumers to serve on State and local policy and decision-making committees which develop policies and procedures and monitor progress. The parents, family members, and consumers also serve on individual child and family teams. Each CST site develops and supports a Coordinating Committee comprising parents/consumers and individuals representing agencies and organizations serving children and families. Responsibilities include developing policies and procedures such as interagency agreements, developing and implementing sustainability plans, and being involved in evaluation and quality assurance processes such as assessing family and provider satisfaction. The four phases of team involvement are as follows: completing the Strengths and Needs Assessment; developing the Plan of Care and Crisis Response Plan; ongoing monitoring of the plan of care; and planning for transition and closure while ensuring that the parent has a voice in decisions, access to resources, and ownership of the plan.

According to information provided by WFT, as of spring 2009, 163 parents/family members of children served on policy advisory boards in Wisconsin. Some of the statewide boards on which parents are involved are the Children Come First Advisory Committee, the DHS Positive Behavioral Intervention and Support Advisory Committee, the Trauma Informed Care Council, WCMH, the Children's Long Term Support Council, the statewide RITF, the Mental Health Transition Advisory Council (MHTAC), the statewide Seclusion and Restraint Workgroup, and the Department of Public Instruction's (DPI) Positive Behavioral Intervention and Support Advisory Committee. There are also 100 family members on county-level Wisconsin Collaborative Systems of Care Coordinating Committees. Other county-/local-level policy advisory boards with parents/family members include the Family Support Advisory Board, the county DHS board, the CCS Coordinating Committee, the Suicide Prevention Task Force, and the Children's Mental Health Advisory Board.

Consumer and Family Rights

Consumers and families receive information regarding their rights orally and in writing. If needed, interpreters are available in several languages including, but not limited to, Spanish, Cambodian, Hmong, American Sign Language, Vietnamese, and Braille. During site visits, client rights posters and information were available and visible.

Wisconsin State statutes define patient rights and grievance procedures and apply to anyone who is receiving services for mental illness, developmental disability, or substance abuse in Wisconsin. Grievances are tracked, reported, and incorporated into the quality management process. There are no different rights protections for different populations, except for inpatient and community-served consumers.

When a complaint occurs, a program-level review is conducted first. This occurs within the program or facility. A Client Rights Specialist is assigned within 3 business days. A complete report is issued within 30 days if the complaint is a non-emergency and within 5 days if it is an emergency. Informal resolution can occur at any time. If either the client or program manager disagrees with the decision by the Client Rights Specialist, the program manager issues his/her decision within 10 days if it is a non-emergency and within 5 days if it is an emergency. The client may appeal to the next level within 14 days. For county programs, the next level is the county-level review. There the director of the county department reviews the prior report and decision and conducts any additional investigation. The director issues a decision within 30 days if it is a non-emergency and within 10 days if it is an emergency. Any party may appeal to the State level within 14 days. If it is an independently operated program, the next level of appeal is the State-level review. The State Grievance Examiner in DMHSAS reviews prior reports and decisions and conducts any additional investigation. The Administrator of DMHSAS conducts the desk review of the State level review and all earlier documentation.

The Wisconsin Coalition for Advocacy has also published a brochure titled “Wisconsin’s Patient Rights Grievance Procedure.” This explains client rights and the various levels of grievance reviews. The DHS area administration also issues a monthly report identifying summary complaint reports by region.

ADULT MENTAL HEALTH SERVICES

Service Array for Adults

In discussing gaps in services with State staff, it was reported that barriers to services in rural areas are greater due to a lack of psychiatrists, transportation, and resources. Access problems also exist for special populations, such as individuals who are homeless with a mental health disorder, primarily because they are viewed as populations that are difficult to serve. Access to dental services continues to be a problem for Medicaid recipients in the State. Many dental providers choose not to serve Medicaid and other indigent patients, many of whom have mental health issues. There is a lack of mental health parity in the State. Parity legislation for mental health and substance abuse has yet to be enacted by the Wisconsin Legislature. Not every

county has a certified crisis program, but grant funds are in place to further develop this service. Most counties have Section 8 housing, but State staff reported that there are waiting lists in most communities. Tenant-based rental assistance helps in most populous areas, however.

The major service gaps identified by consumers and families are as follows:

- Insufficient early intervention/prevention efforts
- Lack of Spanish-speaking providers in rural areas
- Need for additional jail diversion programs, drug courts, and mental health courts
- Availability of affordable, suitable housing for consumers and families
- Expanded employment opportunities
- Problems of workforce retention
- Waiting lists for services

Accessibility, Coordination, and Continuity

Wisconsin provides CCS for persons with mental health and substance use disorders. The CCS offers a flexible array of individualized, community-based psychosocial rehabilitation services authorized by a mental health professional for consumers with mental health or substance use issues across the lifespan.

The CSP is a coordinated care and treatment program that also provides a range of treatment, rehabilitation, and support services through an identified treatment program. Program staff ensure ongoing therapeutic involvement, individualized treatment, rehabilitation, and support services.

The State does not have standards and/or performance indicators for access based on geography and urgency. In the contract for BadgerCare Plus and/or Medicaid Supplemental Security Income (SSI) Health Maintenance Organization (HMO) services between the HMO and DHS, the HMO must provide to enrollees medical care that is as accessible to them in terms of timeliness, amount, duration, and scope as those services are to non-enrolled BadgerCare Plus and/or Medicaid SSI members within the area served by the HMO. The HMO must also have a mental health or substance abuse provider within a 35-mile distance from any enrollee residing in the HMO service area or no farther than the distance for non-enrolled members residing in the service area.

The DMHSAS continues its efforts to collaborate with the Department of Veterans Affairs (VA) on increasing access to mental health services for veterans. The availability of mental health services for veterans is becoming a higher-profile issue with an increasing number of soldiers returning home from Iraq and Afghanistan. In Madison, the Veteran's Recovery Coordinator is active in the RITF, as well as on the WCMH Adult Quality Committee. Also, a PSS provides support at the VA's CSP, and another PSS from the VA is actively involved on the RITF. These emerging partnerships with the Madison VA have enhanced the statewide recovery network. Moreover, the VA is using video equipment for telehealth to reach and serve veterans across the State.

Wisconsin has established a goal of developing a statewide system of Aging and Disability Resource Centers (ADRCs) offering the general public a single entry point for information and assistance on issues affecting older adults and individuals with disabilities (including mental illness) and their families. There are 18 ADRCs currently operating, including two regional ADRCs for rural areas (serving three counties each). The ADRCs are required by contract to provide three services to persons with mental illness: information and assistance, emergency response, and services of a disability benefit specialist. The DMHSAS is providing TA to ADRCs on outreach planning for mental health populations, including persons who are homeless, and on linkages to agencies providing services and supports to those with mental health issues.

Adults with SMI leaving forensic hospitals are referred to the Pre-Release Program established to improve their chances for making a successful transition to the community. The program provides information and skills to aid the consumer in seeking and maintaining employment, managing finances, using community agencies, developing an appropriate and productive relationship with the parole agent, developing positive family relationships, maintaining a healthy lifestyle, and using leisure time productively. The program is intended to complement those programs operating on the various living units as well as the individual work done with the consumer by his social worker. The groups which compose the program are designed to provide general information and skills development which can be used to facilitate the transition back to the community and adequate community adjustment.

The BPTR has established the goal of providing all mental health services in a culturally competent manner by 2010. The bureau maintains a variety of interagency agreements with other State agencies and county governments. These agreements include, but are not limited to, the following formal linkages:

- Department of Corrections: County mental health staff work with inmates scheduled for release in order to establish Medicaid benefits for those who are eligible.
- Criminal Justice: County mental health agencies provide services to consumers in jail. Individuals granted conditional release after being judged not guilty by reason of insanity must return to their home county and receive outpatient mental health care.
- Vocational Rehabilitation: As part of the CSP, counties have agreements for the provision of employment and training services.
- Preadmission Screening and Resident Review (PASRR): This is an interdivisional agreement between DMHSAS and DHCAA, establishing the parameters and responsibilities for PASRR activities.
- Wisconsin Department of Commerce: The agreement provides services for implementation of the Project for Assistance in Transition from Homelessness (PATH), and Shelter Plus Care programs.
- Government-to-government relationship between the State and Wisconsin Native-American tribal governments: The goal is to improve the planning and delivery of health

and human services to tribal members who are entitled to services provided at the county level and through the tribal nation.

The State is also providing geriatric psychiatric expertise to local long-term care programs that request it, with coordination provided by DMHSAS staff. An important component of the planning process is the development of the Wisconsin Geropsychiatry Initiative (WGPI). The WGPI provides indirect care to older persons via case-specific consultation by geropsychiatrists to long-term care, geriatric, and public agencies. In addition to this initiative, State staff continue to work with county agencies implementing CCS programs to ensure that this lifespan program serves older adults.

Integration efforts are developing between mental health, substance abuse, and primary care providers and systems. The DMHSAS has supported activities, along with educational events initiated through its prevention and early intervention contract agency, MHA Wisconsin. Learning events have included information and data dissemination through symposia for primary care physicians and for mental health and substance abuse professionals on integrating mental and physical health.

Homeless Services

The PATH is administered through the Wisconsin Department of Commerce and serves approximately 2,800 individuals with SMI, including those with co-occurring substance abuse disorders who are homeless. Services include the following:

- Outreach
- Screening and diagnosis
- Community mental health
- Case management
- Alcohol and drug treatment
- Habilitation and rehabilitation
- Supportive and supervisory services in residential settings
- Referral to other services such as healthcare

PATH funds are also used to provide training on the Social Security application process. The majority of individuals who have SMI and are homeless is likely to be eligible for Supplemental Social Security benefits and Medical Assistance; however, the complex process of assembling the materials needed for a disability determination and the tendency of these individuals not to stay long in one place often impedes submitting the application.

The U.S. Department of Housing and Urban Development (HUD) Continuum of Care grants are shared by a variety of homeless provider agencies throughout Wisconsin. These grants fund transitional and permanent supportive housing for individuals and families who are homeless, to assist them in moving beyond the cycle of homelessness. In addition to providing permanent and transitional housing, the grants support important services, including job training, healthcare, mental health counseling, substance abuse treatment, and childcare.

A Shelter Plus Care grant provides up to 50 percent of the operating budget of a homeless shelter or homeless voucher program and funds government agencies as well as private for-profit and nonprofit agencies. The grants provide a consistent funding source on an annual basis to many of the smaller emergency programs. Support services include the following:

- Working with landlords or neighbors
- Supplying furniture
- Providing transportation to work or treatment
- Assuring that rents are paid and property is maintained
- Providing food when needed
- Making needed interventions during periods of illness
- Offering outreach and education to community leaders

CHILDREN'S MENTAL HEALTH SERVICES

Service Array for Children

Wisconsin has developed collaborative systems of care, including CST, Wraparound, the Integrated Service Project (ISP), CCS, Children Come First, and Wraparound Milwaukee. All of these services target children and families with serious multiple service needs, and services are delivered in the least restrictive environment. The series of processes used to meet the child and family's needs are individualized and based on family and community values that are unconditional in their commitment to address needs innovatively and incorporate the strengths of the child, family, and other team members. Parents and family members are viewed as equal partners, and all team members have ownership of the plan for service.

Wisconsin began developing collaborative systems of care in 1989 with the implementation of the ISP program. The ISP's focus was on supporting families of children with SED in their homes and communities, and these projects receive \$80,000 each year in MHBG funding. In 2002, the ISP collaborative process was expanded with the development of the CST program, which uses the same wraparound process but serves a broader group of children who do not have to have a diagnosis of SED but who do have complex needs and are involved in at least two systems. These systems may be substance abuse, child welfare, juvenile justice, special education, and/or mental health. Annual funding for CST sites ranges from \$33,000 to \$63,000. In 2007, 43 counties and 2 tribes received Mental Health and Substance Abuse Block Grants, as well as Hospital Diversion and Department of Children and Families (DCF), the State child welfare agency, funds to provide CST.

Although the State has a wide range of initiatives to enhance service coordination, there are still children in the child welfare, juvenile justice, and education systems whose mental health service needs are not being met. Thus the State's perspective is that there are too many foster care placements and that the timing of interventions and placement back into the home are not always consistent with the child and family's needs.

The DMHSAS's perspective was confirmed when a Federal review of Wisconsin's child welfare system highlighted insufficient efforts to address the mental health needs of children, including

systemic inconsistency in providing mental health assessments and an inadequate number of mental health providers to meet the needs of children in the child welfare system. In 2006, Wisconsin submitted a Child Welfare Program Enhancement Plan to improve child safety, permanency, and well being. The plan requires the child welfare system to work with child mental health experts as well as county and tribal child welfare agencies in developing a statewide policy to screen and assess the mental health needs of children who have been abused or neglected. Consequently, child welfare staff will be trained on identifying mental health issues.

As a result of these actions, in March 2007 tribal and county child welfare agencies received an administrative memo outlining the application process for requesting funds to participate in a mental health and substance abuse screening pilot project for children and families involved in the child welfare system. The Division reviewed and evaluated the proposals and used MHBG funds to support the development and implementation of 10 pilot projects which received continued funding in 2009. A Child Welfare Screening Team, with representatives from DMHSAS, DCF, and Medicaid, leads this effort to develop and implement a pilot program providing mental health and substance abuse screening for children entering the child welfare systems of funded counties and tribes.

Parents, other children's mental health system stakeholders and the Division have a shared perspective that there are also service access issues for children and their families, especially in rural areas. Access to treatment provided by child and adolescent psychiatrists, as well as other mental health professions such as psychologists with specialized child training, have also been identified as major unmet needs by parents, family members, other child- and family-serving systems, advocacy groups, and DMHSAS.

Efforts to address issues of mental health service system access in rural areas have included the writing of CCS into the State's administrative rules effective November 1, 2004. Since that time, more than 20 counties have been certified for CCS and may bill Medicaid for these services. In addition, Wisconsin has established three new telehealth services which will assist rural counties in particular in attracting child and adolescent psychiatrists, with the counties paying only for the time that the psychiatrist is actually working with clients.

The DMHSAS's perspective is that, during Federal fiscal year (FFY) 2008, it made significant progress in continuing the development of comprehensive, community-based services for children, such as the ongoing implementation and expansion of the Medicaid-reimbursable CCS benefit, which serves adults and children across the lifespan.

Accessibility, Coordination, and Continuity

The State's 67 county/regional programs are the single point of entry for children seeking mental health services. Chapter 51 of the Wisconsin State statutes is clear in favoring the provision of a range of services that enable children to receive treatment in the least restrictive environment consistent with their needs.

Wisconsin uses MHBG funds to develop and implement the CST program in collaboration with the child welfare, substance abuse, juvenile justice, and education systems. Funding is currently a blend of Mental Health and Substance Abuse Block Grants, State general purpose revenue, and child welfare dollars. The goal is to change the way that supports and services are delivered to families in need of substance abuse, mental health, and/or child welfare services. This initiative has succeeded in reducing out-of-home placements, treating the family as a unit, developing productive cross-system partnerships, supporting family participation in the decision-making process, serving children in less restrictive settings, and reducing the cost of services. Also of note, of the 922 children served between 2003 and 2006, 68 percent had no involvement with the juvenile justice system while involved in the ISP/CST programs.

Division staff are engaged in DHS cross-divisional and cross-department efforts that result in a system of integrated social services for children with SED. These efforts include the DHS Infant Mental Health Leadership Team, charged with carrying out the Governor's KidsFirst initiative to integrate infant and early childhood mental health principles and practices across DHS Divisions and other Departments and community organizations.

Other efforts include Wisconsin's Integration of Physical Health, Mental Health, Substance Use, and Addiction Initiative. Current efforts involve working with emergency room and crisis response personnel. The DMHSAS has also supported educational events through a prevention and early intervention contract with MHA of Wisconsin. Learning events have included information and data dissemination through symposia for primary care physicians and mental health/substance abuse professionals regarding the integration of mental and physical healthcare. Other partners in this Department-wide undertaking include the Maternal and Child Public Health Program Advisory Committee and DPH.

Staff of DMHSAS have the lead on the Seclusion and Restraint Workgroup, which is focused on reducing the use of restraint and seclusion in community-based programs regulated by DHS and DCF. The DHS has convened workgroups to reduce the use of seclusion and restraint and conducted trainings for approximately 22 providers and 460 participants. In December 2008, Disability Rights Wisconsin (DRW) issued a report titled "A Tragic Result of a Failure to Act: The Death of Angelika Arndt." It focused on the death of a child who had been restrained in a day treatment facility, recognized DHS/DCF efforts to respond to the tragedy, and challenged the two Departments to do more and move faster. On March 3, 2009, the DHS Secretary responded to the DRW report and agreed to act on most of its 16 recommendations.

Ten days later, the Secretaries of DHS and DCF collaborated in issuing a memorandum called "The Prohibited Practices in the Application of Emergency Safety Interventions with Children and Adolescents in Community Based Programs and Facilities." It delineated practices that should not be used at any time during emergency safety interventions due to the high risk of causing serious injury and possibly death. The DHS will provide additional guidance to day treatment centers, develop a review process for day treatment centers regarding situations where the use of restrictive measures might be appropriate, and continue relevant training and TA.

The day treatment center review process will be based on DHS's DLTC guidelines and policies regarding the use of restrictive measures which apply to children whose presence in the centers is

funded by the Children's Long-Term Support Medicaid Waivers and who live in the community. In addition to children with SED, other children with special healthcare needs covered by the Wisconsin waiver are children with physical disabilities and those with developmental disabilities (DD). These guidelines and policies already cover adults with DD served by county waiver agencies or managed care organizations (MCOs). Consistent with its goal of reducing seclusion, restraint, isolation, and other coercive measures, DLTC allocated MHBG funds to DPI to train school personnel on promoting positive behavior supports in the State's schools.

Other formal linkages between the SMHA and related agencies, organizations, and intermediary entities that result in a system of integrated social services for children with SED include the following memorandums of agreement (MOAs):

- The Wisconsin Coordinated School Health Program MOA covers the Centers for Disease Control and Prevention's cooperative agreement, "School Health Programs to Prevent Important Health Problems and Improve Educational Outcomes" with the State of Wisconsin. Issues addressed collaboratively by DPI and DHS include mental health and alcohol and other drug abuse (AODA).
- The Youth Suicide Prevention through Middle School Based Programming Toolkit Production and Web Casts is delineated in an MOA between DPI's Division for Learning Support, Equity, and Advocacy (DLSEA) and DHS's DMHSAS.

Wisconsin also has two Medicaid managed care programs which serve children with SED at risk of out-of-home placement. Both programs are partially funded through the State's Medicaid program and monitored by DHCAA. Dane County's Children Come First targets youth diverted from psychiatric hospitals, childcare institutions, and the juvenile justice system. Services are provided in two broad groups: one group works with youth who have been in treatment institutions and transitions them back to the community, and the other works primarily to divert youth at immediate risk of institutionalization.

Wraparound Milwaukee was initially funded in 1995 through a 5-year, \$15 million grant from the Center for Mental Health Services (CMHS) for children with SED identified by the child welfare and juvenile justice systems as being at immediate risk of residential, juvenile justice, or psychiatric center placement. The program's average enrollment is 615 and, in 2007, the program served 1,220 children and adolescents and their families. Currently, three Milwaukee County agencies (Bureau of Milwaukee Child Welfare, Delinquency and Court Services, and Behavioral Health Division) partner with the Wisconsin Medicaid program to finance Wraparound Milwaukee. Funds are pooled to provide a comprehensive and flexible approach to service delivery that meets the needs of families served. Wraparound Milwaukee is part of the Milwaukee County's Behavioral Health Division and oversees the management and disbursement of funds consistent with its public care management entity responsibilities. Wraparound Milwaukee contracts with 9 community agencies that manage approximately 72 care coordinators to facilitate the delivery of services and other supports to families using a strength-based, individualized, wraparound approach. The program has a network of 204 agency and individual providers that offer more than 80 services to families. In addition, Wraparound

Milwaukee operates a Mobile Urgent Treatment Team to ensure that families have access to crisis intervention services as needed.

An example of the process used by the State to ensure that services are provided to individuals with DD is a joint memorandum issued by the directors of mental health and developmental disabilities services in 2003. This memorandum clarified the local policies and procedures that should be in place in local mental health and developmental disabilities service delivery systems to ensure access for individuals with developmental and other disabilities who are in crisis. It states that “if a person is exhibiting behaviors that require crisis services, that person is eligible for such services.”

The State’s 2003–05 budget included the authority to expand the scope of psychosocial rehabilitation services under the Medical Assistance (MA) program. In 2006, DMHSAS began allocating startup funds to assist counties in providing CCS in underserved areas of the State. The CCS delivers flexible, consumer-centered, recovery-oriented psychosocial services for children and adults needing more than outpatient therapy. The CCS also enhances opportunities for collaboration among child- and family-serving systems and provides an additional source for funding integrated mental health and substance abuse services. The CCS covers individuals who are receiving services across the lifespan and who must be certified in order to be funded by Medicaid; counties provide the non-Federal cost share.

These programs may coordinate with other funding sources and agencies to enhance service delivery to individuals receiving CCS. The 25 counties providing the program must have a CCS Coordinating Committee with one-third of its membership comprising consumers. In Jefferson County, the site of the local program visit, the CCS individualized service team that works with the youth and family when the youth is receiving children’s mental health system services continues to work with the client and family as they begin receiving adult mental health system services. This facilitates a smooth transition into the adult system for the youth and family being served.

The Department of Workforce Development’s (DWD) Division of Vocational Rehabilitation (DVR), DPI-DLSEA, and DHS-DLTC and -DMHSAS have entered into the DPI/DHS and DVR Interagency Agreement to fulfill interagency agreement mandates in the Individuals with Disabilities Education Act (IDEA) and Rehabilitation Act to coordinate services for persons transitioning from education to employment. The DPI/DHS and DVR Interagency Agreement also provides guidance to school district special and regular education staff and DVR counselors, as well as counties, MCOs, and ADRCs regarding students with disabilities transitioning to the adult long-term care and mental health/substance abuse systems. Moreover, this agreement includes transition services information for students and parents to enhance their participation in transition planning. It clarifies, as well, the roles and responsibilities of staff of school districts, DVR, and entities contracting with DHS (counties and CMOs) regarding students with disabilities, including mental health and substance abuse issues, who have identified long-term needs in the areas of employment and independent living.

The DMHSAS’s Wisconsin MHTAC has developed and distributed “Do-It-Yourself Case Management and Advocacy” and “Transition Resources for Adolescents with Mental and/or

Emotional Disorders and Their Families”. The latter guide is intended to assist adolescents with emotional or behavioral difficulties with their transition to adulthood and includes a list of the following:

- Statewide agencies and organizations that provide information and referral regarding mental health transition resources and/or direct services.
- Contact information by city/region for Disability Navigators, who help individuals access programs and services leading to employment and provide resources and training to school staff.
- Contact information for Disability Navigators serving Native Americans not living on reservations, Native Americans living on reservations, and Southeast Asians.
- Other information regarding TA and family assistance centers, WFT and other advocacy groups, private consultants/advocates, helpful Web sites, suggested reading, and DPI’s Statewide Transition Initiative, as well as contact information by county for Benefit Counseling Providers.

Out-of-State Placement

The SMHA does not make out-of-State placements for children with SED. The vast majority of children served by children’s mental health as well as other child-serving systems are served within the State through certified community-based crisis services and other programs and services described elsewhere in this report. In rare cases where children are served out of the State, it is often because they live in areas of Wisconsin that border other States such as Minnesota and, in those cases, are able to be served closer to home than they would be if placed in a Wisconsin program. State policies and statutes making county mental health programs financially responsible for residential/institutional care support the care of children in their family home and home community and reduce financial incentives for out-of-home and out-of-State placements. The wraparound approach to service delivery also assists and encourages providers in partnering with other systems to develop and implement service plans and approaches that can be provided in the least restrictive environments.

Homeless Services

At some point during the last school year, there were at least 8,957 homeless students in Wisconsin, and DPI reports a high volume of calls from school districts regarding information and advice on the issue during this school year. Each of the State’s public school districts is required to designate a homeless liaison to identify, immediately enroll, and help children who are homeless and unaccompanied youth in homeless situations continue their education. Grants and TA are also provided by DPI to support programs for homeless students throughout Wisconsin.

FINANCIAL MANAGEMENT

Fiscal Context of Community Mental Health Services

Wisconsin's population in 2008 was estimated to be 5,627,967. Its population under 18 years old was 23.6 percent, 63.3 percent for persons between the ages of 18 and 64, and 13.1 percent for those over 65. In fiscal year (FY) 2007, the SMHA expended \$585,806,971 million for mental health services. The DMHSAS is responsible for community mental health services and State inpatient treatment facilities. The DHS is responsible for health and human services. The Department's biennial appropriation for 2007–2009 was \$13,634,133,000 in State and Federal funds to provide needed human services to the citizens of Wisconsin.

The State's community mental health and inpatient hospital system is directed by DMHSAS. The Division is responsible for setting forth the biennial budget, procuring mental health services, and accounting for the use of State and Federal appropriations. Within the Division, staff are responsible for community service contract development, implementation of contracts, and the monitoring of contracted community services' effectiveness. Within DHS's DES and the DHS Office of Policy Initiatives and Budget (OPIB), staff are also responsible for assuring that contracts are processed, entered in the Department's Financial Management System (FMS) and the Wisconsin State Management and Reporting Tool (WSMRT). State law sets forth the biennial budget process and accounting system and procurement procedures for the purchase of community mental health services for children and adults.

The Wisconsin community mental health system is built on the concept that counties are responsible for the mental health treatment of the citizens who live within their designated geographic area. Within the State, the 72 counties and 11 Native-American tribes play a primary role in the delivery of community and inpatient mental health services. These entities are mandated by State statute (51.03) to be responsible for the treatment and care of persons with mental illness who reside in the county. Counties must also ensure that persons in need of immediate emergency services receive those services. Under standards established by rule, each county establishes its own services and budget. The county budget includes county tax funds, State funds, Federal funds, Medicaid funds, client fees, and third-party payments. Community mental health Medicaid services which require matching funds are provided from county tax funds. When a county citizen requires inpatient, State-operated hospitalization, the county is responsible for payment to the State.

The DMHSAS, in State fiscal year (SFY) 2007 (the last fiscal year for which all appropriations and expenditures are fully accounted) reported State and county mental health system expenditures of \$585,806,971, which included community outpatient services and inpatient hospitalization. In addition to responsibility for the community mental health system, DMHSAS operates two State inpatient psychiatric hospitals; a prison treatment center, and a treatment center for persons who are sexually violent.

The financial management of State and Federal appropriations directed to support both community and inpatient mental health services is tracked through electronic data systems which address contracting, the Community Aids Reporting System (CARS); appropriation

management, and the FMS. Also, all appropriations and expenditures of State government are tracked through the Wisconsin State Management and Reporting Tool (WSMRT).

A significant service system transformation activity in which DHS and DMHSAS have entered is the Wisconsin Public Mental Health and Substance Abuse Infrastructure Study. This study will entail an in-depth review of the current State-supervised, county-based system of financing and provision of publicly funded mental health and substance abuse services. The goals are to measure the strengths and weaknesses of the Wisconsin system as well as to assure equitable access to services across the State, accountability for outcomes/EBPs, IT, equitable and affordable funding of services, and efficiency of service delivery. The study findings are intended to assist the State in making service system changes and funding decisions during the 2011–2013 biennial budget process.

Budgetary Planning

Wisconsin laws require that a biennial budget be developed by the Governor and presented to the legislature, setting forth funds for the operation of State services in the next 2 upcoming fiscal years. The budget is to be balanced in regard to revenue and proposed expenditures. The process requires the approval of the State House and Senate prior to the signature of the Governor. The biennial budget begins in the even-numbered fiscal year and extends through the end of the odd-numbered year.

The State's biennial budget development cycle begins more than a year and a half before the beginning of the final year of the biennial budget. Every even-numbered year between June and September, approximately 9 months in advance of the biennial budget being presented to the legislature by the Governor, the State's Department of Administration (DOA) issues instructions for preparing the continuation budget submission and procedures to propose service expansion initiatives for the next biennium. The instructions set forth the timeframes in which budget development information must be submitted. In DHS, the OPIB works with the Secretary's Office and the program divisions to develop initiatives and identify statutory language changes needed and prepares the Department's budget submission. After the DHS budget has been submitted, the OPIB responds to questions and concerns of the DOA that result in the finalization of the Governor's budget in early January of the odd-numbered year.

The Governor's budget is issued at the end of January; by statute, the Governor must deliver the biennial budget message to the legislature the last Tuesday in January. Once the Governor's budget is issued, DOA briefs agency managers and provides OPIB with budget detail. Over the next 4 months, DOA, the legislature's Fiscal Bureau (LFB), and State Departments conduct budget deliberations that result in budget completion by the legislature. Once the budget bill is passed, it is submitted to the Governor for signature. The Governor is permitted to veto specific items of the budget passed by the legislature or sign and implement the biennial budget.

At the time of the monitoring visit, the House and Senate were debating the budget for the next biennial budget that begins in July this year. The economic forecast for Wisconsin indicated a deficit in State funds of more than \$7 billion for the next 2 years. The State was considering budget reductions and possible tax increases to address the projected deficit. It is possible that

both State and county funds for mental health services might be reduced, resulting in decreased access to needed services.

Revenues and Expenditures for Mental Health

The economic downturn in the United States in the last year has negatively impacted almost every SMHA budget. Wisconsin has also experienced an economic decline, which has resulted in State funding reductions in the current year and possible additional reductions in the new biennial budget beginning in July 2009. In the current year, State funding for 21 counties was reduced, affecting the CSP Wait List.

The DMHSAS and the DHS Division responsible for Medicaid services (State Medicaid agency) have taken steps to maximize the expansion of community mental health Medicaid services throughout the State. With Medicaid match funds contributed by the counties (40 percent), additional Federal Medicaid revenue (60 percent) for the community mental health system has become an increasing source of funding for the community system.

State, Federal, and county funds utilized by DMHSAS to address mandated responsibilities for the adult and children’s mental health service systems have varied between SFY 2005 and SFY 2007 (the last fiscal year for which all appropriations and expenditures are fully accounted). Table 1 describes revenue under DMHSAS control for inpatient and community mental health systems in SFY 2005, SFY 2006, and SFY 2007. The major revenue sources were State revenue (57 percent) and county revenue (22 percent) in SFY 2007. The majority of Federal revenue was Medicaid funds that supported community mental health and children’s inpatient services.

Table 1: Division of Mental Health and Substance Abuse Services Revenue SFY 2005, SFY 2006, and SFY 2007

DMHSAS Revenue Sources	SFY 2005	%	SFY 2006	%	SFY 2007	%
State Revenues	\$358,107,866	62	\$366,795,287	61	\$334,788,811	57
Federal Revenues	95,885,748	17	101,714,056	17	113,050,561	19
Local County Revenues	113,634,682	20	121,337,002	20	126,567,599	22
Other Third Party Revenues	12,100,000	2	10,600,000	2	11,400,000	2
Total	\$579,728,296	100	\$600,446,345	100	\$585,806,971	100

Data Source: DMHSAS reports HSRS 942, Human Services Revenue Report (HSRR), Medicaid (MA), and Sexually Violent Persons Program (SVPP) used to develop annual State Mental Health Agency Controlled Revenues Report for National Association of State Mental Health Program Directors (NASMHPD) (SFY 2005, SFY 2006, and SFY 2007).

State, Federal, and county expenditures for the State mental health system, by major activity, are described in Table 2. Approximately 68 percent of all expenditures occurred for community-based services. The majority of these expenditures was paid with county tax funds from the 72 counties.

Table 2: Division of Mental Health and Substance Abuse Services Expenditures SFY 2005, SFY 2006, and SFY 2007

DMHSAS Expenditures	SFY 2005	%	SFY 2006	%	SFY 2007	%
State Psychiatric Hospitals	\$160,900,000	27.8	\$166,300,000	27.7	\$183,700,000	31.4
Community-Based Programs	417,643,413	72.0	433,282,846	72.2	401,134,371	68.5
State Administration	1,184,883	0.2	863,500	0.1	972,600	0.2
Total	\$579,728,296	100.0	\$600,446,346	100.0	\$585,806,971	100.0

Data Source: DMHSAS reports HSRS 942, HSRR, MA, and SVP used to develop annual State Mental Health Agency Controlled Expenditures Report for NASMHPD (SFY 2005, SFY 2006, and SFY 2007).

Contracts and Grants Management

The DMHSAS contracts with 72 counties, Native-American tribes, and specialty providers, which are government agencies and not-for-profit entities. Federal MHBG funds are included in the contracting process and receive the same review and approval as the State general revenue funds supporting counties and specialty community mental health providers. The contracting process begins with an initial funding allocation for each county and specialty provider. In SFY 2008, MHBG funds were included in contracts with counties, and allocations were based on a formula which took into consideration the following variables: county Medicaid case load, per capita income, urban/rural designation, and population. Counties are to use the MHBG in one or more of the following priority areas: certified CSP development and service delivery; supported housing program development and service delivery; initiatives to divert persons from jails to mental health services; development and expansion of mobile crisis intervention programs; consumer peer support and self-help activities; coordinated, comprehensive services for children with SED; development of services for persons with co-occurring disorders; and mental health outcome data system improvement.

The WSMRT and FMS, in addition to CARS, are used to document the receipt of fund appropriations, contracts, and expenditures. All county and specialty provider contracts are entered into the accounting system, noting specific community services and funds allocated to support those services. The DMHSAS's BPTR is responsible for funds allocation, contract development, and service delivery monitoring. The DHS Bureau of Fiscal Services is responsible for entry of fiscal information and initiates specific electronic transactions to authorize payment to the counties and specialty providers.

All counties and specialty providers utilize a uniform DHS contract format which contains effective date, expiration date, description of work to be performed, scope of services, MHBG non-allowable cost, required reporting, confidentiality requirements, financial requirements, and audit requirements. In addition, the contract does identify the Catalog of Federal Domestic Assistance (CFDA) number (93.958) of MHBG funds received by the community provider. The BPTR develops the contract for approval by the Director of DMHSAS.

Staff of BPTR are responsible for ongoing oversight of the provider system. Fiscal data are collected and compiled by the bureau and provided to DMHSAS administrators for use in addressing daily operational issues and special information requests and in negotiating contracts with counties and specialty providers. Almost all county agencies are certified to provide

Medicaid services and are subject to review by the Medicaid Services Division. The BPTR collects revenue and expense reports from counties and specialty providers. Annually, the bureau receives a Human Services Revenue Report (HSRR) from each county that is used to capture total expenditures by revenue source for all human service programs. The HSRR provides individual county fiscal information for adults and children for both community mental health services and inpatient mental health treatment. These data are compiled and used to address State budget development and special fiscal information requests.

The BPTR provides oversight and controls to ensure that MHBG funds are obligated and expended. Based on the review of written material and discussion with fiscal managers, DHS financial management is complying with the necessary requirements of the Federal Cash Management Act.

The Community Mental Health Services Block Grant Expenditures

The MHBG funds received in Wisconsin are used to support clinical services in 67 county agencies, including 3 multicomunity programs (these services cover all 72 counties in the State). In addition, MHBG funds are provided to NAMI Wisconsin, WFT, Wisconsin Alliance for Infant Mental Health, Native-American Tribes, and the consumer-run Grassroots Empowerment Project (GEP). Funds are directed to the support and development of mental health services for adults with SMI and children with SED. Allocated MHBG funds are entered in the WSMRT and FMS. The Federal funds are identified with a separate appropriation code for tracking expenditures within the State's biennial budget.

The MHBG funds are obligated and expended in accordance with State accounting requirements and within the 2-year Federal fiscal requirement. Table 3 describes the expenditures from MHBG funds in FFY 2008. The DMHSAS awarded the grant funds to support direct services in the 67 county agencies (including 3 multicomunity programs), consumer-run services, consumer/family support, training activities, prevention/early intervention, recovery, and WCMH operations.

Table 3: FFY 2008 Division of Mental Health and Substance Abuse Expenditure of CMHS Block Grant

Expenditure by Program Area	Expenditure
Community Aids for All Counties	\$2,513,400
Children's Mental Health Programs (ISP & CST)	1,775,576
Family/Consumer/Peer Support Activities	867,883
Mental Health Service System Change Activities	621,248
Training Activities	26,438
Prevention/Early Intervention and Recovery	68,792
State Mental Health Planning Council & DMHSAS Adm.	600,149
Total FFY 2008 MHBG Expenditure	\$7,027,814

Data Source: DMHSAS report data from HSRS and CARS reflecting data from submitted by counties in county fiscal year (CFY) 2007.

Maintenance of Effort (MOE) (Section 1915(b)1)

“A State involved will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.”

For the purposes of calculating Maintenance of Effort (MOE), it is necessary to show State expenditures for adults with SMI and children with SED for community mental health services from the entire State government, not just SMHA expenditures. Federal funds from other grants and contracts are not allowable in the MOE. Title XIX (Medicaid) State expenditures over the amount of the Federal reimbursement for Medicaid may be counted in the MOE if the funds were used for community mental health services for adults with SMI and children with SED.

The DMHSAS, in calculating the annual State MOE, incorporates the funds spent by counties from their Community Aids allocation. Through the HSRR, counties report their total annual mental health expenditures, including county funds, State funds, and Federal funds. Unallowable expenditures are subtracted from the data collected on the HSRR, and other State funds are added to arrive at the data presented in Table 4.

Table 4: Division of Mental Health and Substance Abuse Services MOE

Division Expenditures	SFY 2005	SFY 2006	2-Year Average	SFY 2007
Adjusted HSRR Expense Total	\$160,957,320	\$160,204,440		\$185,098,648
PATH-State Match	45,000	0		0
ISP State General Program Review (GPR) Funds	133,000	133,000		133,000
Conditional Release Program	4,452,201	4,783,634		4,446,736
Total	\$165,587,521	\$165,121,074	\$165,354,298	\$189,678,384

Data Source: DMHSAS MOE-Master 1-2009.xls, MOE Calculation Spreadsheet.

The DMHSAS is in compliance with the MHBG MOE requirement through SFY 2007. The review was conducted using SFY 2005, SFY 2006, and SFY 2007 as expenditure data; SFY 2008 was incomplete at the time of the monitoring visit.

Children's Set-Aside (Section 1913 (a))

“The State must maintain expenditures of not less than the FY94 base amount. This amount can be made up of expenditures for children with SED from MHBG funds, State funds, or a combination of both. State funds for Title XIX Medicaid expenditures over the amount of Federal reimbursement for Medicaid may be counted if the Medicaid expenditures were for services for children with SED. State expenditures for hospital inpatient services may not be included. No revenue from other sources such as counties, fees from participants, etc., is allowable.”

Table 5 describes the FY 1994 funding base and the Federal site visit review year of SFY 2007. In SFY 2007, DMHSAS reported expenditures for child and adolescent services of \$2,122,311, which exceeds the FY 1994 target of \$1,122,573.

Table 5: Division of Mental Health and Substance Abuse Services Set-Aside for Children's Mental Health Services

Funds Expended for SED	FY 1994 Base	SFY 2007
Child and Adolescent Services	\$1,122,573	\$2,122,311

Data Source: DMHSAS report data from Human Service Revenue Report HSRR reflecting data submitted by counties.

The DMHSAS is in compliance with the MHBG children’s set-aside requirement. Expenditure documents provided indicated the Division was expending both general program funds and Federal funds through contracts for services with county children’s community services providers.

Administrative Expenditures (Section 1916 (b))

The DMHSAS is in compliance with the MHBG administrative expenditure requirement. Discussion with fiscal staff indicated the administrative expenditure was less than 5 percent. Administrative expenditures supported the cost of staff responsible for the management of Federal grants in the DHS fiscal division.

Annual Audit (Section 1942)

The DMHSAS is in compliance with the annual audit requirement as no findings were made in the last State single audit.

Other Requirements Not Covered Elsewhere

The Division is in compliance with the MHBG requirement to award funds only to public or not-for-profit entities; it uses purchase of service contracts with for-profit entities.

CHAPTER III: URBAN LOCAL PROGRAM VISIT

Program Description

The Jefferson County Human Services Department's (JCHSD) primary focus is assisting county residents to live successfully in their communities. The JCHSD's target population includes individuals and families who need assistance in remaining safely in their living situations, maintaining employment, and sustaining relationships. The JCHSD also works with persons with long-term mental health conditions and individuals with developmental disabilities (DD). The County Board of Supervisors appoints the Human Services Board and County Administrator to whom the JCHSD Director reports. The Department comprises the following Divisions: Family Resources, Behavioral Health (DBH), Administrative Services, and Economic Support. It also includes Developmental Disabilities and Long Term Services, Aging and Disability Resource Centers (ADRCs), and Aging Services.

The DBH contains the following programs and services: mental health, alcohol and other drug abuse (AODA), Community Support Program (CSP), Comprehensive Community Services (CCS), Emergency Mental Health (EMH), Adult Alternate Care, and Lueder Haus. (Lueder is the name of a municipality in Germany. Haus is the German word for house. Lueder Haus serves as an acute care facility for adults with serious mental illness (SMI) who are in crisis but not in need of hospitalization.) Child Waivers and Wraparound are part of the Family Resources Division.

Jefferson is designated an urban county, has an agricultural history, and is located between Madison and Milwaukee. Its unemployment rate, more than 10 percent, is one of the highest in the State. It has four nursing homes and two large institutions for individuals with DD, 81 adult family homes, as well as other residential programs. The county does not have a public transportation system, has a growing elderly population, and the JCHSD budget, which was 20 percent last year, is 40-percent county tax levy this year and one-third of the county budget.

In response to the lack of public transportation, the Department has organized a volunteer driver program. These drivers transport elders to medical appointments and persons with disabilities to needed services.

The JCHSD is faced with the possibility of reduced State funding in the new State biennial budget that begins in July 2009. In addition, changes in State laws governing the Medicaid matching funds for child and elderly inpatient State hospitalization will require the county to pay more of its resources for inpatient services. At the time of the monitoring visit, JCHSD was projecting a \$900,000 reduction in upcoming State biennial funding.

Quality Improvement

Outcome measures include consumer satisfaction reports (i.e. Recovery Oriented System Indicators (ROSI) listening sessions), functional screen data, mental health database information which includes percentage of treatment plan goals accomplished, crisis bed days, emergency

room visits, cost data, and pre-and post-treatment measures. These data are used for quality improvement (QI) projects.

In 2008, the Outpatient Clinic conducted a consumer satisfaction survey. The ROSI measures the satisfaction of the participant and the degree to which services are recovery oriented. Person-centered services and empowering the consumer were both strongly endorsed in the survey. The staff approach area was negatively impacted by the statement that “staff lack up-to-date knowledge on the most effective treatment.” Barriers to treatment were also noted, along with basic needs being met, adequate income on which to live, and affordable housing. The agency’s goal for 2009 is to address the concerns identified in the 2008 consumer satisfaction survey. The overarching theme for 2009 goals is improved accountability for results and increased consumer satisfaction.

Consumers did not feel they had enough service options from which to choose. The clinic will increase the number of mental health groups being offered in 2009. In addition to the depression and anxiety groups, groups for trauma, wellness, and other identified areas have started in 2009.

On the survey, consumers indicated they wanted access to services more quickly. This will be addressed initially by increasing the number of groups provided. A QI project to evaluate alternative methods to increase consumer access to services will be completed in 2009.

The QI and quality assurance (QA) will be integrated into clinic programs. A quality improvement team composed of both management and staff will be developed to assess quality in various aspects of service provision.

A new employee training handbook will also be developed to ensure adequate training in all areas of the clinic. Assessment of current employee needs will be conducted periodically, and training resources will be offered through in-house staff and Web-based training sites.

The ROSI was also implemented in the Jefferson County CSP. Thirty-three consumers participated as part of the annual consumer satisfaction survey. The results indicated that consumers feel empowered by CSP staff and by person-centered planning. Consumers also reported liking the approach of staff and found that barriers to seeking needed services are minimized. The employment scale reflects that more people are interested in working.

The CSP has also partnered with the Comprehensive Community Services (CSS) program to work on quality assurance through a 3-year grant from the Bureau of Prevention, Treatment, and Recovery (BPTR). The grant provides \$59,000 per year through 2009. The goals of the QA project include the following:

- Developing a sustainable quality team.
- Identifying all available data to inform the QI team's selection and monitoring of QI projects.

- Reviewing all documents and processes used for intake, assessment, and recovery planning.
- Using QI practices to improve the efficiency of agency operations and quality of services for consumers.

The CSP also completed two QI interventions. The first intervention involved utilizing fiscal data to identify that one of the high-cost areas continues to be alternate care placements. The goal was to identify where consumers in alternate care placements wanted to live and what the barriers were to living there. All consumers reported that they felt they needed supports on the weekend to be able to live "on their own." The intervention resulted in adding mental health technician hours on the weekends. This resulted in seven consumers moving to their own apartments and out of alternate care placements.

The second QI intervention was related to feedback from consumers gathered during focus groups; this feedback suggested that the consumers were worried about CSP staff "being stressed out" and felt that this led to rushed and hurried sessions. Staff stated that they were indeed "stressed out." The intervention involved using Heartmath techniques to reduce and manage stress levels.

Jefferson County also provided information on Quality Improvement Projects using the Best Clinical and Administrative Practices (BCAP) framework. Four components of BCAP are typology, rapid cycle improvement, measurement and evaluation, and sustainability. The needs assessment includes consumer surveys, consumer focus groups, provider surveys and interviews, CCS Coordinating Committee suggestions, and experiences of staff or departments.

The DBH reflects the State process for the protection of consumer and family rights. A brochure on client rights and grievance procedures is provided to clients. It includes information on their bill of rights, personal rights, treatment rights, privacy rights, records access, grievance procedures, and contact information for the local Client Rights Specialist.

Consumer and /or Family Involvement

Consumers and parents/families participate in the CSP Council, CCS Coordinating Committee, Human Services Board, Wraparound Coordinating Committee, and Parent Advisory Group. Membership and participation are aligned with the area of service and population.

In addition to outreach to encourage consumer and parent/family involvement, other strategies used to enhance and support consumer and parent/family involvement include financial support for consumers and parents/families to attend training and conferences and childcare for parents attending training in the service area.

The National Alliance on Mental Illness (NAMI) Jefferson County and Grassroots Empowerment Project (GEP) have participated on the CCS Coordinating Committee. The GEP has sponsored consumer listening sessions and facilitates Horizons, a consumer-run, drop-in center. The CCS Coordinating Committee currently comprises consumers and parents, staff, and community members. The committee meets every other month, and the meetings are held at

Horizons. Elections are held for Human Services Board positions. The Coordinating Committee submits annual recommendations for the CCS program.

ADULT SERVICES

Coordination and Continuity

The three main programs are outpatient clinic, CCS, and CSP. They offer comprehensive case management, supportive psychotherapy, benefit coordination and financial support, employment and educational support, medical coordination, coaching in activities of daily living, crisis intervention, and medication management.

In addition to Assertive Community Treatment (ACT), the local program also provides Illness Management and Recovery, Integrated Dual Diagnosis Treatment, Supported Employment, Dialectical Behavioral Therapy, Family Psychosocial Education, Functional Family Therapy, and Person Centered Planning.

The DBH partners with the Department of Vocational Rehabilitation (DVR) and also assists consumers in completing financial aid applications and Plan to Achieve Self- Sufficiency for Social Security Income. Staff also work with consumers in managing symptoms and stress levels connected with school.

Supported Employment is utilized with a rapid job search. The DBH actively recruits employers to participate in the program and provides employers with support upon hiring consumers to solve problems. The program also assists consumers in obtaining a benefit analysis.

The agency's psychiatrist has admitting privileges at St. Mary's Hospital in Madison for continuity of care. The DBH also has working relationships with medical providers in the area. Staff will provide transportation and accompany clients to medical appointments when indicated. The CSP nurse is available 1 day per week for clozapine management, blood work, blood pressures, weights, and dietary consultations. The CSP nurse consults with the psychiatrist to coordinate treatment issues.

The CSP offers individual and group counseling for substance abuse services. Through a contracted agency, the program provides a medically monitored detoxification unit for alcohol and other drugs. In addition, there is a residential program for primary and secondary treatment. Continuity of care while in jail occurs through coordination with the CSP.

On a regular basis, the CSP staff continue to see consumers while in the program if they go to an inpatient facility. Contact is maintained with unit staff to ascertain progress toward discharge. The psychiatrist sees consumers daily while they are at St. Mary's inpatient unit for treatment and assessment. The CSP staff provide transition planning and transportation upon discharge. The Lueder Haus group home is sometimes utilized temporarily as a transition back home. The JCHSD utilizes a Peer Support Specialist (PSS) in the CSP who works 6 hours per week to co-lead groups, deliver medications, and accompany consumers to higher levels of care.

Delivery Strategies

In its 11th year of operation, the CSP provided services to 118 consumers ranging in age from 22 to 76. These consumers had mental health diagnoses such as schizophrenia, schizoaffective disorder, bipolar disorder, major depression, and various anxiety disorders. The CSP utilizes ACT to enhance mental health services for adults with serious mental illness (SMI). It has been effective in reducing symptoms and hospital costs and improving overall quality of life. The Jefferson County CSP has the capacity to function as a mobile inpatient unit. It provides psychiatric services, symptom management, vocational placement and job coaching, supportive counseling, and opportunities for social interactions. Other services include individual and group psychotherapy, medication management and distribution, education, money management and budgeting, coaching in activities of daily living (including maintaining a household and homemaking skills), crisis intervention, case management, and supportive services. Presently, CSP services can be titrated up and down quickly as the need for more intensive treatment arises.

The CCS program, in its third year, reduces the effects of an individual's mental health and/or substance use disorders, assists individuals in living the best possible life, and helps participants on their journey towards recovery. The CCS offers an array of psychosocial rehabilitative services which are tailored to the individual consumer. The CCS program also contracts with outside providers of residential services to teach consumers the skills needed to move into their own home or apartment, provides therapy services and a mix of in-home and individual and/or family therapy, and also provides PSS services.

The ADRC is a service center that provides a place for the public to get accurate, unbiased information on all aspects of life related to aging or living with a disability. Individuals, family members, friends, or professionals working with issues related to aging or disabilities can receive information specifically tailored to each person's situation.

The ADRC is also a place where persons can access Wisconsin's publicly funded, long-term care programs, including Family Care and Partnership and the new Self-Directed Supports Waiver Program called IRIS (Include, Respect – I Self Direct).

The ADRC assists consumers in completing financial aid applications and the Plan to Achieve Self-Sufficiency (PASS). The ADRC has developed working relationships with Centers for Students with Disabilities, a Madison-area technical college, and University of Wisconsin Whitewater to obtain accommodations, and the Center teaches consumers to manage symptoms and stress levels connected with school.

Criminal justice services are a jail counselor for 12 hours a week for mental health crisis assessments, a Literacy Council that offers classes in the jail, and a General Equivalency Diploma Program in the jail. In addition, there are Elderly and Disability Benefits Specialists on staff, Family Care, Southeastern Wisconsin Center for Independent Living, and interpreters for the deaf and hard of hearing.

CHILDREN'S SERVICES

Coordination and Continuity

Strengths of the Jefferson County children's mental health system include its operational linkages with area school districts, as well as the juvenile justice and child welfare systems. The CCS team which serves children works closely with the county Justice Services Delinquency Team and Teen Court. The team's collaborative efforts with Child Welfare Services include working with the Child Protective Services Team and holding weekly team meetings to review, collaborate on, and coordinate joint cases. The CCS receives numerous referrals from the child welfare system and has experienced success in working with that system to keep children in the community. When out-of-home placements occur, staff of the collaborating child-serving systems coordinate their efforts so that the child can return home or be placed in a less restrictive environment as soon as possible.

The Jefferson County Wraparound Coordinating Committee's collaboration with other child-serving systems is extensive and ongoing. A review of the minutes of the children's system Coordinating Committee meetings confirms the regular attendance of juvenile justice, Head Start, Community Action Coalition, juvenile court, police officers, clergy, staff from service area school districts, parents, other relatives, and informal supports.

The Coordinated Service Team (CST)/Integrated Services Program (ISP) is another Jefferson County wraparound initiative which uses a team approach to serve children with multiple needs in their homes and community. It serves approximately 45 of the service area's highest need children and families. Children served have mental health, AODA, child protection, juvenile justice, and special education service system needs. The project promotes early identification and intervention and provides access to a comprehensive array of services, including physical healthcare. The CST/ISP delivers services that maximize coordination and collaboration, and ensure a smooth and coordinated transition to the adult service system when appropriate.

The project's Coordinating Committee membership includes representatives from the following Jefferson County organizations and programs: Board of Supervisors, JCHSD, Health Department, Head Start, Delinquency Prevention Council, Early Intervention Program, Literacy Council, and AODA. There are also committee members who represent seven area school districts and six police departments and Wisconsin Family Ties (WFT), as well as parents/family members of children served by the program. Community mental health providers, ministers, and other community agencies are also represented on the committee.

Division procedures regarding discharge/transition planning from residential, inpatient, and juvenile justice placements reflect State procedures. Individualized service teams work with and support the child and family throughout the treatment process. Discharge/transition planning responsibilities rest with the team, which includes the parent/family. The team and parent/family continue to be involved throughout the treatment process.

Delivery Strategies

Jefferson County has a small population of ethnic, cultural, and linguistic minorities and a smaller number of staff who are part of those groups. The county does, however, have three staff who are Spanish speaking and provide interpreter services in situations where the need for such services could not be anticipated. The county contracts for Spanish interpreter services at other times and also has the computer capability to translate forms and brochures into other languages.

FINANCIAL MANAGEMENT

Fiscal Context of Community Mental Health Services

The JCHSD had an annual budget of \$35,871,616 in county fiscal year (CFY) 2008 and provides human services, including mental health clinical services. The agency has a staff of approximately 170 (full and part time) who provide aging, economic support, and child/family resource services for adults with serious mental illness (SMI), children with serious emotional disturbance (SED), persons in need of substance abuse treatment, and individuals with DD,. The JCHSD provides the following mental health programs: CSP, CCS, Wraparound, Emergency Mental Health/Crisis Intervention, and Outpatient Mental Health Clinic.

The agency's Administrative Services Division (ASD) Manager is responsible for daily management of all revenue and expenditures, the development of the agency's annual budget, payroll and grants/contract management, and production of fiscal management reports for the County Board of Supervisors, the Human Services Board, and agency executive staff. The fiscal year is January through December (calendar year), and the annual budget development process begins in the spring prior to the start of the fiscal year in January. The ASD Manager will develop a draft budget based on current programming/personnel along with a capital budget. Based on known cost increases and projected increases, a budget will be reviewed and discussed with key administrators. The JCHSD Director, along with these key administrators, will modify the budget in light of expected revenue from State, county, and Federal funding. The JCHSD budget will be submitted to the County Administrator and Board of Supervisors for final review and approval.

Revenue and Expenditures for Mental Health Services

The revenue history, Table 6, for JCHSD depicts growth between CFY 2006 and CFY 2007, with a slight downturn in CFY 2008. In CFY 2008, JCHSD received more than 58 percent of its operating revenue from State and Federal resources. The Department is currently planning for possible State funding reductions and increased Medicaid match requirements related to the county's State inpatient hospitalization for children and adolescents. The loss of State funds and increased demand on county funds for match could lead to staff layoffs and reductions in services for persons with mental illness.

Table 6: Jefferson County Human Services Department Revenue CFY 2006, CFY 2007, and CFY 2008

Resources (actual)	CFY 2006	%	CFY 2007	%	CFY 2008	%
State and Federal Aid	\$19,256,019	60.1	\$22,092,581	61.0	\$20,994,439	58.5
Collections	6,651,470	20.8	7,435,854	20.5	7,828,676	21.8
County Tax Levy	6,128,899	19.1	6,666,127	18.4	7,008,501	19.5
Fund Balance Carryover	0	0.0	35,910	0.1	40,000	0.1
Total Resources	\$32,036,388	100.0	\$36,230,472	100.0	\$35,871,616	100.0

Data Source: Jefferson County Human Services Department Resources & Expenditures (unaudited) documented in the Annual Report and Financial Reports for CFY 2006, CFY 2007, and CFY 2008.

In CFY 2007, JCHSD received \$26,128 in Mental Health Block Grant (MHBG) funds for the provision of crisis intervention services for adults, children, and adolescents. Its contract with the Division of Mental Health and Substance Abuse Services (DMHSAS) for MHBG funds contained a statement regarding the receipt of MHBG funds and the amount to be received.

The JCHSD expenditures of State, county, and Federal funds are depicted in Table 7. Approximately 35 percent of the funding was directed to the support of staff who provide various services and programs provided by the Department.

Table 7: Jefferson County Human Services Department Expenses CFY 2006, CFY 2007, and CFY 2008

Expenditures (actual)	CFY 2006	%	CFY 2007	%	CFY 2008	%
Personnel and Operating	\$10,733,294	33.5	\$11,648,176	32.5	\$12,641,140	35.2
Client Assistance	\$387,973	1.2	\$333,756	0.9	\$340,854	1.0
Medical Assistance Waivers	\$16,264,841	50.8	\$19,620,799	54.7	\$18,180,237	50.7
Community Care	\$797,486	2.5	\$746,062	2.1	\$748,594	2.1
Child Alternate Care	\$1,534,716	4.8	\$1,442,568	4.0	\$1,884,637	5.3
Hospitalizations	\$609,149	1.9	\$479,466	1.3	\$620,435	1.7
Other Contracted Services	\$1,707,671	5.3	\$1,603,989	4.5	\$1,451,968	4.0
Total Expenditures	\$32,035,130	100	\$35,874,816	100.0	\$35,867,865	100.0

Data Source: Jefferson County Human Services Department Resources and Expenditures (unaudited) documented in the Annual Report and Financial Reports for CFY 2006, CFY 2007, and CFY 2008.

Community Mental Health Services Block Grant Expenditures

The JCHSD expended \$26,128 in CMHS Block Grant funding in CFY 2007 (last completed year in which expenditures are fully accounted for by DMHSAS). The Center for Mental Health Services (CMHS) Block Grant funds received from DMHSAS were used to fund crisis intervention services for the citizens of Jefferson County. The DMHSAS contract with JCHSD identified the Catalog of Federal Domestic Assistance (CFDA) number/grant program and the amount of Federal funds to be received. The JCHSD is in compliance with the submission of the A-133 audit to DHS. All CMHS Block Grant funds received by JCHSD were used for the provision of services to adults with SMI and children with SED.

The JCHSD and DBH provide many services and supports that add to the effectiveness of the adult and children's mental health systems. The partnerships and collaborative efforts of Jefferson County's mental health, human services, and other service systems reflect and are consistent with the principles and values of recovery and resilience in a transformed mental health system.

NOTE OF APPRECIATION

The Center for Mental Health Services (CMHS) and the monitoring team wish to thank the staff of DMHSAS and JCHSD for their time and effort preparing for this monitoring visit.