# WISCONSIN'S

# COMMUNITY HEALTH BLOCK GRANT PLAN

# FOR

# ADULTS AND CHILDREN

# FFY 2012-13

# DRAFT

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## 1. Strengths

### Wisconsin's County-Based Mental Health System

In 1971 Wisconsin State Statutes Chapter 51 established a county-based system of community mental health care for all adults with serious mental illness (SMI) and youth with severe emotional disturbance (SED). Presently the state mental health system is organized into 67 regions or counties that provide care and supervision of mental health services at the local level for all 72 counties. Overseeing this county-based system is the Division of Mental Health and Substance Abuse Services (DMHSAS) which is the designated State Mental Health Authority (SMHA) that directs public mental health and substance abuse services in Wisconsin. Inpatient mental health services are available at two state institutes—Mendota Mental Health Institute (MMHI) or Winnebago Mental Health Institute (WMHI)—county mental health hospitals, the two veteran's administration hospitals, private psychiatric hospitals, or general medical/surgical hospitals (some with psychiatric units housed therein).

According to Wisconsin's prevalence estimates discussed in more detail later in the Plan, an estimated 5.4 percent of adults 18 years of age and older have a serious and persistent mental illness. Out of 4,350,035 adults in the state based on the 2009 U.S. Census, this means that 233,717 adults have a serious mental illness compared to the 40,370 adults with an SMI who were reportedly served through the county mental health system in CY 2009 according to the State's Human Services Reporting System (HSRS). Based on the estimated prevalence of 233,717 adults with SMI in Wisconsin, the county mental health system served 17.3 percent of the adults with SMI in Wisconsin. The Management Group's 2009 report combined data across the entire public mental health system including data from Medicaid fee for service, managed care and counties. The study found that 145,953 unduplicated individuals received some mental health service in 2007. Although not all these individuals in the study have serious mental illness, it is likely that the Medicaid data would include additional individuals with severe mental illness in addition to those served by the county system.

Wisconsin shows a reduction in long-term institutionalization of mental health consumers in hospitals and nursing homes over the past number of years. Between 2010 and 2011 the number of total psychiatric beds, beds staffed, and average daily psychiatric hospital census decreased for Wisconsin by a substantial margin. Generally, the average length of stay declined by 34.5 percent while staffed beds went down by about 40 percent. One factor that may have influenced this change is recent legislation which requires that law enforcement personnel consult with and obtain permission from county mental health staff prior to doing an emergency detention. Moreover, a legislative change in a 2009 Act, shifted responsibility for matching the federal share of Medicaid reimbursement for the state institutes for mental health from the state to the county for youth under age 22 and elders over 64.[1] This local control element in conjunction with county options for diversion from hospitals through DHS 34-Sub III Crisis Intervention programs, sometimes including Crisis Stabilization, may be a factor in reducing hospital utilization and possibly length of stay. Provisions of Crisis Intervention services have allowed for a *step-down* approach to having a person finish their acute care outside of the hospital. For example, if the person is not able to return to their home, they could perhaps utilize a crisis stabilization opportunity for a few days or a week or so.

[1] 2009 Wisconsin Act 28: http://legis.wisconsin.gov/2009/data/acts/09Act28.pdf

## Infrastructure Development—Recovery Implementation

Wisconsin over the years has served as a leader in many initiatives, modeling developments in the behavioral health infrastructure for other states. Pioneering efforts in community mental health in psychosocial rehabilitation were researched in Wisconsin through PACT (or Programs for Assertive Community Treatment). Around the same time, in the 1970s the National Alliance on Mental Illness (NAMI) was founded in Wisconsin. Joining partners, DMHSAS is working with groups like NAMI, Wisconsin Family Ties (WFT), Mental Health Association of Wisconsin (MHA), Disability Rights Wisconsin (DRW), Grassroots Empowerment Program (GEP) ,Wisconsin United for Mental Health[2] (WUMH) to continue development of Wisconsin's behavioral health infrastructure for adults and children. These groups are working assiduously to counter stigma and discrimination in Wisconsin while conveying accurate and unbiased information about mental illnesses and severe emotional disturbance in the interest of promoting recovery and the adoption of evidence-based practices.

*Certified Peer Specialists.* Under the leadership of the Bureau of Prevention Treatment and Recovery (BPTR) and Access to Independence Independent Living Center, Wisconsin has developed a certification for peer specialist services. Proof of required training and a state sponsored exam are the central components of the process. The Independent Living Centers in the state serve as exam proctors; the U.W. Milwaukee manages the tests and scores the results.

DMHSAS also partners with the UW-Madison School of Medicine and Public Health to provide Recovery technical assistance and will continue to work with a Recovery Implementation Task Force (made up of a majority of consumers) to develop Recovery training curricula for providers.

*Partnerships With Non-Profit Organizations Supporting Priorities.* With respect to the focus on self-directed care and support in Wisconsin a number of partners support efforts through training . For example NAMI provides a number of courses such as *Peer-to-Peer*, *In Our Own Voice, Peer Support Group Facilitator Training,* as well as *Parents and Teachers as Allies* and *Family-to-Family.* Person-centered planning has been implemented across a variety of sites in Wisconsin through DMHSAS leadership. Other supports of self-directed care include NAMI's Consumer Council, a *Consumer Leadership Summit,* the WFT coordinated *Children Come First Conference,* various club house sites across the state, etc.

*Supporting Health and Home.* Infrastructure development has come about through partnerships with educational institutions, such as the Wisconsin Nicotine Treatment Intervention Project (WINTIP) program through University of Wisconsin (UW) Center for Tobacco Intervention Research (CTIR). WINTIP focuses specifically on the integrating evidence-based approaches in helping to reduce and eventually eliminate the use of tobacco products among persons with behavioral health conditions. Efforts in combating homelessness and promoting safe, affordable, and comfortable housing to persons with mental illness are made through the Division of Supported Housing at the Department of Commerce through Projects to Assist in the Transition from Homelessness (*PATH),* and SOAR (SSI/SSDI Outreach, Access and Recovery) and programs such as Tenant Based Rental Assistance (TBRA). Housing-first models have been implemented by some PATH sites; whereas SOAR has helped many homeless and disenfranchised individuals obtain urgently needed disability benefits with which to support a life off the street, as well as Medicaid such that they have insurance for medical and behavioral health treatment. The Social Security Administration (SSA) has an identified homeless specialist in each SSA office that is sensitive to the transient nature of persons who find themselves without housing in order to help shepherd disability benefit applicants through the complicated system. Housing and Urban Development (HUD)

[2] Wisconsin United for Mental Health (WUMH) Website: http://www.wimentalhealth.org/

funded efforts such as Shelter-Plus-Care and other rental subsidy programs help support the critically important element of *home* in SAMHSA's vision for a high quality, self-directed, and satisfying life in the community.

*Supporting Purpose for Consumers.* Wisconsin's strengths within the realm of SAMHSA's vision of *purpose* in the community is the web of employment resources from Wisconsin's network of Job Centers in many communities, the provision of vocational rehabilitation services through the Department of Workforce Development, Division of Vocational Rehabilitation (DVR) and a variety of other efforts such as supported employment initiatives through a continuum of psychosocial rehabilitation programs. Employment agencies use Ticket to Work (TTW) vouchers to assist individuals in swimming upstream in a difficult employment environment. Many technical and university campuses have special needs counselors or programs which can help persons with disabilities successfully complete training programs. A network of twelve Cooperative Educational Service Agencies (CESA) across the state supply supportive and educational services, employment assistance, job coaching, and a host of other services, each to their own respective region. Similarly, eight Independent Living Centers (ILCs) across the state are consumer-directed, non-profit organizations that provide four core services: peer support, information and referral, independent living skills training, and person and systems advocacy.

*Mental Health and Substance Abuse Infrastructure Study.* Completing the second phase of work in 2010, the MH/SA Core Benefits and Eligibility Work Group developed a core benefit set for the public MH/SA system which should be available to eligible individuals statewide. A related contingent, the Shared Service/Regional Pilots Work Group, established five possible areas to pilot including: core benefits, physical and behavioral health care integration, system innovation, early intervention and MH/SA integration for children, and psychosocial rehabilitative model continuum of care. In addition to the listed priority areas for pilots, the Work Group developed potential elements that pilot programs should include. In November of 2010, Requests for Information (RFI) were received from organizations interested piloting innovative three-year demonstration projects utilizing shared services across organizations or in multi-county regional approaches. Ultimately, through this process the Department will gauge interest toward opening a Request for Proposal (RFP) process.

## Emphasis on Expanding Trauma-informed Care

Another infrastructure strength within Wisconsin, consistent with SAMHSA's Strategic Priorities around trauma and justice, is the Trauma Informed Care (TIC) initiative lead by the DMHSAS Trauma Informed Coordinator. Through TIC a diverse and large set of agencies have been trained in TIC, a list serv has been set-up, online training resources have been established[3], a TIC Advisory Council which meets regularly has been established, several statewide training opportunities have been offered, etc. Efforts with TIC have been made not just to behavioral health providers but to child welfare, law enforcement, homeless providers, and others.

In December 2008, the Division of Mental Health and Substance Abuse (DMHSAS) received $221,000 Transformation Transfer Initiative grant issued by NASHMPD, although grant funds have ended, the initiative is still active in 2011. The initiative supported the implementation of Trauma-Informed Care (TIC) within the public mental health and substance abuse services. Recent activities included the expansion to the child welfare system.

Currently, a portion of the MHBG is used to fund the Trauma-Informed Care Consultant through the UW Department of Psychiatry. The initiative incorporates an understanding of trauma's impact, including the consequences and the conditions that enhance healing in all aspects of service delivery. The Trauma

[3] Trauma Informed Care example of online resource:
http://dhsmedia.wi.gov/main/Viewer/?peid=41df585c36bf4da2b56e95c52329b2fb

Services Coordinator provides administrative and service-level technical assistance leading to modifications in practices, activities, and settings. Additionally, service systems are educated about trauma-specific services which address the impact of trauma and facilitate trauma recovery. Essential objectives to the TIC initiative are as follows:

- Disseminate the trauma-informed care values and practices statewide
- Staff Trauma-Informed Care Advisory Committee (TIC AC) meetings
- Identify, train and support TIC Champions and developing TIC organizations
- Develop outcome measures and data to monitor TIC implementation

The targeted population for the initiative is the public behavioral health service system and other integral stakeholders, including the child welfare system. During this grant period, fifteen different groups encompassing 1,865 people from across the state of Wisconsin received TIC training and technical assistance.

Additionally, two specific groups received more intensive training. In March 2010, about 50 consumer leaders from across the state met for two days in March 2010 to learn about trauma-informed care and practical strategies for implementation. In that same month, 80 Youth Residential and Day Treatment Providers met for a full day to review TIC action plan progress and learn about a trauma therapy model ('Trauma Systems Therapy').

Some examples of significant activities have included the following:

- Eight TIC Consumer Champions from across the state were provided a full-day training and technical assistance to consumer / peer groups. Toward the Consumer Champion project the group created a mission statement, as well as short and long-term goals.
- A TIC List Serve now approaching 400 names was created to maintain TIC momentum and provide continued support to people who have received TIC training
- The statewide TIC Advisory Committee is well-attended and meets every other month to provide the trauma initiative with continued input and direction. The group is currently focused on ways to integrate lasting TIC change into Wisconsin's wide range of human service systems. Planning is underway to organize a TIC summit with participants including the Dept. of Health Services, Dept. of Public Instruction, Dept. of Corrections, Dept. of Commerce, and the Dept. of Children and Families.
- The Wisconsin Youth Services TIC Champion Teams (approximately 6 teams) established a 'Learning Collaborative' which meets every other month to discuss TIC successes and barriers.
- *Meaningful Consumer Involvement:* TIC has become a central theme included in consumer conferences and peer specialist trainings. Providers are reporting that consumers are requesting and, at times, requiring that services be trauma-informed. The TIC Consumer Champions are regularly asked to present TIC concepts to a wide range of consumer groups and are paid for their time and knowledge.
- *Cross Systems Collaboration:* The Dept. of Public Instruction and the Dept. of Children and Families have incorporated TIC into training and programming. The Trauma Services Coordinator was included on a small work group which developed TIC tools to be distributed to Wisconsin schools. The Trauma Services Coordinator has been asked to serve on several DCF committees and frequently provides TIC training and technical assistance to child welfare staff.

## Employment Services for Adults

Adults with serious and persistent mental illness in Wisconsin meet their employment needs in a variety of ways, but not always with success. Many individuals seek employment on their own. Others use mainstream services such as temporary employment agencies or the services of the state's network of

over 60 job centers funded under the Workforce Investment Act. While these avenues may result in securing employment, some individuals with serious and persistent mental illness may have difficulty maintaining employment due to job stress and variations in the status of their disorder.

Additionally, DVR in partnership with DMHSAS applied and received a Johnson and Johnson Dartmouth Community Mental Health grant. This grant will allow Wisconsin to use an Individual Place and Support (IPS) model that incorporates employment into a treatment component and focus with people that have severe mental illness. The grant began on April 1, 2010 and will end in March 14, 2014. DHS will act as the fiscal agent for the $280,000 grant allowing for training and systems change.

In the prior two years, DVR utilized American Recovery and Reinvestment Act (ARRA) funds to make DVR services available to more consumers who had been put on a wait list. DVR's purpose is to assist all persons with disabilities regardless of the type of disability to achieve their employment goals by removing barriers to their full employment. With this clear statement of financial support for our work from these federal funds, DVR will be able to provide employment services to people who would otherwise need to remain on a waitlist for much longer.

Employment options for persons with serious and persistent mental illness can be challenging. The complexities of eligibility, fragmentation of services and sources, accuracy of information about the impact of earnings on benefits, workplace stigma and prejudice, often limited access to critical health care supports, are just a few factors that have traditionally made employment outcomes generally poor for citizens with disabilities. Wisconsin offers a number of programs designed to help people with disabilities, including those with serious and persistent mental illness, seek and retain employment. A large number of mental health consumers, for example, receive long-term employment supports via CSP, CCS and community rehabilitation programs around the state.

## Wisconsin Pathways to Independence

Wisconsin Pathways to Independence (WPTI) is a partnership between people with disabilities, business and government. It is a collection of federal grant and state funded projects within the DHS Office for Independence and Employment (OIE). The many and varied array of Pathways projects include development of employment related community resources and leadership, integration of employment goals and services in long-term care programming, support for work incentive benefits counseling, dissemination of employment support information and basic employment policy research, alternative policy development and evaluation.

WPTI partners with community-based support providers around the state including CSPs, clubhouses for individuals living with serious and persistent mental illness, Independent Living Centers, county human service agencies, developmental disability advocacy agencies, the Departments of Public Instruction and Workforce Development among others. Examples of projects involving individuals with serious and persistent serious and persistent mental illness include capacity building of person-centered approaches to employment services, incorporating employment and benefits counseling training and information into existing consumer-driven support systems at the grassroots level, directly engaging individuals with serious and persistent mental illness in project planning and advisory capacities.

The Social Security Administration has granted WPTI demonstration authority that permits selected participants to earn over the usual limit of the Social Security disability program. Twenty-two community agencies around the state began enrollment in this waiver starting late summer 2005, with four of these agencies serving primarily people with severe and persistent serious and persistent mental illness. In addition, 14 of the other agencies actively work with individuals living with serious and persistent mental illness. As of 2010 participants continue in the demonstration although the community

agencies no longer are under contract to provide services. However, the agencies continue to provide follow along benefits counseling services as needed that are funded by OIE through the Medicaid Infrastructure Grant. Also, participants are referred to the appropriate employment supports as needed by OIE staff and the community agencies.

Wisconsin, using grant funds allocated to OIE, is involved in professionalizing Peer Specialists by developing a certification exam and process and a professional association of Peer Specialists, and implementing evidence based practices in supported employment for people with serious and persistent mental illness throughout the state. The peer mentors are trained, certified and work closely with their peers in the process of recovery through employment. A new effort in Wisconsin has been established between the Department of Instruction and the Wisconsin Technical College System to train individuals with behavior disorder diagnosis in specialized employment fields, while they are in high school. The intent is to improve graduation rate and secure employment prior to the time that they might have more significant symptoms so that they are less likely to need benefits.

## Paths to Employment Resource Center (PERC)

The mission of PERC is to provide education, technical assistance, research, and resources to promote choice; increase integrated employment options; and expand opportunities for persons with disabilities to earn income and fully participate in community life. PERC project partners include: UW Madison Department of Rehabilitation Psychology and Special Education; UW Stout Vocational Rehabilitation Institute (SVRI); Employment Resources, Inc. (ERI); and the Department of Health Services (DHS), until 2011. PERC is funded through DHS in the Division of Long Term Care, Bureau of Aging and Disability and the Office of Independence and Employment. The program primarily serves:

- People with disabilities and families
- Family Care: Managed Care Organizations, Aging and Disability Resource Centers, and Include, Respect, I Self-Direct (IRIS) and county long term care agencies
- Community employment providers
- Partners (DVR, Public Instruction/transition, Independent Living Centers, and the university/technical college systems)

PERC provided evidence-based training by state and national experts in a variety of formats including face-to-face, remote-live, remote self-paced and facilitated distance learning. Training is provided on programs such as the Medical Assistance Purchase Plan (MAPP). MAPP will be the first course to be piloted through the program in March of 2010. Through virtual learning, the program will provide information in a time saving and cost effective manner, support the long term viability of the program through a pre-recorded training curriculum, and permit the real-time assessment of student learning. PERC developed a website that provides easy access to integrated employment services/supports, and information and contacts that are presented in an accessible, searchable format.[4]

## Ticket to Work Program

The Ticket to Work Program provides most people receiving Social Security benefits (beneficiaries) more choices for receiving employment services. Under this program, the Social Security Administration (SSA) issues tickets to eligible beneficiaries who, in turn, may choose to assign those tickets to an Employment Network (EN) of their choice to obtain employment services, vocational rehabilitation services, or other support services necessary to achieve a vocational (work) goal. The EN, if they accept the ticket, will coordinate and provide appropriate services to help the beneficiary find and maintain employment.

[4] PERC Website: http://www.percthinkwork.org/

While beneficiaries are actively participating in the Ticket to Work program, they can get help needed to find the right job and safely explore work options without losing benefits.

- Beneficiaries can easily return to benefits if they have to stop working (known as "expedited reinstatement of benefits");
- Beneficiaries can continue to receive healthcare benefits; and
- Beneficiaries will not receive a medical continuing disability review (CDR) while using their Ticket.

## Disability Program Navigators

Disability Program Navigators is a program offered in Wisconsin and funded through the federal Department of Labor and the Social Security Administration. The program assists persons with disabilities (including serious and persistent mental illness) to access and navigate the complex provisions of various programs that impact their ability to gain, return to, or retain employment. They develop linkages and collaborate on an ongoing basis with employers to facilitate job placements for persons with disabilities. Navigators work to facilitate youth transitioning (aging out) from schools to secure employment and economic self-sufficiency through schools and the Cooperative Educational Services Areas (CESAs). They also serve as a resource to businesses to expand workplace opportunities for persons with disabilities to enter and remain in the workplace. There are Disability Navigators working in a limited number of counties in the state and they are of racially diverse backgrounds (Hmong, African American, and Native American).

The Navigators have partnered with Wisconsin United for Mental Health to offer a train the trainer opportunity for Navigators to increase understanding and awareness of stigma and discrimination as it impacts adult mental health consumers, adolescents/youth and their families, as the youth transition into the workforce and schools with a focus in rural and major urban areas.

## Housing Services

In Wisconsin, the goal is to affirm the right of consumers with serious and persistent mental illness to have safe, decent, affordable housing and choice in selecting a residence in their community. Decent, safe, affordable housing is a cornerstone for anyone struggling to be self-sufficient. Federally-financed HUD programs, administered by the Department of Commerce, Bureau of Supportive Housing, provide the majority of supportive housing programs in Wisconsin. Along with the housing services provided by the Department of Commerce, over 200 other public housing agencies, independent of the State, operate in Wisconsin. Supportive housing has proven to help people who face the most complex challenges (individuals who have serious, persistent issues that may include serious and persistent mental illness, substance use, and HIV/AIDS, as well as very low incomes). Without a stable place to live, and a support system to help them address underlying problems, people often bounce from one emergency system to another. According to a recent study by the University of Pennsylvania Center for Mental Health Policy and Services Research, it costs less to house someone in stable, supportive housing than it does to keep that person homeless and stuck in the revolving door of high cost crisis care and emergency housing.

HUD funds several levels of supportive housing including Safe Havens, Transitional Housing, and Shelter-Plus-Care. Safe Havens provide a soft entry refuge for people who are unable or unwilling to immediately engage in supportive services. They provide a 24-hour a day residence, of unspecified duration, where people can feel at ease, out of danger, and subject to no immediate service demands. Safe Haven's often serve as a portal of entry to basic services such as food, clothing, bathing facilities, telephones, storage space, and a mailing address.

There are HUD-Supportive Housing program funded Transitional and Permanent Housing programs in both urban and rural communities across the state. This type of supportive housing is used to facilitate movement of homeless individuals and families to permanent housing and to assist them in maintaining their housing. They may live in transitional housing for up to 24 months and receive supportive services such as case management, outpatient health services, employment assistance, nutritional counseling, child care, assistance in getting permanent housing, and help in accessing other types of assistance. Permanent housing provides for affordable living arrangements with supportive services necessary to assist the resident in maintaining their living arrangement.

Projects to Assist in the Transition from Homelessness *(PATH)* is quite active in the larger population centers in Wisconsin. Shelter-Plus-Care, also HUD-funded, provides rental assistance for hard to serve homeless individuals with disabilities, in connection with supported services provided from sources outside of the program housing subsidy program. Milwaukee, Dane, Racine and Rock County have Shelter-Plus-Care programs. Shelter-Plus-Care is "permanent housing," and the rental assistance is available to the participants on an ongoing basis as long as services, equal in value to the amount of rental assistance, is provided from other sources.

## LGBTQ Populations

Within LGBTQ populations, it is known that there are impacts from misunderstanding, myth and stigma. Moreover it is known that being gay or different during the already challenging adolescent years can be very difficult for young people. Having a minority sexual identity can make a person much more vulnerable to teasing, bullying and discrimination. The already unacceptably high risk of suicide during adolescence and young adulthood can be compounded by social stressors such as these. In larger communities, there are some social, educational and supportive resources for LGBTQ but in smaller communities, the sense of isolation can be incredibly stark. DMHSAS has begun to reach out to some of these supportive resources to learn more about perceived needs and ways to guide the behavioral health system to align better with emerging data sources and recognized needs. As part of the phased development of Wisconsin's Mental Health/Substance Abuse Plan, this subgroup needs to be much better understood and involved as a partner in planning, evaluation, and support in all arenas—prevention, intervention, and recovery.

## Racial, Ethnic, and Diverse Cultural Populations

Demographics show Wisconsin to be a predominately Caucasian, European-Scandinavian state. Yet there are significant minority populations in certain regions. Wisconsin has Native American concentrations in Tribal regions and other areas. Moreover, areas with higher representation of African Americans include Milwaukee with a quarter of the population being Black. Racine's population, just south of Milwaukee is more than 10 percent African American. Southeast Wisconsin also has slightly more than a 10 percent concentration of Hispanic members. The rest of southeast and south central Wisconsin has about five percent each of Hispanic and African American citizens. Asian American populations are smaller and tend to be concentrated around Dane, Milwaukee, Sheboygan, La Crosse, and Eau Claire.

As these populations grow, the necessity for culturally competent and linguistically appropriate services is magnified. It is not known how many behavioral health settings are prepared to serve people of color, non-English-speaking members of the community, nor those with rich and diverse religious and cultural traditions. Through the phased development of the Mental Health State Plan, these cultural, ethnic, and racial considerations must be considered. Minority populations must be meaningfully involved in planning activities. Traditional providers must become aware of blind spots of *white privilege* and other racial and cultural realities. Prevention and intervention efforts must develop and involve people from diverse cultural, racial, and ethnic backgrounds as staff, community leaders, and partners in all efforts. In

working with historically oppressed groups, recognition and awareness must be made over historic cultural traumas of slavery and holocaust.

Another aspect to diversity awareness and planning is with regard to persons with physical disabilities and/or infirmities of aging. Efforts are underway with regard to strategic planning around the needs of those who are deaf, deaf-blind, or hard of hearing. Planning must take into account all of these broadly defined needs of Wisconsin's diverse and rich culture.

## American Indians

Please see the subsection titled *Consultation with Tribes* in Section 6 – Important Elements of the Modern Mental Health System. This is an area where additional strengths, weaknesses, and critical gaps need to be more collaboratively identified.

## Wisconsin Refugee Mental Health Program (RMHP)

Most refugees that come to America have suffered traumas in their homelands. Refugees are at-risk for posttraumatic stress disorder and often struggle with the grief and isolation caused by leaving their homeland, culture, and family members when coming to America and/or the death of family members in their homelands. The RMHP was funded up until January 1, 2009 through a competitive grant from the Office of Refugee Resettlement (ORR) and is administered through the Bureau of Migrant, Refugee, and Labor Services (BMRLS) in the Department of Workforce Development (DWD). BMRLS contracted with counties, private mental health agencies, and refugee resettlement agencies to provide culturally and linguistically competent mental health services. Refugee groups served through the grant included: Hmong, Africans, Bosnians, Croatians, Serbians, Burmese, Middle Easterners including Palestinians, Afghans, Russians (and those from other former Russian territories, Iraqis and others. The three primary goals of the program were:

1. Bilingual and bicultural clinical services;
2. Community education and outreach; and
3. Integration of services through consultation and in-service training to mental health staff at large.

Eligibility for services included being a refugee, having asylum status or being a victim of human trafficking. Enrollment was not based on income and insurance is not required. Services available included:

- Psychiatric evaluation and medication management
- Mental health and substance abuse counseling
- Support groups
- Case management
- Parenting assistance
- Translation
- In-home therapy to remove transportation barriers
- A holistic approach to services including meeting transportation, food and rental assistance and services for the whole family

As of January 2009, federal funding ended for the five regional mental health programs. There are ongoing efforts to retain trained and licensed bilingual staff. Refugee homicides and suicides continue to increase for both older adults and youth. In June of 2009, BMRLS received a $102,110 grant to produce a mental health screening tool (TOOL) for refugees. The goal of TOOL is to help reduce refugees on the Foodshare caseload by identifying refugees with mental health needs, and referring them for screening

and treatment. Expected outcomes for the initiative include development of TOOL, training case managers, and the implementation of TOOL. Sebastian Family Psychology is the lead agency working with all refugee mental health programs.

## Deaf and Hard of Hearing

From 2003-2008, a Mental Health Specialist for Deaf and Hard of Hearing (DHOH) Services worked in DMHSAS to develop a statewide plan to address the needs and concerns regarding access to mental health services for deaf, deaf-blind, and hard of hearing persons. While that position is no longer available, an intra-agency understanding was made in October 2010 between the Division of Mental Health and Substance Abuse Services, Bureau of Prevention, Treatment and Recovery and the Division of Long Term Care, Bureau of Aging and Disability Resources, Office for the Deaf and Hard of Hearing.

A memorandum of understanding (MOU) addressed how to build and sustain an infrastructure which will enhance statewide education, improve the delivery of mental health services, and increase outreach for individuals who are deaf, deaf-blind, and hard of hearing across the lifespan. This strategic planning initiative will complete a statewide work plan which will identify strategies and activities in order to create and sustain an infrastructure that will support enhanced delivery of mental health and substance abuse services statewide. The project's goal is to create an effective process for statewide education, delivery of services, and promote outreach by addressing how to build an integrated framework to meet the social and emotional/mental health and the physical health needs of persons who are deaf, hard of hearing, or deaf-blind across the life span.

A steering committee was convened in November 2010 and has been meeting monthly to work on the development. This initiative is supported through funding from the Mental Health Block grant. This is a combined effort on the part of staff from the DHS, Division of Long Term Care (DLTC), Office for the Deaf and Hard of Hearing and the Division of Mental Health and Substance Abuse Services (DMHSAS), Bureau of Prevention, Treatment and Recovery. A strategic plan is currently being drafted with input of 18 members who also represent the Department of Public Instruction (DPI) and their DPI /DHH workgroup, DHS, interpreters, schools, advocates, business, community, and health care staff with facilitation by Kris Freundlich from the DHS, Division of Enterprise Services. This Strategic Planning Initiative with Steering Committee guidance is leading to a one day Summit to be held in November 2011 or March 2012.

## Veterans' Mental Health Services

The DMHSAS continues its efforts to collaborate with the Veteran's Administration on increasing access to mental health services for veterans. The availability of mental health services for veterans is becoming a higher profile issue with the increasing number of soldiers returning home from Iraq and Afghanistan. In Madison, Wisconsin, the Veteran's Recovery Coordinator is active in the Recovery Implementation Task Force (RITF), as well as the Adult Quality Committee of the Mental Health Council. Also, a Peer Specialist provides support at the Veteran's Administration Community Support Program. An additional Peer Specialist from the Veteran's Administration is an active participant in the RITF. The emerging partnerships with the Madison Veteran's Administration have enhanced our statewide recovery network. Additionally, in January 2010, La Crosse County implemented a Veterans Court initiative to provide mentors who assist veterans in negotiating the legal system. The goal of the initiative is to produce better outcomes for veterans in the justice system by addressing mitigating mental health issues. Mentors discuss options regarding applications for veteran's benefits and refer the individual to the Veteran's Service Office for follow-up screening for potential mental health issues. The mentor program utilizes a "train the trainers" approach using experienced mentors to train newly recruited mentors. Veterans diagnosed with a mental illness and qualifying for Veteran's Administration benefits are candidates for the program. The courts may utilize the diagnosis and treatment for the veteran as a significant factor

when resolving cases. The initiative was designed by local veterans, mental health professionals, justice system representatives and other community stakeholders.

Wisconsin has hosted two summits on veterans and mental health as part of the Wisconsin Warrior Project: October 2009 in Milwaukee and June 2010, in Madison. The goal of the summits, which were coordinated by DryHootch, a veteran's peer support group, MHA, NAMI, DRW, the VA, the National Guard and many others, was to begin coordinating a comprehensive community response to the mental health needs of veterans and their families. Keynote speakers included veterans who shared there stories and perspectives regarding services and supports needed by individuals who have experienced traumatic events through combat or other military duty. Through breakout sessions the Summit informed mental health and substance abuse clinicians, veterans and their families, as well as the public on the needs of veterans and their families. The Summit also provided information on available treatment and support services in Wisconsin.

Much of the work Wisconsin has done regarding returning veterans has been based on Veteran's Administration (VA) data showing that only 25 percents of vets in the state use VA services. This has highlighted the need to reach out and educate civilian health, human and social service providers about the needs of vets and their families and the services available from the VA and National Guard. Mental Health America-WI (MHA-WI) worked with MCW, the VA in Madison, Marshfield Clinic and Aurora HealthCare on a grant proposal to try to identify the degree to which vets are accessing various parts of the health systems (e.g., primary care, behavioral health, emergency dept.). Unfortunately, the initiative was not funded.

More recently, the data in the Burden of Suicide in Wisconsin report, which was produced by MHA-WI, the Medical College of WI and the DHS in 2008, stimulated discussion at a Department of Veterans Affairs Board meeting. The report shows that 20 percent of suicides are identified as veterans, but very little is known about their military experiences. There may be some effort to link databases to learn more about what the combat experiences of these veterans were or relate to other data the military has that is not in the public health databases used to create the report.

In the wake of repeated military deployments and increased military involvement related to Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF), younger veterans (between age 18-34 years) had the highest firearm and total suicide rates. Younger veterans have had increased rates of suicide when compared to older veterans. Not directly related to suicide, recent studies show children of deployed military personnel have increased stress and anxiety, parent-child interaction problems, emotional and behavioral problems, as well as elevated levels of depression. Specific recommendations are included in the *Blue Ribbon Work Group on Suicide Prevention in the Veteran Population* suggesting a revision of the current approaches to suicide screening, establishing firearm safety programs for vets with children, encouraging training for implantation of suicide prevention programs, as well as outreach programs for vets and families.

Another finding from the Wisconsin National Guard is that most of the National Guard troops who have completed suicide in Wisconsin had never been on active duty. Thus, although it is widely thought that suicide by veterans is a response to the trauma of combat or issues upon return, the issue appears to be more complex.

An additional initiative through the DMHSAS is to continue to support joint planning to increase access to mental health services for veterans across the state through the use of tele-medicine. The Veteran's Administration is using video equipment for tele-medicine (or tele-health) to reach and serve veterans living around Wisconsin and in out state areas. The collaboration between counties and the VA will continue to focus on the set up of tele-medicine. The DMHSAS and Regional Area Administration

Offices of DHS are informing counties of the availability of these services and informing providers of the special needs of returning veterans.

## Adult Forensic Program Success

Often situated in a culture of poverty, social disenfranchisement, or racial/ethnic minority, the criminal justice system has many interfaces with persons with SMI or SED. Through the Wisconsin Department of Health Services' Conditional Release program, persons who have been adjudicated not guilty by reason of mental disease of defect have been afforded the opportunity to transition into the community under judicial authority. When mental health professionals can make appropriate arrangements for an individual who has been stabilized in the state institutes to be released under a Judges authority to community supervision, the individual can regain some of the natural supports of community living and save the state costs of confinement. Through the Conditional Release Program, many are able to reacclimatize to community living, securing supports and developing relationships with treatment providers before their commitment period expires. After the commitment expiration date, the individual can no longer be confined so it is optimal to have the person get established in the community under supervision beforehand.

The Conditional Release Program has funded, coordinated and administered quality forensic mental health services to 397 clients in FY 2010, with an average daily population of 269 clients. Community safety remains the programs first priority. FY 2010's revocation rate was 11% of the total population served (397) with a recidivism (new crime) rate of 1%. This year's measurable performance goals were identified as core program issues. Overall, outcomes were met or exceeded in these important areas. These goals also provided focus points for our community teams to set as priorities and engage the clients in during the year. For example, the lack of clients engaging in meaningful daily activities has consistently been identified as one of the elements present in clients use of alcohol and other drugs and as a factor leading to conditional release revocations. In the process of pursuing this goal of identifying and then increasing client activity meaningful to them, the case managers gained insight as to what a client's personal goals and desires were. This opened discussions with the team and the client as to what barriers existed to achieving those goals. Over the course of the year, the number of hour's clients engaged in these self identified activities steadily increased. Such client centered actions improve recovery outcomes and further the goal of positive community reintegration.

Of critical importance is the goal that clients are financially able to sustain their treatment, housing and medical needs by the time their legal commitment discharges. The DHS contracted providers have done an outstanding job in this area.

All of last year's measurable performance goals are continued into FY2011.
This is an exciting time in the field of community forensics. A number of evidence based practices offer new opportunities to improve the lives of this challenging population and bring an enhanced level of safety to our communities. Among the best practice initiatives the Conditional Release Program is pursuing in the coming fiscal year include:

- Piloting the Integrated Dual Disorder Treatment (IDDT) model for treating individuals with severe and persistent mental illness and co-occurring substance use disorders in Brown, Eau Claire, Marathon and Sheboygan Counties.
- Provide training opportunities and modeling to the Conditional Release Program case managers in Person Centered Planning.
- Engaging the Conditional Release Program case managers in the use of Motivational Interviewing techniques with follow up fidelity supervision.

- Integrating the Supported Employment evidence based practice model for clients to obtain competitive employment.
- Exploring the use of the Tobacco Recovery Across the Continuum (TRAC) model to assist the clientele in stopping smoking.
- Expanding the use of peer specialists in the Conditional Release Program.

State forensic programs serve persons who are to be assessed for competency to stand trial, who have been committed for treatment to competency, or were found by a court of law to be not guilty by reason of mental disease (NGI) or defect of a felony or misdemeanor. Individuals found NGI by a court may be placed directly into the community under Conditional Release or committed for institutional care. If committed for institutional care, the person may then petition for Conditional Release every six months. A Conditional Release requires community placement and mental health treatment with coordinated supervision by a contracted case manager and a Probation and Parole agent who has received training in mental health issues. The Conditional Release Program not only produces direct cost savings, but significant indirect cost savings and positive outcomes for the clients and society:

Over the past year only 1.9 percent committed a new crime (1.1 percent a non-violent offense and 0.8 percent a violent offense):

- Only 10 percent were revoked (versus 38 percent for similar individuals exiting corrections without this program);
- 33 percent achieved competitive employment; and
- 76 percent were living independently.

Progress has recently been made in reducing the size of the Forensic admission list to Mendota and Winnebago Mental Health Institutions. From a high of 30 or more at various times over the past year, the numbers have come down to a more manageable range of around ten. This has reduced the wait for any particular individual and there have been no complaints from the courts or jails. The Institutes have been doing a good job of arranging admissions as soon as a bed is vacated and the court liaison staff have been successful in getting hearings set for those restored to competency.

Managers of the State Department of Health Services, Division of Mental Health and Substance Abuse Services and Wisconsin's two mental health institutions have undertaken a series of strategic planning sessions over the fall/winter of 2009-10, designed to reflect the current state of Wisconsin's mental health delivery system and to plan for the future role of the institutions. One of the changes which will start on August 1, 2010 is the reorganization of a new 20 bed medium security male admission unit at Mendota Mental Health Institution. This new unit will be located in a space which is currently a vacant unit at the institution. It is anticipated that this unit will allow more flexibility in admitting new Forensic patients and should all but eliminate the current Forensic waiting list. Other strategic planning actions will focus on patients at both institutions who have successfully progressed through treatment levels and consider them for placement in current Forensic Transitional Unit (a minimum security community preparation unit). This will facilitate the overall patient flow through the institutions

Piloted in Milwaukee County in the fall of 2008, the Outpatient Competency Restoration Program has since expanded and restored defendants in 10 Wisconsin Counties. In fiscal year 2009, this program restored 16 defendants to competency in the community. The advantages of this program include avoiding major disruptions in the defendant's life by not having to go inpatient and helping to manage the high demands for inpatient beds at the mental health institutions. In addition to the defendants restored in the community, 9 DOC inmates who were committed for competency restoration based on crimes occurring while in prison were treated at the Wisconsin Resource Center. These individuals would

previously have had to come to an Institute bed. All of these factors have enabled the Department to manage the list effectively and to go into 2010 with a relatively small number of names on the waiting list.

The average length of time to restore to competency to proceed with a criminal case in the community is 124 days at a cost of $14,282 per person. The average length of time to restore to competency to proceed with a criminal case in a mental health institution is 86 days at a cost of $52,985. For the 16 defendants restored to competency in the community alone, this resulted in a saving to the state of $619,248 in GPR dollars.

The Wisconsin Resource Center serves persons in the Wisconsin prison system with a severe and persistent mental illness. These persons have been convicted, pled guilty or pled no contest to a crime and are serving a prison term. Those persons whose mental health needs cannot be met in the prison setting are transferred for specialized mental health services to the Wisconsin Resource Center. The Wisconsin Resource Center has also been able to take individuals within the corrections system who were committed for competency restoration based on crimes occurring while in prison. These individuals would previously have had to come to an Institute bed. All of these factors have enabled to Department to manage the list effectively and to go into 2011 with a relatively small number of names on the list.

The Sand Ridge Secure Treatment Center provides specialized treatment services for persons committed under Wisconsin's sexually violent person's law. This facility provides inpatient treatment in a secure setting and oversees the Supervised Release program whereby individuals committed under the law and are released by the courts, are placed in the community with intensive supervision and a full array of specialized treatment services.

The Department of Corrections estimates that approximately 20 percent of its inmates have serious and persistent mental illnesses requiring treatment. This has led to significant increases in the need for mental health and substance abuse staff including a new facility for women with serious and persistent mental illness. Persons with serious and persistent mental illness who are released from prison tend to return within the first two years; 56 percent are back in a correctional facility within five years. However, if adequate community treatment was provided, these numbers could be significantly reduced. This has been the experience with the DHS conditional release program that serves persons who have committed a crime but were found not guilty due to mental disease or defect.

The Becky Young Community Corrections appropriation was created in the 2009-11 biennial budget act, Act 28, along with statutory language (s. 301.068) to provide services to persons who are on probation, or who are soon to be or are currently on parole or extended supervision, following a felony conviction, in a effort to reduce recidivism. The provisions were adopted from recommendations by the Legislative Council's, Justice Reinvestment initiative Oversight Committee (JRIO Committee). The JRIO Committee worked with the Council of State Governments' Justice Center to review the state's criminal Justice trends and develop options related to correctional practices.

One of the Act 28 initiatives was for the Department of Corrections to partner with the Department of Health Services to work with offenders with serious and persistent mental health illness, being released to the community and who were identified to be at medium to high risk of being revoked or of committing a new crime.

Named Opening Avenues to Reentry Success (OARS), comprehensive pre-release services will be provided to inmates at the Wisconsin Resource Center and Taycheedah Correctional Institutions to facilitate their transition to the community. The target enrollment for the FY 2010 is 52 male offenders and 36 female offenders.

Based upon the DHS conditional release model, case management and mental health services will be provided to this population in concert with DOC community corrections agents and other treatment specialists. The OARS program goals are:

- To increase public safety by reducing revocation and recidivism rates
- To improve continuity of care and coordinated services for offenders releasing from prison to the community
- To enhance offender involvement in structured activities (employment, schooling, volunteer work, etc.)
- To promote offender self-sufficiency

The OARS program is currently offered to offenders releasing from WRC/TCI to one of the following counties: Adams, Calumet, Columbia, Dodge, Fond du Lac, Green Lake, Jefferson, Kenosha, Kewaunee, Manitowoc, Marquette, Milwaukee, Outagamie, Ozaukee, Portage, Racine, Sheboygan, Walworth, Washington, Waukesha, Waupaca, Waushara and Winnebago. The Department of Health Services is excited to be partnering with the Department of Corrections in working to reduce the revocation and re-offense rates of this population and look forward to reporting on the programs progress next year.

## Criminal Justice Committee of the Wisconsin Council on Mental Health

The Mental Health Criminal Justice Committee of the Wisconsin Council on Mental Health continues to facilitate coordination between the Department of Corrections, Department of Health Services, Division of Vocational Rehabilitation and the Social Security Administration by holding eight meetings per year involving key personnel from each agency. The Committee is addressing a broad spectrum of issues that are directed at: 1) diversion; 2) improving conditions of individuals with MI in our jails and prisons; and 3) significant re-entry issues that will assist them in successful re-entry back into our communities. Specific initiatives include:

- The Committee was instrumental in the creation of a Department of Corrections Administrative Directive establishing a benefits application process to expedite the availability of medical insurance and cash benefits shortly following release from the State prisons.
- A work group of the Committee collaborating closely with the Social Security Administration has modeled a system whereby Social Security knows everyone who receives Social Security Income benefits and is incarcerated in Wisconsin jails. This allows the benefits to be terminated so that the individual does not have a pay back problem. The model also included timely reinstatement of benefits upon release. Meetings were held across the state to spread the use of the model.
- The Committee recommended expanding the use of a successful “Conditional Release” program in use for “Not Guilty for Reason of Insanity” discharges from our State Mental Health Institutes. In the summer of 2010, the Opening Avenues to Re-entry Success (OARS) program was begun in pilot counties in the Fox Valley and Southeastern portion of Wisconsin. This program is a partnership between the Department of Corrections and the Department of Health Services and mirrors the Conditional Release program’s mental health service delivery system. Inmates are selected from the Wisconsin Resource Center and Taycheedah Correctional Institution, who have severe and persistent mental health issues, have been determined to be at a medium to high risk of revocation and who have reached their mandatory release dates from prison. 52 men and 36 women are enrolled in the first year of this pilot program. It is the expectation that the traditionally high rates of revocation of this population will be substantially reduced by this approach.
- The Committee is now seriously considering a state wide analysis of the gaps in mental health

treatment in our 60 some jails that are each administered by local sheriffs and administrators--each with their own individually developed policies. Wisconsin's jails have many of the same problems that were reported in an extensive study conducted in North Carolina. The Committee has studied the success of the Kentucky triage approach of providing professional mental heath guidance on demand from all State jails on a 24/7 basis through a centralized communications system.

- The Committee has just established an Employment Work Group dedicated to improving employment opportunities for persons with serious and persistent mental illness. The Work Group includes representation from the Department of Health Services, Division of Vocational Rehabilitation, Department of Workforce Development, Department of Corrections, DRW (Disability Rights Wisconsin--The federally funded disability advocacy agency in the State), GEP (Grassroots Empowerment Program--A statewide consumer-managed agency funded by the MHBG) and members of the State Mental Health Council. The Work Group goal is to coordinate all the disability employment programs in the state to maximize their effectiveness.

## Training for Local Law Enforcement

Even before arrest, law enforcement officers are being trained in Wisconsin to more effectively intervene with persons who have behavioral health conditions through the Crisis Intervention Training (CIT) initiative, the so-called *Memphis Model*. Spearheaded by NAMI-Fox Valley, over 1,000 officers have been trained in Wisconsin toward achieving optimal outcomes when law enforcement is interacting with a person with mental illness. A related training, Crisis Intervention Partner, is a two-day curriculum designed to help recognize and understand signs and symptoms of mental illness, such as depression, bipolar disorder, schizophrenia, and anxiety disorders, and also associated illnesses, such as dementia. It is a proven system of effective management of psychiatric crisis situations which emphasizes safety for those in correctional settings.

## Long-Term Care Infrastructures

Wisconsin has developed various infrastructures over the years to provide long-term care to persons who have disability or infirmities of aging. Presently, the long-term care arena in which to help frail elderly and physically or developmentally disabled with community living skills is largely under the *Family Care* program. Family Care provides long-term care services to Medicaid-eligible adults in a cost contained managed care environment. Family Care does not pay for inpatient hospital or physician services as those are handled as Medicaid card services. The Family Care benefit includes community mental health services including out patient mental health and Community Support Program services. Family Care Partnership and Program of All-Inclusive Care for Elders (PACE) provide all Medicaid services as well as all Medicare services for those who are Medicare eligible. A program related to Family Care is called IRIS or *Include, Respect, I Self-Direct.* IRIS is a home and community-based waiver program with a monthly allotment where the participant can use public funds and natural supports to craft their own support and service network. These programs are connected to Aging and Disability Resource Centers (ADRC), which is the entry point for a person who believes they may need supportive community services. Thirty five ADRCs serving 59 counties are located across the state in counties that provide Family Care. Data show that over half of those enrolled in Family Care also carry a mental health diagnosis.

## Children's Support and Treatment Structures

For youth, there are growing initiatives to assist children with behavioral health conditions. The Coordinated Services Team or CST initiative is designed to develop coordinated systems of care for children and adolescents with SED and their families requiring support from multiple community-based agencies. State awards give the county projects the capacity to provide the flexibility needed by both

children/adolescents and their families. Emphasis is on collaboration across the various systems serving children, creating a "systems change." The plan is for the county or tribe to establish strength-based system of care that supports children and adolescents along with their families, mental health, juvenile justice, and/or child welfare services. Wisconsin 2009 Act 334 allowed for the expansion of CST services to youth who were not diagnosed with an SED but who were involved in more than one system of care and had a risk of going into an out of home placement. Another promising approach for youth in Wisconsin is the Healthy Transitions Initiative (HTI). A strength-based, recovery-oriented, age- and culturally-appropriate project to support older youth and young adults with severe emotional and behavioral disorders who need additional time and support to make a positive transition into adult roles as caring, competent and contributing members of their communities. Statewide, the initiative endeavors to make this traditionally cumbersome transition between youth and adult mental health systems seamless. Project O'YEAH is a wraparound effort in Milwaukee helping youth make the transition to adulthood.

## Initiatives to Promote Infant and Early Childhood Mental Health

The vision of the *Wisconsin Alliance for Infant Mental Health* or *WI-AIMH*[5] is for every infant and young child in Wisconsin to have his or her social and emotional development needs met within the context of family, community, and culture. The DHS created an internal Infant and Early Childhood Mental Health Leadership Team (IMHLT) comprised of key staff from all DHS divisions to incorporate this vision in state training, policies, and practices which impact infants, toddlers and their families. They are working actively on a number of practice, policy, and training initiatives.

The current Leadership Team's goals fall under the major categories of: early identification of children's developmental delays through screening; utilizing the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, Revised (DC:0-3R) system; and disseminating early childhood mental health information to providers and other stake holders. Their recommendations include:

1. Early identification of social emotional delays in children under the age of five should be implemented through a universal screening protocol.
2. Utilization of DC:0-3R should be encouraged and monitored. Technical assistance should be provided based on data showing need for increased capacity or training, including need for training within state departments.
3. Information on early childhood mental health should be disseminated to mental health providers, early childhood workers, public policy makers and other stakeholders.
4. Infant and early childhood principles and practices should be integrated across Divisions in DHS as well as other Departments and stakeholders.

The Department of Health Services Infant Mental Health Leadership group has identified the use of the DC: 0-3R as a priority for mental health clinicians providing treatment to children under the age of four. In-service training is required to build the knowledge and skills needed to effectively provide clinical interventions with this population. Training in the use of DC: 0-3R is one step in building the needed knowledge and competencies. Statewide training of practitioners has occurred including development of a cadre of state DC: 0-3R trainers.

In working with Zero-To-Three on DC:0-3R training for Wisconsin trainers, the state has taken an important step in developing a much needed infrastructure to assure capacity to address mental health problems early, alleviating current distress and helping to restore young children to a healthy developmental trajectory.

[5] Wisconsin Alliance for Infant Mental Health Website: http://www.wiimh.org/

Another development in the area of prevention and early intervention initiative is already underway with respect to screening for behavioral health disorders among children in the child welfare system who are being considered for out of home placement. The *Child and Adolescent Needs and Strengths (CANS)* assessment tool is being used to assess children's level of behavioral health needs. The results are used to determine if the child is appropriate for an out-of-home placement and, if so, then the level of out-of-home placement is also determined. Children with high levels of behavioral health needs may be placed in an intensive inpatient or residential unit while children with lesser needs may be placed in regular or therapeutic foster care settings. The CANS tool is significantly improving the child welfare system's capabilities in identifying behavioral health needs so that service interventions may begin much earlier than in the past.

Wisconsin's Suicide Prevention initiative has had a specific focus on prevention of youth suicide and collaborated with community partners including the Department of Public Instruction (DPI), the Department of Children and Families (DCF), and the Division of Public Health. Although a large element of grant funding ended for this initiative, the work continues. Among other things, a number of school districts have established suicide prevention and post-vention protocols. Almost half of Wisconsin counties have Suicide Prevention Coalitions. Efforts have been branded "*Prevent Suicide Wisconsin.*[6]"

Another important development in Wisconsin with respect to prevention is legislation to prevent bullying by providing guidance to both private and public schools regarding the development of school safety plans and giving students and their families recourse for students who believe they have been bullied. Both of these latter two efforts would presumably have some impact on traditionally underserved or possibly at-risk groups (e.g., LGBTQ youth). The Positive Behavior and Supports Initiative (previously called the Seclusion and Restraint Reduction Initiative), focuses on reducing seclusion and restraint in children's community-based programs across the various divisions of DHS and DCF (Child Welfare). DHS has developed a policy that requires children's day treatment programs to report all incidents of seclusion and restraint within 24 hours. Data are collected and the Division of Mental Health and Substance Abuse (DMHSAS) follows up and visits agencies that have large numbers of reports providing technical assistance in contending with challenging behaviors. Positive Behavior Supports[7] is a related evidence-based practice to help children fare better in schools.

## Children's Long-Term Support (CLTS) Waivers

DHS received official notice of approval in December of 2003 for three children's home and community-based services waivers from the Centers for Medicare and Medicaid Services, the federal Medicaid agency. These waivers provide federal financial participation funds for all state and local funding for the services included in the waivers.

Children's Long-Term Support (CLTS) waivers address the needs of children age 17 and under who meet different federal target groups, including physical disabilities, severe emotional disturbance (SED) and developmental disabilities. [8] For children with SED, the eligibility age extends out to age 21. Aside from age and disability, the CLTS wavier requires that the child live at home but require services at the level of care typical to an intermediate care facility for the mentally retarded (ICF-MR), nursing home, or psychiatric hospital. Moreover, the cost of care under the waiver program must not exceed that which it would cost to provide services in such an institution. Each of the approved waivers provides community supports and services to children with significant disabilities and long-term support needs. The waivers offer services such as service coordination, supportive home care, respite care, specialized medical and

[6] Prevent Suicide Wisconsin Website: www.**preventsuicidewi**.org/

[7] Positive Behavior Supports Website: http://dpi.wi.gov/rti/pbis.html

[8] CLTS Waiver Webpage at DHS: http://www.dhs.wisconsin.gov/bdds/clts/index.htm

therapeutic supplies, and other supports for children. The waivers also include intensive in-home autism treatment services. The community supports available through the waiver are cost-effective and assure that children are at home with their families.

As of December 31, 2009, there were 848 children waiting for intensive in-home autism services through the CLTS Waivers. In 2009, numbers of children served who had the following disabilities include: developmental disabilities, 2,775; physical disabilities, 297; and severe emotional disturbances, 1,137. There are 1,377 children that transitioned from the intensive in-home autism services to the on-going services in the CLTS Waivers. There are 1,210 children receiving services through locally matched waivers, 50 children in pilot slots, 95 children in crisis slots and 629 children in special state-funded slots. As of October 31, 2010 there are 4956 children participating in the CLTS Waivers. The cost estimated to keep serving current children on waiver is $25.5 million in 2011 and $26.2 million in 2012. The autism waiver was expected to remain at $41.7 million per year in 11-13 biennium.

An initiative showing very good promise for mitigating disability of youth whose trajectory is into the adult mental health system is the youth initiative of the PACT program. PACT is admitting youth before their 18th birthday in an effort to help them achieve mental stability and to complete school and obtain employment. Results of this effort in the first number of years of operation are very encouraging and may serve as another PACT-inspired national model.

## Expanding the Range of Medicaid Benefits in Wisconsin

Tandem efforts between Medicaid and administrative program rules, have made Wisconsin an environment where there are currently fairly good number of both Medicaid programs to help poor and disabled people secure needed health insurance and providing the kinds of service programs to allow them to remain or return to the community. In the realm of Medicaid, the State plan includes several ways for people to enroll into Medicaid benefits. Aside from the standard card eligibility there are also programs for low income families and more recently programs for low income childless adults. There are also programs for disabled people who would like to return to work but not lose their Medicaid benefits as a result. The Medicaid Purchase Program or MAPP allows people to work and pay a Medicaid premium fairly commensurate with their earnings (at least until they approach coming off of benefits entirely). These programs (described in Criterion 1 of this plan) are some of the ways individuals can obtain health insurance coverage.

Medicaid SSI Managed Care involves individuals who are at least age 19 who receive Medicaid or Medical Assistance (MA) and SSI or receive SSI-related MA due to a disability and who do not live in an institution or nursing home and who do not participate in a home or community based waiver program. There is a requirement that for all MA-only eligible individuals who live in counties with two or more Health Maintenance Organizations (HMO) to remain in an HMO of their choice for a minimum of 60 days. Should the individual choose to opt out of the HMO, the member may opt out within the first four months or after 12 months of enrolment. In counties with only one HMO, the individual with MA-only is automatically assigned to the HMO if the individual does not make an active choice not to enroll within the initial six week enrollment period. Within the first 90 days of assignment to the HMO, the individual can opt out and return to fee for service (FFS) benefits. After 90 days, the individual must remain in the HMO through the balance of the year. The SSI Managed Care initiative was designed to contain costs and to provide better continuity of care. Most enrollees are satisfied with their HMO and choose not to disenroll.

## Service Continuum for Mental Health Treatment Services

Within Wisconsin there has been an array of services that have developed to meet the needs of persons with behavioral health disorders. Originally there was a large divide between mental health and substance

use treatment programs. With the evolving service system, various programs are not only expected to treat persons with co-ocurring disorders but are progressively more skilled at doing so. One of the original programs was the outpatient mental health program which is designed as a Medicaid reimbursed clinic where a person can see a psychotherapist and or psychiatrist or nurse prescriber. Other models, not as prominent in the current day is the Medical Day Treatment model where the individual with a mental illness can receive day treatment or what used to be referred to as "day hospital" services. Targeted Case Management (TCM) services can provide assessment, planning and brokered service coordination for adults with disability. More continuous or intensive service systems include the Community Support Program (CSP) model for persons with serious and persistent mental illness, the more recent and comprehensive version of which was codified in 1989 and loosely modeled on the original PACT model, but without the high fidelity requirements. Subsequently the Comprehensive Community Services (CCS) rule was published in 2005, allowing for a more flexibly arranged continuum of services for a broader diagnostic population than CSP's serve. CCS services are available not only for adults and seniors, but also for children. Twenty percent of CCS clients in 2009 were under the age of 18. The Crisis Intervention Standard or "Emergency Mental Health Service Program" developed standards under *DHS-34, Subchapter III* to allow for service reimbursement under Wisconsin Medicaid in 2006[9], crisis stabilization and crisis residential stabilization services. A minority of Crisis Intervention programs also have the capacity to provide reimbursable *tele-health* services, breaking down the geographic confines of office-based or limited mobile Crisis services. Many of the counties in Wisconsin have both a CSP and Crisis Intervention program. Some also have a Comprehensive Community Support (CCS) program. The outpatient rule was revised (2009) to allow for more flexibly rendered services and most recently licensed psychotherapists can now practice independently. In 2010, Community Recovery Services (CRS) was approved for a Medicaid Home and Community Services State Plan Amendment under the 1915i authority which supports three services: supported employment, peer specialist and community living supportive services. CRS is an option for adults with SMI . Under CRS Supported Housing may be provided in several licensed community settings.

Tele-health services in Wisconsin have been available through a state certification process since 2004. Currently 31 counties have public agencies, public/private hospitals, or clinics that are certified to provide MH/SA services via tele-health as part of their certification for other specific MH/SA services, i.e., outpatient, CSP, CCS, Crisis, etc. Twenty-one of these counties are in primarily rural areas. Training and technical assistance has been provided primarily by qualified staff at Marshfield Clinic at specific agencies as well as at state conferences.

## Community Recovery Services (CRS)—1915(i) State Plan Amendment

Wisconsin filed a State Plan Amendment (SPA) with the Centers for Medicare and Medicaid Services (CMS) in November of 2009. The plan was approved by CMS on June 2, 2010. The application covered psychosocial rehabilitation services for adults and children with serious and persistent mental illness living in a community setting (i.e., home, adult family home, a community based residential facility, or residential care apartments; not an institution). The services provided to Medicaid members through the CRS Medicaid benefit are done so via contracts between certified counties/tribes and local service providers. Infrequently, a county or tribe may provide one or more of the services directly. Eligibility requires that the consumer have a diagnosis of mood disorder, schizophrenia, or other psychotic disorder in combination with a functional need for community assistance. Eligibility for the CRS State plan HCBS benefit is determined through an independent evaluation of each individual according to the requirements of 42 CFR §441.556(a)(1) through (5). During calendar year 2010, twelve Wisconsin counties were actively participating and submitting CRS service plan packets. A total of 87 participants were receiving services. Out of the 87 participants, 85 were receiving Community Living Supportive Services, 3 were receiving Peer Support Services, and 5 receiving Supported Employment Services.

[9] *Wisconsin Medicaid Update:* https://www.forwardhealth.wi.gov/kw/pdf/2006-55.pdf

Wisconsin's CRS benefit expects recovery-oriented, outcome-based services that are individualized based on the needs identified through the comprehensive assessment and person-centered planning process. Three services are provided through the CRS initiative:

1) Community Living Supportive Services (CLSS) covering services necessary to allow individuals to live with maximum independence in community integrated housing including skill training, cuing and/or supervision as identified by the person-centered assessment.
2) Supported Employment Services includes services necessary to assist individuals to obtain and maintain competitive employment using Individual Placement and Support (IPS) model recognized by SAMHSA as an evidence-based practice.
3) Peer Support Services utilizing individuals trained and certified as Peer Specialists to serve as advocates, provide information and peer support for consumers in outpatient and other community settings. Certified Peer Specialists perform a wide range of tasks to assist consumers in regaining control over their own lives and over their own recovery process.

Passage of the Patient Protection and Affordable Care Act of 2010 (ACA) had a substantial impact on the state's ability to implement the CRS Medicaid benefit. The ACA added two requirements to section 1915(i), the first eliminated the ability for states to utilize waitlists to control the number of consumers who are allowed to enroll in the benefit. Waitlists were an important feature of CRS, and served to safeguard the financial interests of the certified counties (who must provide the non-federal match). The second requirement was that the benefit must be provided statewide, whereas before counties could "opt in". These changes necessitated resubmitting the 1915(i) State Plan Amendment effective 10/01/10. In addition, the elimination of waitlists caused numerous counties who had previously expressed interest in CRS to discontinue plans to implement the benefit. In order to assist the localities with implementation, the DHS responded by enacting more stringent functional criteria. However, local concerns ought to be mitigated by preliminary financial data showing that the benefit has proved cost-effective for those counties who have implemented CRS.

**Fact Sheet**

**Publicly-supported Clients Served:**
57,663 in CY 2009

**Primary substance:**

| | |
|---|---|
| Alcohol | 69% |
| Marijuana | 14% |
| Opiates | 9% |
| Cocaine | 6% |
| Stimulants | 1% |
| Other | <1% |

**Gender:**

| | |
|---|---|
| Male | 71% |
| Female | 29% |

**Age:**

| | |
|---|---|
| Under 18 | 3% |
| 18 – 29 | 38% |
| 30 – 39 | 23% |
| 40 – 49 | 23% |
| 50 – 59 | 11% |
| Over 59 | 2% |

**Race/ethnicity:**

| | |
|---|---|
| White | 82% |
| Black | 11% |
| Hispanic | 5% |
| Amer. Indian | 2% |
| Asian | <1% |

**Treatment modality:** (n=34,485)

| | |
|---|---|
| Outpatient | 62% |
| Detox | 24% |
| Residential-long | 6% |
| Day Treatment | 4% |
| Residential-short | 3% |
| Inpatient | 1% |

## Substance Abuse Services

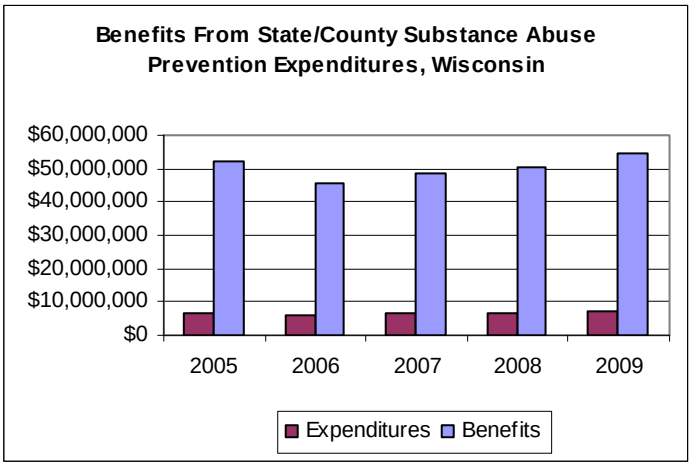
Wisconsin is one of the states with the highest prevalence of alcohol use in the United States. As of 2008, current use of alcohol use and misuse among adults is among the highest—if not the highest-- in the country. Wisconsin rates of underage drinking (ages 12-20) exceed national levels. Based on combined data for the years 2004-2006, Wisconsin has the highest prevalence of self-reported drinking and driving of any state in the nation. An estimated 26 percent of current drivers age 18 and older in Wisconsin drove under the influence of alcohol in the past 12 months. This was markedly higher than the percentage among all current drivers in the nation (15 percent). Data for the years 2001-2008 consistently show that Wisconsin women of childbearing age are more likely to drink—and to binge drink—than their national counterparts. This has important implications for unplanned pregnancy and infant health. As a whole, consumption patterns of illicit drugs in Wisconsin mirrored national trends with few exceptions.

Perhaps the best synopsis of the Wisconsin's substance abuse services is the annual report to the Governor: *Substance Abuse Services in Wisconsin: 2009 Annual Report to the Governor.* During 2009, substance abuse services were provided to individuals, families and communities who were affected by the consequences of the use of alcohol and drugs. DMHSAS is the lead state agency in assessing the capability, needs and resources of the state's current drug and alcohol services system. DMHSAS oversees Wisconsin's Administrative Code DHS 75 and 62 (which contain the requirements and standards for treatment services and the intoxicated driver program respectively), provides prevention and grant specific programming, and offers information, conference opportunities and teleconference training

DHS is designated by the Governor to administer and manage the $27 million federal Substance Abuse Prevention and Treatment (SAPT) Block Grant. DHS delegates DMHSAS the responsibility for program oversight and partnership with County departments of human services or community programs. DMHSAS provides staff services to the State Council on Alcohol and Other Drug Abuse, a Governor appointed Committee responsible for promoting effective alcohol and drug abuse policies. This report describes the principal community substance abuse prevention and treatment programs administered by the DMHSAS and funded with State and federal funds. DHS prepares and submits this report under Section 51.45(4) (p), Wisconsin Statutes.

## Substance Abuse Prevention and Treatment are a Good Investment of Public Funds

Twenty-one substance abuse treatment and fourteen substance abuse prevention cost-benefit studies were analyzed to arrive at average cost-benefit ratios (references available upon request). For each public dollar invested in substance abuse treatment, there is an average benefit of $6.35 realized from increased employment income, reduced health care costs and reduced crime costs. For each public dollar invested in substance abuse prevention, there is an average benefit of $7.65 realized in reduced health care and social services, reduced public assistance, reduced crime and increased potential earnings. As the graph depicts, over the past five years, the State of Wisconsin and its Counties have achieved over $2 billion in benefits for its $320 million public investment in substance abuse prevention and treatment.




*Prevention -- Parents Who Host Lose the Most.* The "Parents Who Host Lose the Most: Don't Be a Party to Teenage Drinking" campaign in Wisconsin is a unique collaboration of seven state agencies and state programs, working together with local coalitions, to increase parental awareness of the legal and health consequences of hosting underage drinking parties. The program was created by the Ohio Drug Free Action Alliance in 2001, granted "Promising Practice" status by the Federal Substance Abuse and Mental Health Services Administration in 2002, and has since been used in 49 states to reduce both commercial and noncommercial access to alcohol by teens.

The program aims to educate parents and other adults about the health, safety, and legal risks of serving alcohol at teen parties. The campaign in Wisconsin has increased awareness of compliance with Wisconsin underage drinking laws with the goal of reducing youth access to alcohol. The first statewide

campaign efforts in 2009 aimed to involve a minimum of 15 communities, and that Spring more than 55 communities participated. The campaign continues to grow and attract attention throughout the state.

*Treatment -- Strengthening Treatment Access and Retention – State Implementation (STAR-SI).* The STAR-SI program promotes implementation of Plan-Do-Study-Act quality improvement (QI) projects to improve access to and retention in substance abuse treatment. DHS is working with the University of Wisconsin and 40 Wisconsin treatment centers to increase admissions, reduce appointment no-shows, reduce waiting times, and increase successful treatment completion. Since the program's inception, waiting times have been reduced from an average of 25 days to 15 days and higher than average treatment completion rates have been achieved – 12 percentage points above the average. The following is a description of one of the 40 local QI projects. Genesis Behavioral Services, West Bend, provides a variety of outpatient substance abuse services for the residents of Washington County. After attending a STAR-SI-sponsored Motivational Interviewing (MI) training, they decided to implement MI for staff who make client appointments in an effort to reduce waiting times and increase intake appointment attendance. Part of the MI script used when speaking with clients was to offer clients the next available appointment slot instead of "whenever it's convenient." As a result, wait times declined from 13 days to 5 days and intake appointment attendance increased from 81% to 94%! Clients too were happier because they were getting the services they needed in a more timely fashion.

*Recovery -- Alliance for Recovery Advocates (AFRA).* AFRA is a statewide, consumer-driven, grassroots advocacy and support organization. AFRA includes people in the recovery community and allies of people in long term recovery. It is expected that a broad range of services will be made available to build and mobilize strong grassroots recovery organizations across the state. Wisconsin Association on Alcohol and Other Drug Abuse (WAAODA) was the successful vendor of the AFRA Grant and will ensure the following:

- Create a statewide advocacy and advisory board called the Alliance for Recovery Advocates that would bring together men and women group members of diverse backgrounds, family members, supporters, and allies. The AFRA Advisory Board should be broadly representative of the recovery communities across Wisconsin.
- Create a self-sustaining, statewide consumer driven organization.
- Establish and maintain a strong affiliation with the National Faces & Voices of Recovery organization.
- Carry a strong message of hope to all affected by addiction that recovery is real.
- Ensure that AFRA has a presence and coordinates recovery activities in both urban and rural areas of the state.
- Organize and coordinate support and resources for the September Recovery Month activities occurring throughout the state.

*Wisconsin Wins.* Wisconsin Wins is a science-based, statewide initiative designed to decrease youth access to tobacco products through state-wide compliance checks and is part of a comprehensive approach to preventing youth retail access to tobacco. States must conduct an annual survey to gauge success in meeting target goals for a reduction in such sales. Failure to meet annual target retailer violation rates (RVR) or to enforce the statute restricting tobacco sales to minors could result in a significant penalty to the state by reduction of 40 percent of the annual Substance Abuse Prevention and Treatment Block Grant.

**Retail Cigarette Sales to Minors: Non-Compliance Rates**

| Year | RVR |
|---|---|
| 2001 | 33.7% |
| 2002 | 20.7% |
| 2003 | 18.5% |
| 2004 | 8.3% |
| 2005 | 7.8% |
| 2006 | 5.5% |
| 2007 | 4.5% |
| 2008 | 7.2% |
| 2009 | 5.7% |

As the chart above illustrates, Wisconsin Wins was implemented in 2001 in response to a reported RVR of 33.7% which put Wisconsin out of compliance by 11.7%. At risk of losing $10 million, the state implemented the Wisconsin Wins campaign. Since that time Wisconsin has seen a steadily declining RVR. In 2009, Wisconsin achieved a rate of 5.7%.

## State-County Partnerships to Ensure Substance Abuse Services at the Community Level

*State Aids to Counties.* The total number of persons served statewide under DHS' substance abuse treatment services program for the most recent three-year period available were 60,935, 56,110 and 57,663 for 2007, 2008 and 2009 respectively. In 2007, 2008, and 2009 expenditures from all sources (including state aids, federal Substance Abuse Prevention and Treatment Block Grant, county match, and private sources) reported by county agencies totaled $74,419,803, $74,451,803 and $81,449,664 respectively. In 2009, Human Services Reporting System (HSRS) data indicated that 49 percent of consumers successfully completed treatment, 68 percent were abstinent from alcohol and drugs at the time of discharge, 49 percent were employed at the time of discharge, and 96% had not been arrested in the 30 days prior to discharge.

*Intoxicated Driver Program.* Since its enactment by the Legislature in 1982, DHS in partnership with the Department of Transportation (DOT), county agencies, law enforcement, vocational-technical schools, and local treatment centers, has reduced alcohol-related traffic crashes, injuries and deaths. In 2009, over 35,000 adjudicated intoxicated drivers received assessments of their alcohol and other drug use under this program. Of these, 17,200 received substance abuse treatment services from community programs. Data reported by the DOT show that 69 percent of convicted drivers complete their treatment-oriented driver safety plan and 86 percent do not re-offend during the five years following their arrest. The Intoxicated Driver Program is one of the Department's most successful programs of intervention and treatment for substance use disorders.

## Federal Discretionary Grant Awards to Improve the Service System

*Prevention - Strategic Prevention Framework Special Incentive Grant.* In September, 2006, Wisconsin was awarded a five year Strategic Prevention Framework State Incentive Grant (SPF SIG) of $2.1 million per year from the Substance Abuse and Mental Health Services Administration, (SAMHSA). Wisconsin's SPF SIG seeks to build state and local infrastructure to reduce 1) underage drinking among individuals between the ages of 12 – 21; 2) young adult binge drinking among individuals between the ages of 18 – 25; 3) alcohol related motor vehicle fatalities and injuries among individuals between the ages of 16-34; and build prevention capacity at all levels. Annually, $1.8 million in funding was awarded to 20 community coalitions who were selected using a competitive request for proposals process. Successful applicants are required to use a data-driven, evidence-based, collaborative, and culturally competent approach to address one of Wisconsin's three priority areas. During 2009, the rate of youth heavy-episodic drinking in Wisconsin (24%) fell below the United States average (25%). Over half a million Wisconsin children and adults received some form of substance abuse prevention awareness, education or other activity and 93% of Wisconsin youth reported hearing, reading or watching an advertisement about the prevention of alcohol/drug use.

*Intervention - Screening, Brief Intervention, and Referral to Treatment (SBIRT).* SBIRT is an evidence-based and cost-saving approach to addressing Wisconsin residents' use of alcohol and drugs. Based on a 5 year SAMHSA grant, the Wisconsin Initiative to Promote Healthy Lifestyles (WIPHL; http://www.wiphl.com/) is implementing SBIRT services in selected health care clinics across Wisconsin. As of December 2009 (Year 3 of the grant), WIPHL and its clinic partners conducted 76,980 brief screens, 14,826 brief interventions, made 323 referrals to treatment, and saw 116 patients receive treatment. Preliminary outcome data reported by the UW Population Health Institute shows substantial

reductions in alcohol use (20% for women, 15% for men) for those who received SBIRT services. Reductions in alcohol use are associated with improved public health and safety, worker productivity, and reduced healthcare costs.

Since March 2007, the service has been offered to all patients 18 and older in participating primary care settings. Since January 2010, Medicaid, BadgerCare, and BadgerCare Plus reimburse for SBIRT services.

- A Brief Screen, consisting of four brief questions on alcohol and drug use and additional questions on other health behaviors, is administered to each patient once a year as part of any health care visit. The screen identifies people who are at risk for alcohol and drug abuse even at an early stage.
- Patients who score positive meet with on-site health educators—who are trained and supported by WIPHL—to discuss their drinking or drug use and agree upon changes.
- This brief intervention consists of one to three consultations taking about 20 minutes each. For many patients, that service is enough to help them significantly decrease their alcohol and drug use, studies show.
- The health educator and patient may agree that a referral to treatment for more intensive care—outpatient or residential—is needed. Costs for treatment may be covered by WIPHL.
- WIPHL serves patients from a range of ethnic and socioeconomic backgrounds. Health educators are trained in cultural competence.
- The program uses motivational interviewing, in which patients are helped to identify and strengthen their own motivations for change. Counseling is nonjudgmental and respectful of the patient's own degree of interest and readiness.

WIPHL staff have also obtained funding to research providing depression screening in primary care and offering motivational interviewing for those patients identified as at risk for depression and to refer for treatment services as appropriate.

*Treatment and Recovery - Access to Recovery, Milwaukee.* Wisconsin received in 2004 the first round of federal grant awards for Access to Recovery (ATR) for the creation of a voucher based system for substance abuse treatment. The program, named WIser Choice, offers every participant, after a full assessment, choices for providers and recovery support services. Wisconsin also competed successfully for ATR II and received a new grant for an additional three years. Federal ATR grants for round 2 will end September 30, 2010. Wisconsin has now received notice that it has successfully competed for an ATR III grant beginning September 30, 2010. ATR III will expand Wiser Choice beyond Milwaukee to additional counties in the SE region and focus on the National Guard personnel returning from overseas duty.

ATR II funding totals $4,830,000 for each of three years. ATR III is for $3.3 million for each of four years. The program is located in Milwaukee County with a focus on treating individuals re-entering the community from the Correctional system. Milwaukee braids the funding for the program with other sources including federal block grant funds, TANF funds, community aids and tax levy. The program is a major success and model for other states. Over 3,000 individuals each year are assessed, enter into treatment and receive recovery support services such as transportation, child care, peer support, and temporary housing. The program involves 125 providers in Milwaukee including approximately 30 faith based organizations. The program has demonstrated that for those individuals completing treatment, compared to those who do not receive or complete treatment, there is a much lower probability of committing a new crime or being revoked while on parole. There is also a greater likelihood of finding employment and housing stability. Since the inception of ATR/Wiser Choice, Milwaukee has also seen

an increase in the number and percentage of individuals successfully completing treatment which is often the necessary condition for achieving other positive outcomes.

*Summary*. During 2009, a reduction in State revenues presented a challenge for some treatment providers. County human services departments and service providers responded by planning and allocating resources to their public service priorities. While difficult to project, publicly supported substance abuse services may still experience an impact due to the economy. DHS recognizes the importance of its partnership with County Departments of Human Services and Community Programs and their providers and will continue to support them with resources available. In 2009 the Department examined numerous studies that analyzed the financial benefits achieved from substance abuse prevention and treatment. Over the past five years, Wisconsin has realized over $2 billion in benefits for its $320 million public investment in substance abuse prevention and treatment. DHS also documented the most pressing substance abuse issues for planning purposes by the completion of a comprehensive Epidemiological Study which will be updated every two years. In large numbers, consumers of substance abuse services are completing treatment, abstaining from alcohol and drugs, becoming employed and not reoffending. Access to tobacco products among adolescents remains low, alcohol/drug abuse screening is occurring at more and more health care providers, prevention initiatives are reaching more areas of the state, improved service quality spreads and several legislative initiatives are slated to do even more. Looking to the future, DHS will continue to strive to assure that mental illness and addiction are recognized as important health issues. DHS will support the principles of investing in outcomes, changing attitudes, building partnerships, committing to quality, and working on a common goal that emphasizes prevention and assures access to individualized treatment and recovery services across the state.

## Services For Persons With Co-Occurring Substance Abuse/Mental Health Disorders

DMHSAS is focusing efforts to provide increased education and outreach to providers on best-practice integrated treatment services. The sixth DMHSAS-sponsored conference on integrated services was held in fall 2010. All of the DMHSAS conferences since 2005 have had a track for professional development in integrated services. Many county agencies are encouraging their mental health staff to obtain the substance abuse counselor specialty for community services and the Department of Regulation and Licensing and DMHSAS are working together to promote training for the specialty that is accessible and flexible. The CCS benefit was designed to provide integrated mental health and substance abuse services. County programs are just beginning to focus on developing their substance abuse services array.

## Administrative Code Regarding Dual Diagnosis Services

DHS 75 is the Administrative Code for Community Substance Abuse Services Standards in Wisconsin. These standards address concurrent treatment of both mental health and substance use disorders. The code language states: “If a counselor identifies symptoms of a mental health disorder and trauma in the assessment process, the service shall refer the individual for a mental health assessment conducted by a mental health professional.” In addition, the code provides that: “A mental health professional shall be available either as an employee of the service or through a written agreement to provide joint and concurrent services for the treatment of dually diagnosed patients.”

In 2010, the percentage of adults with an SMI served by the State Mental Health Authority (SMHA) who also have a diagnosis of substance abuse was 17 percent. In the same year, the percentage of children with an SED served by the SMHA who also had a diagnosis of substance abuse was 3 percent. These individuals are served through the county mental health system and tracked through the Human Services Reporting System (HSRS), therefore are only the proportion of individuals with dual diagnoses served through the state.

# 2. Weaknesses

## Local System Differences

Wisconsin's county-based mental health system not only allows for local control it leads to wide regional variations in how services are available and accessed around the state. Counties with a larger population have a greater economy of scale for the provision of services. Accordingly, larger counties have more challenges in terms of numbers of people to be served. Essentially, although counties with larger populations can establish service structures, the greater numbers of consumers in need may not be able to access those service systems. Conversely, smaller counties are often unable to establish more comprehensive service structures. Setting up a CSP, Crisis Intervention, CCS, etc. can be costly in terms of infrastructure. Yet, a single high cost consumer in a smaller system can usurp a county's mental health budget in short time owing to a smaller risk pool. Counties are responsible for paying for most of the costs associated with hospitalization at the state mental health institutes, which are classified as institutes for mental disease (or IMDs). Therefore hospitalization for a person between the ages of 22 and 64 can cost upwards of $900 per day at one of the institutes. Owing to smaller service structures, meeting the diversity of needs can also be a challenge for counties with smaller populations. Particularly when it comes to individuals who have multiple service needs, it can be quite challenging for smaller counties not only to have services available but also funds to pay for those services. Not infrequently smaller more rural counties are geographically set apart from population centers where specialized services are available. For example, the two Veteran's Administration (VA) hospitals are located in Milwaukee and Madison. A consumer in a north-central county can have trouble connecting with services through the VA. But perhaps one of the more challenging factors is the funding for services. With the FMAP and local match requirements it can be viewed as particularly burdensome to a smaller county to consider another program which requires a local contribution.

## Strained Service Capacity—Particularly in Rural Counties

In an era of economic challenges and budget reductions it is increasingly difficult to meet the growing fiscal challenges in a County-based system. The Wisconsin Legislature in the upcoming 2012-13 Biennial Budget has included additional general purpose revenue (GPR) funding for Medicaid and other low income insurance programs. However, due to the serious nature of the state's budget challenges and the phase out of federal support, Wisconsin's health care programs will face budget reductions. State aids to localities are being reduced by about 10 percent, making it even more difficult to meet the growing demands at the local level. In the rural sector, provider challenges are quite pronounced. Two areas have been especially acute in all areas of the state but are most stark in outlying areas. A lack of psychiatry—particularly for child and adolescent specialty—and dental services makes it very challenging to obtain services. With respect to psychiatry, it is a matter of shortage of practitioners generally and the fact that the too few providers that are practicing in Wisconsin tend to be in the rural areas. Complicating the situation was the departure of the consultation psychiatrist from the Bureau of Prevention, Treatment and Recovery (BPTR). The Bureau is still attempting to fill the vacancy.

Minority and special at-risk populations tend to be disproportionately underserved generally, but in smaller communities the problem is more pronounced. Again economies of scale and availability of services and providers in smaller communities is more challenging, unless there is a concentration of individuals with similar needs in a given community (e.g., more deaf in the vicinity of Delavan where the Wisconsin School for the Deaf is; blind in Janesville where the residential blind school is located; Menominee where there are a large number of Native Americans; or Milwaukee and Racine where there are larger concentrations of African Americans). On the other hand, obtaining behavioral health services for the deaf in Menomonee might be more challenging.

## Prevention and Early Intervention

Prevention services are another area where Wisconsin needs to focus energies. In the area of suicide, Wisconsin has a higher than national average suicide rate at about 13/100,000. An upward trend in suicide deaths was turned back slightly in the last year of reporting, but efforts must continue. Being a gun and hunting state, many households have ready access to lethal means. New efforts at concealed carry legislation may lead to an even greater proliferation of firearms. Collection programs for old prescription drugs vary from community to community. Some communities have drop boxes that can be used year round. Other communities have drug *round-up* days once or twice a year. Wisconsin's suicide prevention plan is outdated, having been created for the first and last time in 2002.

Prevention and early intervention activities in the areas of contagious disease among behavioral health populations need to be increased as well. Similarly efforts at controlling preventable disease that are diet and behavior related are in need of more attention within behavioral health populations. Smoking and alcohol reduction and prevention efforts are in need of more robust efforts. Wisconsin has a high alcohol use rate and perhaps the highest binge drinking rate in the country. Obesity, type-II diabetes and metabolic syndrome are big problems in the behavioral health population as well. At the younger spectrum, children who are under the age of five are not well-understood in terms of their behavioral health needs and risks However, helping parents to manage stress and their own behavioral health needs is known to have a positive impact on children.

## Infrastructure Needs—Deficits in Home, Health, Purpose, and Community

Better infrastructures for meeting needs of specialty populations are needed. Despite some services in place for persons who are homeless and have a mental illness, there are still considerable gaps in securing housing and treatment for this most disenfranchised population. Despite efforts to divert persons with mental illness from incarceration in the criminal justice system, the fact remains that there are disproportionately large numbers of people with behavioral health conditions in jails and prisons. The fact that Wisconsin has only one specialty mental health court attests to failing diversion efforts. Provision of screening, assessment, and treatment service in correctional settings is highly variable in local jails and is most often inadequate. Services in prisons are needing improvement[10]. In both prisons and jails, pre-release planning and linkage for treatment of behavioral health needs and application for initiating or reinstating Social Security or SSI benefits along with related health insurance coverage is lacking, despite protocols being in place advocacy efforts of people knowledgeable in both corrections and Social Security.

Services to seniors is another infrastructure need in Wisconsin as the *age wave* continues to gather around an ill-prepared behavioral health system. Age appropriate screening, assessment, and treatment services are needed for senior citizens with life long or late-life behavioral health disorders. Moreover, seniors with neurological disorders such as dementia often enter the behavioral health system. Appropriate diagnostic and treatment services for dementia, delirium or pseudo-dementia are often lacking. Inadequate bi-directional interconnections between primary medical settings and behavioral health settings complicate the situation for seniors as well as anyone with a more complex health situation.

[10] Seriously Mentally Ill Individuals in Jail. (Steadman, H., Osher, F., et. al. Prevalence of Serious Mental Illness Among Jail Inmates, *Psychiatric Services*, vol 60(6), 2009.). Evidence indicates that a substantial percentage of persons in prisons and jails have a serious mental illness, perhaps 20 percent of those in prison. A recent study showed that almost 15 percent of males and 31 percent of females in jails had a serious mental illness. Data from Kevin Kallas, M.D. (per Marty Ordinans 05/04/2011) indicate that 35 percent of prison inmates are considered on the mental health caseload and 18 percent of the prison population are on psychotropic medication. Of the 35 percent who have a mental illness, 10 percent are considered to have a serious mental illness. They do not presently have a database that allows for statistical information regarding diagnosis.

Failure to attend the needs of elderly people in a proactive manner often leads to a potentially avoidable hospitalization or inappropriate detention in a psychiatric hospital or state institute.

Previous and current efforts notwithstanding, infrastructures to support successful education and employment for recovering individuals with behavioral health conditions are inadequate. Far too often individuals with behavioral health disorders are without purposeful activity in the community.

Lastly, Wisconsin has needs in terms of meeting the needs of special at-risk populations generally. Wisconsin has to do a better job of connecting with the key stakeholders and consumers for a variety of these populations toward identification of relative strengths and weaknesses and related needs and approaches to address behavioral health concerns around prevention, early intervention, and treatment and recovery. Tribes, ethnic and racial minorities, LGBTQ, physically disabled, deaf and hard of hearing, military families, intravenous drug users parents with mental illness, etc. all need to be better connected to DMHSAS and other groups. Despite anti-stigma efforts from many sectors, the issue of stigma persists in Wisconsin. As recently as February 2011, there was a prominently publicized account of a high school dance troupe putting on a routine called, "we get crazy" routine where the dancers were wearing wild grotesque make-up and wearing what appeared to be straight jackets with bold print of "Psych Ward"[11] However, advocates were able to use it as a platform for disseminating more accurate information about behavioral health disorders.

## Data, Performance Measures, and Quality Improvement

Measuring effectiveness of services in Wisconsin with the outdated data systems remains challenging. Efforts are underway to upgrade systems with the Data Infrastructure Grant (DIG), but presently it is difficult to have an up to date comprehensive picture of needs, services, and opportunities throughout the state. Perennial issues of Wisconsin's data through NOMS not reflecting consumers served outside of the county-based system persist. The outdated Human Services Reporting System (HSRS) is being replaced by a system that allows either uploaded data or direct web-entered data. The new data system encourages county providers to record state and federal mental health data in their own local information systems as opposed to recording data in State data entry screens only. The data can then be transferred from the provider's local information system to the State. For counties and contracted providers who do not initially have the capability to record MH/SA data in their local information system, the Wisconsin DHS is developing a web-based direct data entry system administered by the State. Permanent new dual options for data entry and submission will be available for counties to choose from depending on their local information technology capacity. Updating the technology is Phase 1 of the project. In Phase 2, new data elements will be added to improve the type of data that is collected for the monitoring of client outcomes. In the 2012 Plan, current data is being used to formulate dashboard indicators, including hospital readmission data.

Performance measures and fidelity to evidence-based practices remain a challenge to broadly measure outside of the self-report survey data. The Division of Quality Assurance at the Department does provide site visit surveys of programs for compliance with administrative code; however, they do not have systems nor charge to evaluate adherence to evidence-based-practices in certified programs.

[11] *Capitol Times* online newspaper report on "Psych Ward" dance routine: http://host.madison.com/ct/news/local/health_med_fit/vital_signs/article_c8afffb0-3097-11e0-af24-001cc4c03286.html

# *Section 3 - Unmet Service Needs & Critical Gaps in Wisconsin for Youth, Adults, & Seniors*

Efforts at empowering initiatives such as Person-Centered Planning and self-directed care notwithstanding, there is still a critical gap at the practice level to allow consumers and families to have meaningful choices in their recovery and to use more peer support resources. In a related sphere, while aspiring to be the best stewards possible of taxpayer resources involved in the funding of mental health services—federal, state, county and tribal—the focus on outcomes becomes critically important. Yet, the infrastructure for gathering, aggregating, and analyzing outcomes is still challenged. Another way to conserve resources is through preventative and harm-reducing upstream measures, particularly for children and their families. In order to operate in an up-stream environment, increasing awareness needs to be brought to systems and providers with a growing focus on early screening, assessment, and timely care. When intervention is required, the best practice insofar as practicable is community-level and holistic services, care and treatment. The focus must be on the person in his or her own environment, attending not just to health, but home, purpose and community. Hospital or more institutional care models must be used more advisedly and judiciously, matching service to need. In Wisconsin, it has already been demonstrated that the great majority of services that were once provided in a hospital not only *can* but *should* be provided in community. Moving from the old "hospital without walls" model of the original PACT program, the walls must not just be removed but the notion of hospital must be replaced by the notion of healing environments and community, where the child's or adult's natural supports exist.

However, not all communities are healing and supportive environments. For some who have been victimized or traumatized, what would be benign to most is threatening and disruptive. As such, in the natural and community environments, systems of behavioral health as well as primary medical and even other environmental niches need to be able to effectively identify those at risk and guide them into helping or preventative services. Behavioral health—mental health as well as substance use risks—must be screened and assessed along with their corollaries of trauma and suicide. Within the Veteran's population of men and women returning from deployment to war zones, it is known that although the Veteran's Administration has made great strides to provide outreach and connection for these service members, there are still considerable gaps. On the extreme end are untreated mental illness, substance use and dependence, homelessness, and suicide. Nationally, it is found that a cumulative total of 654,348 of nearly 1.3 million returning, "separated," veterans between the years 2002 and 2001 only about half obtained health VA care. An even smaller number (414,761) accessed VA health care in the past year. In Wisconsin there are over 400,000 veterans. Twenty percent of the suicides in Wisconsin in past analyses have been veterans.

## Short Supply of Certified Peer Specialists and Parent/Family Peer Specialists

While Wisconsin is increasing the capacity of consumers and families to self-direct care and treatment, while focusing on recovery peer specialists remain in short supply. Moreover, where there are Certified Peer Specialists, they tend to be under-utilized and -employed or not in the region ready to hire them. Wisconsin will expand its peer specialist initiatives, not only by training more Certified Peer Specialists but through the offering of two more course offerings and certification examinations in the next fiscal year. Though progress has been made, there are currently only141 individuals who have completed the Peer Specialist Certification. Marketing efforts will need to be made to educate behavioral health

programs and show them the value of the specialty and to encourage behavioral health programs to hire Certified Peer Specialists

## Counties Need to Understand and Connect Military Families to Services

Linkages between standard public or private service systems and services for military families or veterans are in their infancy. Although counties have Veterans' Service Officers to help veterans link with services, outreach to and linkages with the larger numbers of military families can be quite challenging. Moreover, despite service availability for vets and military families, some vets don't avail themselves of services of services to which they are entitled. Although the Veterans Administration is making good progress with respect to outreach to areas outside of urban centers, there is a need for improved identification and connection to Veterans services or resources for military families. Not only is there a substantial need for services for the person in the military or returning from military service, but there are needs for his or her family. Issues of trauma, PTSD, substance abuse and serious mental illness along with elevated suicide risk are all associated with military service, particularly in view of the repeated deployments that many service members experience. Many returning vets have substantial difficulty re-integrating into civilian life. During deployment, a *de facto* single parent impact on families and children has its own challenges and consequences.

## Suicide Rate Higher Than National Average

Despite a reduction in total number of suicides last year the rate remains in the vicinity of 13/100,000. In Wisconsin, the majority of suicides occur in Whites, but disparity with American Indians having the highest rate of death. Across all ages, the highest rate of suicide is in those aged 25-44 years. Men die from suicide four times more frequently than women (see table below). Regionally, rates of suicide are more evenly dispersed, with the highest rate in the northeastern region and the lowest rate in the southeastern region. Veterans accounted for one out of every five suicides in Wisconsin between 2001 and 2006 (Wisconsin Interactive Statistics on Health). Wisconsin's State Suicide Prevention Plan is almost a dozen years old. Currently, the best synopsis on the problem of suicide in Wisconsin is from a summary produced by Mental Health America. Although the focus is on the problem with youth suicide, it provides an excellent summary of the overall problem[12]:

> **"1.** Wisconsin Suicide and Suicide Risk Data. The need for Wisconsin (WI) to address youth suicide is clearly identified from the available data. Suicide in WI youth (ages 10-24) resulted in 471 deaths from 2004-2008. In 2007 (the most recent data year), the suicide rate for this age group was 9.23 per 100,000 population in the state and 6.85 per 100,000 population in the United States (US). [2,3] A five-year trend analysis demonstrates that the rate for older youth (age 18-24) was higher than that of the younger-aged group (10-17 years) for all years in both WI and the US. However, while national trends over time have shown relative stability in rates for both age groups, WI has seen a decline in suicides in 10-17 year olds. The 18-24 year old rate for the state has been higher than the national rate for the past two years. Suicide is the second leading cause of death in 10-24 year olds in WI4, whereas nationally it is the third leading cause of death. [4]
>
> Sex differences in suicide rates in WI mirror those nationally in that males have a higher rate (WI 15.01/100,000; US 11.13/100,000) than females (WI 3.16/100,000; US 2.32/100,000). [2,3] Approximately 88 percent of WI youth are white.[2] American Indian youth have the highest rate of suicide compared to all other racial groups in WI

[12] Mental Health America-Wisconsin Website: www.mhawisconsin.org/Data/Sites/1/media/Prevention/SuicidePrevFunding/GS11-narrative-final.pdf.

(14.25/100,000) while Asian (6.60) and Black (5.22) youth have lower rates compared to Whites (8.16). [2] The suicide rate for Hispanic youth is half that of Non-Hispanic youth (4.97 vs. 8.13). [2] Additionally the rate of years per life lost due to suicide is significantly higher in WI than the nation (457.04 v. 269.66) [2], indicating that people who die by suicide in WI are younger. Wisconsin does not differ significantly from the national average with respect to means and circumstances associated with youth suicide. Among those WI counties with over 20 suicides during this period the rate varies almost twofold from 5.27 to 11.61 per 100,000.[2]

Suicide represents only one portion of the spectrum of suicidal behavior[5]. The emergency department visit rate for WI youth (10-24) is slightly lower than national rates (185.63 vs. 224.24); although one-quarter of the counties are above the national rate. [6,3] Data from the 2009 Youth Risk Behavior Survey (YRBS) indicate that more WI youth reported "feeling sad or hopeless, two weeks in a row" that the national average (26.1% vs. 20.8%). However, the US and WI reported similar percentages of youth who "seriously considered attempting suicide" (13.8% vs. 13.2%), who "made a plan for suicide" (10.9% vs. 11.0%) and who "attempted suicide one or more times" (6.3% vs. 5.8%).[7,8] WI YRBS data indicate clear downward trends on all of these variables from the period of 1993-2009. [8]

**2.** Sub-populations at risk. Recent literature surrounding adolescent suicide illustrates particular sub-populations that are at increased risk: DHOH, LGBT; Veterans; and children in military/veteran families. We do not have state or national data on suicide rates for youth who are DHOH; however, youth who are DHOH are more likely to have more physical health problems, are more likely to suffer depressive symptoms and are more likely to be socially isolated which may put them at increased risk for suicide or suicidal behavior.[9] Analyses of data from Norwegian adults indicate deaf respondents had significantly more symptoms of mental health problems than their hearing counterparts.[10] Another study comparing prevalence of mental health problems in children and adolescents who are DHOH to hearing counterparts in Australia indicated that the two groups were similar in terms of mental health problems but that parents of DHOH children and adolescents reported their children experienced increased feelings of isolation, low self-esteem and being bullied at school.[11] Additionally, people who are DHOH report difficulties in using health care services due to communication difficulties as well as the fact that their needs are underserved by the health care community.[12,13] These types of access issues may further increase suicide risk. Such findings point to the need for increased attention to DHOH sub-populations and suicide prevention, and thus, a focus on this subpopulation is included in WI's proposed approach.

Similar to DHOH populations, it is difficult to determine rates of suicide among LGBT persons due to absences of sexual orientation data on death certificates.[14] Several population based studies and systematic reviews have illustrated an increased risk of suicide attempts and suicidal ideation among LGBT youth compared to heterosexual youth.[15,16] In 2007, WI included questions about same-sex and opposite-sex sexual behaviors on the YRBS. An analysis comparing respondents who had same sex sexual contact (same-sex) to those respondents who had only opposite sex sexual contact (opposite-sex) demonstrated at least a two-fold reporting of increased suicidal ideation and attempts on all five suicide related questions.[17] Again, findings point to the need for focused attention on preventing suicide in the LGBT population, a subpopulation of interest in WI's proposed approach.

Finally, young veterans (age 18-24) and children in military and veteran families are also a sub-population of interest due to increased risk of suicidal behavior and increased military involvement due to Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF). Data from the National Violent Death Reporting System demonstrate that younger veterans (age 18-34 years) had the highest firearm and total suicide rates.[18] A similar, unpublished analysis of Wisconsin Violent Death Reporting System (VDRS) data also found that younger veterans had increased rates of suicide compared to older veterans. Recent studies show children of currently deployed military have increased stress and anxiety, parent-child problems, emotional and behavioral problems, and higher levels of depression.[19,20] It is also important to consider how military parent mental health affects children and the family.[20] The report of the Blue Ribbon Work Group on Suicide Prevention in the Veteran Population calls for many recommendations including revising and re-evaluating current policies on suicide screening assessments in primary care, promoting training in implementing suicide prevention programs, implementing gun safety programs directed at veterans with children in the home and pursuing opportunities for outreach for enrolled and eligible veterans and their families.[21] These findings point to inclusion of young veterans and children of veterans in WI's proposed approach."

## Crisis Services Still Do Not Exist in Parts of the State

Although progress is being made at expanding services throughout the state, including regional crisis initiatives, there continues to be a lack of ongoing mental health services and crisis services across counties in the state. Beyond the lack of psychiatrists in rural areas, there are also needs in urban areas. Moreover, there is a need in other types of mental health providers, such as social workers, clinicians and other direct service workers. Where Crisis Intervention programs do exist, most areas do not have residential crisis stabilization options to serve as a community based diversion alternative to inpatient psychiatric hospitalization. Not until June of 2011 was there an option to use children's Group Homes or foster homes for crisis stabilization[13]. All counties need a DHS-34, Sub III Services. Access to good quality crisis services can often mitigate the need for a psychiatric hospitalization. The five regions of the state will begin their third of five years of funding. As a requirement of these five Regional Crisis Grants all counties will become DHS 34 III certified, enabling third-party Medicaid reimbursement. The Bureau is publicizing and educating mental health providers on crisis response plans as part of the seclusion and restraint reduction initiative.

## Respite Services Needed for Families of SED Youth

The Children and Youth subcommittee of the Wisconsin Council on Mental Health identified needs around respite care for families and the need for crisis services for children and youth (June, 2010). The group identified two major barriers in the lack of availability of respite care: the lack of funding including low compensation for caregivers and the absence of trained providers. In addition, the group identified a need for summer day care/camps for children with SED/challenging behaviors that have trained qualified staff. The group's concerns regarding crisis services included a lack of alternatives for families who have a child in crisis. It was suggested that the state consider an increase in functional crisis respite beds, mobile back up teams, and exploration of other alternative response settings. In addition, the necessity of effective and individualized crisis response plans was discussed.

## Culturally and Linguistically Appropriate Services are Needed

Culturally and linguistically appropriate services are insufficient to level of need. Services to non-English speaking and Deaf and Hard and Hearing as well as services that are attuned to and competent in cultural

[13] Out of Home Care for Crisis Stabilization:
https://www.dhfs.state.wi.us/dsl_info/InfoMemos/DMHSAS/CY2011/imemo2011-01.pdf

context. Exactly how many clinics and service agencies offer services to individuals who are non-English speaking or have English as a second language (ESL) is unknown and needs to be studied. Efforts are underway with respect to strategic behavioral health planning for deaf, deaf-blind and hard of hearing but at present, services are needed.

## People with Complex Needs Have Poorly Coordinated Services

Coordination of services for behavioral health consumers with complex needs to be improved. Barriers in the continuum of healthcare need to be erased, particularly the impact of behavioral health disorders on general health. Primary medical services should be able to perform basic behavioral health screening and referral, eventually coordinating care between the primary medical provider and behavioral health provider(s). As needs get more complex or acute, coordination becomes increasingly important and requires more assertive communication and connection between systems in a cogent care management system.

## Shortage of Dental Providers Accepting Medicaid - Especially for Children

There exists a shortage of Medicaid dental providers that serve Medicaid recipients generally. This gap in health services creates marked problems for behavioral health consumers, particularly children. Deficits in oral hygiene and a range of side-effects to psychiatric medications can increase the risk of dental problems. In turn, the connection between dental health and overall health is being better understood. Historically a rather intractable problem, Community Health Clinics or Federally Qualified Health Centers (FQHCs) may hold some promise for restoring dental service to low-income persons.

## Integrated Dual Disorder Treatment (IDDT) Not Widely Disseminated

Access to integrated mental health and substance use disorder services have historically been limited. Although gains are being made, with the magnitude of co-occurrence, there is a significantly greater need for IDDT. Moreover, the importance of prevention and earlier intervention are recognized to mitigate the degree of disability and related personal and societal toll. Outside of illegal drug use or alcohol there is a prominent need to help those who are addicted to tobacco. Smoking remains a prominent concern amongst the behavioral health population with so many more persons with serious mental illness who smoke (58-88 percent of those with schizophrenia). Wisconsin adults with mental health needs are more than twice as likely as other adults to smoke[14].

## Specialized Services to Seniors are Needed

In the context of a number of factors (e.g., poor awareness and connection to behavioral health systems, limited experience and skepticism with such systems, and limited referral into behavioral health systems from primary medicine, few specialty providers in geropsychology and geropsychiatry) seniors can often have significant trouble accessing behavioral health services appropriate to their needs. Geriatric systems of care need to do a better job of identifying behavioral health issues such as late-life depression, psychosis or substance use disorder.

[14] Wisconsin Department of Health Services, Division of Public Health and Division of Mental Health and Substance Abuse Services. ***Linking Mental and Physical Health: Results from the Wisconsin Behavioral Risk Factor Survey*** (P-00066). Prepared by the Bureau of Health Information and Policy, Division of Public Health; and the Bureau of Prevention, Treatment and Recovery, Division of Mental Health and Substance Abuse Services. April 2009.

## Epidemiology and Access to Treatment Measures Inadequate at Identifying Needs

Sound measurement strategies are needed for adults and youth. Measures are needed to assess level of prevalence of behavioral health needs throughout the state. The Wisconsin HSRS data system only captures a portion of the population accessing services and being served—namely through the county-based mental health system. It does not capture all those served in the private sector, either through free clinics, FQHCs, or those receiving private sector services through either public Medicaid or private insurance.

## Access to Behavioral Health Services Limited in Rural Sector

Many counties in Wisconsin are rural. Especially in these regions, programs to serve individuals with serious and persistent mental illness need to be expanded. Demand for services exceeds ability of localities to render services. In general, owing to matters of economies of scale, rural areas tend to be under-represented where comprehensive or collaborative service models are concerned (e.g., CCS, CSP, CST, etc). Moreover, without public transportation in rural areas, ability to access office-based services remains challenging. With respect to children and youth, access to behavioral health services are constricted in child welfare systems. For children who do not meet the diagnostic criteria for Serious Emotional Disturbance (SED) or who are not being served through two or more systems of care (thus enabling eligibility for Coordinated Services Teams [CST]) services are lacking, potentially leading to a preventable deterioration in their condition. Similarly, the failure to identify behavioral health conditions and to initiate treatment while a juvenile, leads to a disconnect when the youth ages out of the juvenile child welfare or juvenile justice system. Often upon the individual's 18$^{th}$ birthday, he or she finds themselves not only legally an adult with new responsibilities but at the door of an entirely different behavioral health system and challenged by their preexisting condition.

## Stigma Stubbornly Persists

Stigma is an ongoing problem for Wisconsin's mental health consumers. Stress associated with societal attitudes through stigma can exaggerate, trigger, or aggravate serious emotional disturbance (SED), mental illness, substance use, etc. Vulnerable at-risk populations can be more susceptible to the stresses associated with stigma, prejudice, and discrimination. Bullying amongst children and teens can seriously aggravate eroded self-esteem and can play a role in suicide risk.

## HIV/AIDS and Other Communicable Diseases

According to DHS reports, approximately 40-50 percent of the 6,900 people in Wisconsin, living with HIV/AIDS have a comorbid mental illness. DHS funds some mental health services through the Ryan White Foundation, which is only able to assist about 3,500 to 4,000 or about half of those who have an HIV infection statewide. About 20-40 percent of those with HIV infection are not engaged in treatment, either because they don't know they are infected or because they are simply not engaged in treatment. Information is collected from the Ryan White Foundation suggests that about half of those with a comorbid mental illness are those with a severe and persistent mental illness. Recently the medical assessment used in Wisconsin, CAGE AID assessment. It has a two items that are a very brief screening for depression as well as a short screening for PTSD and generalized anxiety disorder.

Not unlike the shortages for psychiatry in other areas, finding practitioners who are willing to manage the complexities of working with HIV/AIDS patients is quite difficult. Not only are their the unique psychiatric variables themselves, but there is the challenge of working with people who may not be able to attend appointments regularly, who may cycle in and out of the criminal justice system, who may end up homeless, etc. Of course, effective treatment of the person's mental illness helps improve treatment adherence overall and may well be highly cost-effective in both human terms and fiscal savings.

Historically, there had been more assertive efforts in working specifically with persons who had both a serious mental illness and HIV/AIDS through the Center for AIDS Intervention Research (CAIR). Protocols for using peer mentors to teach about prevention of HIV/AIDS and to encourage treatment adherence were used. These efforts were piloted and showed promise. These efforts need to be revisited. Moreover, it is essential to reach out to the public health community generally to better understand the scope of the issue with respect to HIV/AIDS and communicable disease generally (e.g., Hepatitis, Tuberculosis, working these understandings into an ongoing phased development of the Wisconsin State Mental Health Plan.

In Wisconsin, the Division of Public Health (DPH) has been in the lead in planning and implementing support for people with HIV/AIDS and communicable disease. The DMHSAS coordinates with DPH primarily through our Substance Abuse Services Section on funding outreach programs to this population. However this population has not been tied closely to the mental health system.

## System Capacity and Access to Services for Children and Youth

Access to children's mental health services needs to be improved in the state. Many children with Serious Emotional Disturbance (SED) do not have access to mental health services in Wisconsin. Only 3 percent of children with SED received any county provided or contracted mental health services in 2008.

Related issues include the fact that pediatricians are frequently the providers of psychotropic meds but have no specialized training; Medical Assistance does not pay for doctor-to-doctor consultation, therefore pediatricians cannot bill time to consult with psychiatrists; providers report that Medicaid reimbursement is overall too low; availability of tele-psychiatry options remain limited and it is ultimately unknown what levels of efficiency might be conferred by more wide-spread use of the technology in treating youth with severe emotional disturbance.

## More Support for the Youth to Adult Transition Process is Needed

Transitional services for youth aging out of children's mental health programs are needed. Often youth are not permitted onto waiting lists for adult services until their 18$^{th}$ birthday. Traditionally services and funding streams have been siloed such that two distinct systems have drawn a sharp line between minors and adults. More enlightened systems change activities have developed good transitional models. Yet those models are not widely disseminated across the state.

Transitional services for youth aging out of children's mental health programs are being developed .The Mental Health Transition Advisory Council (MHTAC) has been in existence since 1999. MHTAC has a statewide plan and action steps that have been developed and updated to improve the transition of youth with SED to the adult mental health services they may need and the highest level of independent living they are capable of attaining. MHTAC members represent a coalition of youth, parents, several Departments, Divisions, advocacy agencies, and adolescent and adult programs in several counties. The BPTR has received a discretionary grant to focus on Transitions. Wraparound Milwaukee is working to develop a model and a statewide advisory group is looking at how to encourage youth transition to CSP programs.

## Trauma Issues Not Adequately Attended to in the Child Welfare System

While progress is being made, there is still a need for the children's welfare system to serve children with mental health and trauma issues. Gaps include a lack of consistency in providing mental health assessment services and too few mental health providers to meet the needs of children in the child welfare system. DMHSAS is working in collaboration with DCF in developing more understanding and competence with Trauma Informed Care (TIC).

## Shortage of Child Psychiatry

About five years ago, a report by Thomas and Holzer showed Wisconsin as one of 35 states with less than the national average of psychiatrists for its youth population.[15] The model number of psychiatrists for optimum care was reported as 14.38 per 100,000 youths; whereas Wisconsin was reported to have 8.2 per 100,000. Wisconsin is one of many states that have a shortage of Child and Adolescent (C/A) Psychiatrists available to treat young people with mental health disorders. Since 2003, a number of studies have cited problems with the medical health care system that discouraged medical students from seeking residencies in C/A Psychiatry. In the authors' report, Wisconsin, with 112 C/A Psychiatrists, was near the national average of C/A Psychiatrists, however it was still one of 35 states with less than the national average for its youth population. Having more C/A Psychiatrists is critical to providing the most appropriate mental health services to Wisconsin youth. Critical need for more C/A Psychiatrists is shown by the September 2007 report by the National Institute on Health (NIH) on increases in diagnosis of bipolar disorder in young people. Often child and adolescent psychiatrists practice in larger metropolitan areas leaving many of Wisconsin rural areas with even fewer C/A Psychiatrists than are necessary for even basic access to care. There is a similar shortage of child psychologists and other mental health treatment providers for children. Historically, the lack of insurance parity has contributed to this problem.

A 2009 article on the critical psychiatry shortage in Wisconsin makes the issue palpable:

> Richard Immler, MD, is a child psychiatrist who works with clinics in northern Wisconsin. As a doctor providing subspecialist care, Immler is the only board-certified child psychiatrist in residence north of Merrill….
>
> "There is an enormous need for child psychiatric services here," Immler says. "I feel it's a crisis. My waiting list at the Human Service Center in Rhinelander is up to two years. To have a two-year waiting list is extremely discouraging. Innocent children and their families are suffering, as they are waiting for months to get optimized care."
>
> … "There is also a high burn-out rate," he says. "Nine child psychiatrists in northern and central Wisconsin have come and gone in last 12 to 15 years. It's a field that demands quite a bit of time and coordination with others involved in the child's life."
>
> There are ways to fix the mess, Immler recommends. One is to adopt a collaborative service model that brings families and professionals together. Another is to restructure the reimbursement system for psychiatry payments to be based on "outcomes" rather than "procedures" which work better for other specialties, such as surgery or radiology.
>
> Immler laments, "We haven't done a good job in linking outcomes in healthcare to the work that we do. If we don't find a way to meet the needs of our children, higher-cost outcomes occur – hospitalization, emergency treatment, incarceration and even suicide. These reflect failures to work together with clear goals in mind and come at an enormous cost." [16]

[15] Thomas, C. & C. Holzer, J. Am. Acad. Child Adolesc. Psychiatry, 45:9, September 2006.
[16] Juon, Sarah. 2009. http://www.newsofthenorth.net/article.cfm?articleID=24547

# *Section 4 - Priorities for Wisconsin's Youth, Adults, & Seniors*

## 1. Summary of Wisconsin Planning Priorities

Funding priorities in the previous years have straddled federal objectives and state statutory requirements. Many of the grant resources from prior years do in fact go to the four newly proposed purposes for block grant funding (prevention, assisting those without health insurance, funding services not covered by health insurance, and development of data or outcome measures). In identifying priorities, Wisconsin examined overall needs and demands and then attempted to narrow block grant priorities to a subset that had reasonably good fit with federal priorities and with available Wisconsin indicators in existing or developing data systems. The eight strategic priorities of SAMHSA and the principles of a good and modern healthcare system are also kept in the forefront. As can be seen in tables 2 and 3 below, Wisconsin's identified priorities focus on both adults and children and reach across systems toward building a good and modern health system.

**Table 2: Wisconsin State Priorities**
**(Plan Year: 10/01/11 through 06/30/2013)**

| | |
|---|---|
| 1 | Increase the capacity of consumers and families to self-direct care and treatment with a focus on recovery and support from peers. |
| 2 | To reduce the incidence of suicide in Wisconsin; in particular, reduce the disparities in culturally diverse populations and veterans. |
| 3 | Promote trauma informed care, and in particular, work to promote appropriate treatment for Wisconsin citizens who are returning from combat and their families and children in the Child Welfare System. |
| 4 | Promote the identification and appropriate treatment for children's mental health needs, including children and their parents in the child welfare system. |
| 5 | Promote evidence-based services and treatment to assure good quality outcomes of services and to more effectively use scarce taxpayer resources in all systems that fund mental health services, including county and tribal service systems, Medicaid, child welfare and the criminal justice system. |
| 6 | Promote community-based services for people with serious mental illnesses and children with severe emotional disturbance thereby reducing utilization of inpatient services. |
| 7 | To develop methods to better assess the need and outcome of mental health services in Wisconsin, including improvements to data systems and outcome measurement. |
| 8 | Phased development of the Wisconsin mental health block grant plan toward improved alignment with SAMHSA's priorities under the new generation of block grant guidance and funding. |

# 2. Objectives, Strategies, & Performance Indicators for the Priorities

**Table 3a** **Plan Year: 10/01/11 through 06/30/2013**

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| Priority Area # 1 | Increase the capacity of consumers and families to self-direct care and treatment with a focus on recovery and support from peers. |
| Goal | Develop more Peer Specialists in Wisconsin |
| Strategy | BPTR Recovery Coordinator working in conjunction with other bureau staff and in concert with the Recovery Implementation Task Force of Wisconsin, the Dual Recovery Committee, the Inpatient Recovery Committee, the Wisconsin Consumer Network, NAMI, and Wisconsin Family Ties to expand the total number of Certified Peer Specialists in Wisconsin through provision of at least two course offerings and two examinations; a Parent/Family Peer Specialist program will be developed.<br><br>There are currently four approved curricula for the training of Adult Peer Specialists in Wisconsin: NAMI's Kansas Consumers As Providers (CAP), Recovery Innovations (Formerly META), Depression Bipolar Support Alliance, and the National Association of Peer Specialists (NAPS). The majority of training in Wisconsin as of 2011 has been the NAPS model and the CAP model. The other curricula are approved but tend to be quite expensive. Building on the success of the prior Certified Peer Specialist initiative where there is now a 75-80 percent pass rate on the certification exam, additional peer specialist resources will be developed. Moreover, Wisconsin will further develop a new initiative to create a Parent Peer Specialist certification program. Other components will include developing partner resources to market, promote and educate prospective employers about Certified Peer Specialists and the valuable role they have in the provision of mental health and recovery support and services.<br><br>With respect to the Parent/Family Peer Specialist initiative, the goal is to develop a process to certify parents of a child with serious emotional disturbance as parent peer specialists. A certified Parent/Family Peer Specialist would have training in how to support families, provide advocacy, and how to nurture recovery for the affected family system. A committee—Parent/Family Peer Specialist Workgroup—has been convened to study and recommend how a Parent/Family peer specialist initiative should unfold. Their input will be critical as to how such an initiative takes shape. The committee will consider core competencies and draft standards. Computer-based testing protocols already pioneered for the existing peer specialist exam through the University of Wisconsin and University of Wisconsin-Milwaukee will be considered a resource for eventual adaptation for a Parent/Family Peer Specialist assessment procedure. |
| Performance Indicator | Number of Certified Peer Specialists |
| Description of Collection & Measuring Changes in Performance Indicators | Access to Independence maintains records of Certified Peer Specialists and will report to BPTR on a semi-annual basis the number of Certified Peer Specialists. |

**Table 3b** **Plan Year: 10/01/11 through 06/30/2013**

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| Priority Area # 2 | To reduce the incidence of suicide in Wisconsin; in particular, reduce the disparities in culturally diverse populations and veterans. |
| Goal | Decrease suicides and suicide-related behavior in Wisconsin, particularly with higher prevalence groups (Native Americans, veterans, adolescents) and those where there is suggestive evidence for increased risk for suicide (LGBTQ, deaf or hard of hearing, etc.). |
| Strategy | In collaboration with partners (e.g., Division of Public Health, School Districts, Tribes, Prevent Suicide Wisconsin, Department of Public Instruction, LGBTQ groups, County Human Services Departments, Crisis Intervention Programs, etc.) provide technical assistance, advocacy, education, toward the proliferation of active suicide prevention coalitions in each county. Although Wisconsin realized a reduction in total number of suicides last year over the previous year, the rate remains about 13/100,000. Efforts will continue in the area of prevention while developing a better understanding of suicide as it impacts sub-populations and age groups. Efforts can then be focused to areas with the greatest need and where the more substantial impact can be made. Efforts will then be made to improve screening, detection, and prevention intervention for all groups but particularly children, veterans, LGBTQ, racial and ethnic minorities, and non-English speaking populations, including deaf and hard-of-hearing. Wisconsin will make concerted efforts to expand the development of local suicide prevention coalitions through initiatives of Prevent Suicide Wisconsin and other efforts. This is congruent with SAMHSA's vision. It also aligns with Wisconsin's Health plan, *Healthiest Wisconsin 2020*, which has in its objectives to reduce the prevalence of mental health disorders and related injury and morbidity including suicide and self-harm. Moreover, the plan focuses on reducing the disparities in suicide and mental health disorders for disproportionately affected populations, including those of differing races, ethnicities, sexual identities and orientations, gender identities, educational or economic status. There is a related aspect toward reducing disparity in hospitalization due to these and other causes as well. |
| Performance Indicator | 1) The suicide rates for all racial and age groups.<br>2) The number of suicide prevention coalitions statewide. |
| Description of Collection & Measuring Changes in Performance Indicators | 1) The Vital Statistics unit of the Wisconsin Department of Health Services (DHS) maintains a database of death certificates. Cause of death, including suicide, and demographic characteristics like age are included in the database. Wisconsin will monitor the suicide rates for race and age groups over time. 2) The number of suicide prevention coalitions will be a process measure to complement suicide rates. The DHS will help establish new coalitions and track their creation over time. |

**Table 3c** **Plan Year: 10/01/11 through 06/30/2013**

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| Priority Area # 3 | Promote trauma informed care, and in particular, work to promote appropriate treatment for Wisconsin citizens who are returning from combat and their families and children in the Child Welfare System. |
| Goal | Support child welfare system in their efforts to provide effective behavioral health services for children and families and to further develop TIC systems that promote safety, permanency and well-being |
| Strategy | DMHSAS staff will provide consultation, training and technical assistance to the Dept. of Children and Families regarding TIC, child welfare practice, and state-wide policy. |
| Performance Indicator | The number of local Child Welfare providers trained in the provision of trauma-informed care. |
| Description of Collection & Measuring Changes in Performance Indicators | The State of Wisconsin Department of Children's and Family Services (DCF) establishes training policy and arranges expert training for local county and private child welfare direct service providers. The DCF has a training system in place that tracks the number of local providers that are trained on different topics. Data from the DCF training system will be obtained annually to monitor the number of Child Welfare providers trained in the provision of trauma-informed care. |

**Table 3d** **Plan Year: 10/01/11 through 06/30/2013**

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|---|---|
| Priority Area # 4 | Promote the identification and appropriate treatment for children's mental health needs, including children and their parents in the child welfare system. |
| Goal | To increase the assessment of mental health needs for children at risk of, or already placed in, out-of-home care within the child welfare system. |
| Strategy | The DMHSAS currently uses the *Child and Adolescent Needs and Strengths (CANS)* assessment tool to determine the type and level of need for children in wraparound programs across the state. The DMHSAS is collaborating with the State child welfare agency in the implementation of the CANS tool within their out-of-home care system. Implementation of the CANS tool will ensure all children within the out-of-home care system are assessed for mental health needs and have a plan of care that addresses those needs.<br><br>Wisconsin plans to continue improving its children's mental health assessment capabilities. Developed originally as part of a major reform of the child welfare service system in Illinois, the Child and Adolescent Needs and Strengths (CANS) was developed to assist in the management and planning of services to children, adolescents and their families with the primary objectives of permanency, safety, and improved quality of life. The CANS instrument for children with mental health needs includes domains that cover Clinical Problem Presentation, Child Safety, Risk Behaviors, Functioning, Care Intensity and Organization, Family Needs and Strengths, and Child Strengths. In addition, the CANS offers instruments that are specific to the needs of the child welfare, juvenile justice, substance abuse, and developmental disability populations. Prior to utilizing the CANS instrument in Wisconsin, the Child and Adolescent Function Assessment Scale (CAFAS) was the primary evaluation tool for Integrated Services Projects (ISP) and Coordinated Services Team Initiatives (CST). Due to cumbersome training and re-certification procedures, the decision was made to replace the CAFAS. With the help of the tool's primary developer, Dr. John Lyons, the CANS-MH was modified for use by Wisconsin's ISP's and CST's to include items in addition to mental health related items, such as child safety items.<br><br>There are currently 33 individuals representing 29 sites as well as 3 staff from White Pine Consulting Services who are "Certified CANS Trainers". These individuals, trained by John Lyons, Ph.D. in January and August 2008, are certified to train others in their CST/ISP project as raters of the CANS. There are currently over 200 individuals across the state who have subsequently been trained by the CANS Trainers and received certification as "Certified CANS Raters". The most recent CANS training was held in April 2011.<br><br>A "CANS" page on the Wisconsin Collaborative Systems of Care (WCSOC) website[17] was created as a resource to sites. The page includes background information on the Wisconsin CANS; tools for trainers and raters including manuals and forms; and a section of frequently asked questions. Future enhancements may include access from the site to the CANS training video resources, and information on additional versions of the CANS. |

[17] Wisconsin Collaborative Systems of Care (WCSOC) website: www.wicollaborative.org

| | |
|---|---|
| Performance Indicator | The percentage of children in the State child welfare out-of-home care system with identified mental health needs as measured by a rating of 1-3 on the CANS tool. |
| Description of Collection & Measuring Changes in Performance Indicators | The implementation of the CANS tool in the State child welfare out-of-home care system began in January 2011. Providers across the state were trained in the first six months of 2011. The previous child welfare assessment tool did not have a comprehensive mental health component. The CANS tool ratings are entered into a central State child welfare database. The DMHSAS will work with the State child welfare agency to obtain CANS mental health ratings for this indicator. |

| **Table 3e** | **Plan Year: 10/01/11 through 06/30/2013** |
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| Priority Area # 5 | Promote evidence-based services and treatment to increase employment and to more effectively use scarce taxpayer resources in all systems that fund mental health services, including county and tribal service systems, Medicaid, and the criminal justice system. |
| Goal | Expand total number of programs under Departmental authority demonstrating fidelity to evidence-based practices, and especially supported employment. |
| Strategy | Through provision of technical assistance, program models (e.g., CSP, CCS, CRS, etc.) will be supported and monitored for the actual provision of the EBP of supported employment (SE). In 2010 Wisconsin joined the Dartmouth University Learning Collaborative funded by Johnson & Johnson. Counties were selected through a competitive process to implement high fidelity SE. Site selection, training, technical assistance, monitoring reports, and fidelity reviews are key expectations of the Dartmouth Johnson & Johnson Contract.<br><br>In FFY 2009, the Wisconsin Department of Health Services included the Supported Employment (SE) SAMHSA EBP in its Medicaid Infrastructure Grant (MIG) application. Grant money was awarded to the DMSAS Services to contract for Supported Employment implementation in three sites located in three counties in the state. SAMHSA toolkit materials were provided to successful grant counties to guide their implementation of the SE EBP. Staff from the Bureau of Prevention Treatment and Recovery attended training in Hanover, New Hampshire using MIG funds. Dartmouth staff trained attendees to assess compliance to SE Fidelity. The fidelity scale was developed as part of research and is included in the SAMHSA Toolkit. Dartmouth is involved in the Johnson & Johnson (JOHNSON & JOHNSON) Supported Employment Individual Placement Services Project. Johnson and Johnson funds supported employment and individual placement services (SE-IPS) development within selected states. In 2010 Wisconsin was invited to apply as a state to participate in the JOHNSON & JOHNSON Project. Wisconsin was approved for the grant and became the 13th state in April 2010 to join the Dartmouth JOHNSON & JOHNSON learning collaborative.<br><br>DMHSAS has developed a memorandum of understanding with the Division of Vocational Rehabilitation (DVR) regarding implementation of the Dartmouth model of Supported Employment to assist individuals with mental health needs to attain and retain competitive jobs. The two agencies are currently promoting the use of Supported Employment. The Wisconsin team meets and corresponds regularly. Issues are addressed as raised from a participating county. Procedures are developed as needed and jointly by the SE team to resolve the issues encountered. Of particular satisfaction to county SE sites has been the accommodation to changes in procedures made by DVR staff to be more accessible to the service teams of mutual consumers.<br><br>The Mental Health Block Grant is used to fund an SE State Trainer with primary focus on providing technical assistance to three pilot sites in the first year. Areas of assistance will be in system change to implement SE-IPS at a |

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| | high rate of compliance to the fidelity scale. The State Trainer works with a Wisconsin Johnson and Johnson team consisting of BPTR staff, UW Rehabilitation Psychology Supervisory staff, and a DVR Special Projects manager. Counties selected through a competitive process to implement high fidelity SE-IPS have JOHNSON & JOHNSON grant funding to support Employment Services staff on the county teams. Site selection, training, technical assistance, monitoring reports, and fidelity reviews are key expectations of the Dartmouth JOHNSON & JOHNSON Contract. Monthly State and Quarterly national conference calls are established by Dartmouth staff with state teams. Data is reviewed, process discussed for consistency and consultation specific to a site stage of need is provided by the Dartmouth staff. County program staff have also attended trainings from overview to supervisory training in the model provided by Dartmouth staff to target awareness at the broader state level. |
| Performance Indicator | 1) The percentage of adults with SMI in the labor force who are employed in FFY 2012.<br>2) Total number of clients receiving supported employment from programs trained by the Dartmouth SE Initiative. |
| Description of Collection & Measuring Changes in Performance Indicators | Programs participating in the initiative will be tracked for the provision of SE with fidelity using the General Organizational Index (GOI) and the Supported Employment fidelity scale. The State Division of Mental Health and Substance Abuse Services (DMHSAS) tracks which programs are trained in SE through the initiative. Trained programs will submit data on a form describing the number of clients served with SE directly to DMHSAS staff on a semi-annual basis. |

| **Table 3f** | **Plan Year: 10/01/11 through 06/30/2013** |
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| Priority Area # 6 | Promote community-based services for adults with serious mental illnesses and children with severe emotional disturbance through the reduction in use of inpatient services |
| Goal | Decrease the rate of readmission to psychiatric hospitals within 30 days. |
| Strategy | The DMHSAS has implemented a joint project with the University of Wisconsin, Madison, NIATx program and eleven counties in Wisconsin on a process improvement project, called the Mental Health Collaborative. The Mental Health Collaborative is using NIATx coaches to work with these counties to develop specific quality improvement projects with a common aim of reducing psychiatric hospital readmission rates.<br><br>NIATx is a pioneering improvement collaborative that works with substance abuse and behavioral health organizations. Founded in 2003, NIATx works with behavioral health care organizations across the country to improve access to and retention in treatment for the millions of Americans with substance abuse and/or mental health issues. NIATx is part of the University of Wisconsin–Madison's Center for Health Enhancement Systems Studies (CHESS)[18]. NIATx was formerly the acronym for the Network for the Improvement of Addiction Treatment. They are known simply as NIATx.<br><br>Round I ran from January - December 2010 with 10 counties participating. Round II began January 2011 with eleven counties participating (Dane, Door, Grant, Iowa, Jefferson, La Crosse, Langlade, Lincoln, Marathon, Milwaukee, and Wood) and will run for one year. Each county has initiated change projects using the NIATx process to meet the unique needs within the county. For example, one of the participating counties found that persons who have a co-occurring substance use disorder with a mental illness accounted for a large percentage of the hospital readmissions, so they focused on changes to quickly initiate community treatment following hospital discharges.<br><br>Many of the counties are working on improvements in the discharge planning process and the transfer to community providers (e.g., outpatient mental health clinic), such as making a follow-up call two days after the hospital discharge to ensure that the person has an appointment with the community provider, has filled the prescription given to the person by the discharging hospital, etc. |
| Performance Indicator | 1) The percentage of consumers discharged from all state and county psychiatric hospitals in FFY 2012 who are readmitted within 30 days. 2) To reduce the percentage of consumers discharged from the Mental Health collaborative counties who are readmitted within 30 days. |
| Description of Collection & Measuring Changes in Performance Indicators | This is a national outcome measure required by CMHS. The data to monitor readmissions to psychiatric hospitals for adults is taken directly from Uniform Reporting System (URS) Data Table 21, which states are required to report in the annual MHBG Implementation Report. The data source is the Human Services Reporting System (HSRS) data. |

[18] NIATx website: Center for Health Enhancement Systems Studies (CHESS)

**Table 3g** **Plan Year: 10/01/11 through 06/30/2013**

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| Priority Area # 7 | To develop methods to better assess the need and outcome of mental health services in Wisconsin, including improvements to data systems and outcome measurement. |
| Goal | To increase the number of counties reporting substance abuse problems for mental health clients. |
| Strategy | The current State mental health data system is being replaced with modern information technology and new data fields. To meet the new federal requirements, data on substance abuse problems is being added to the data system. Improving Wisconsin's data system will allow for tracking of substance abuse problems among mental health clientele. These data will provide a fuller behavioral health picture, ensuring that attention can be paid to improving services for both mental health as well as co-occurring substance use disorder. |
| Performance Indicator | The percentage of all county mental health clients with diagnosed or undiagnosed substance abuse problems reported by counties in the new mental health data system. |
| Description of Collection & Measuring Changes in Performance Indicators | The new data system will allow counties to report a substance abuse DSM-IV diagnosis and/or an undiagnosed substance abuse problem. The current data system allows for DSM-IV diagnoses, but does not allow for undiagnosed problems. The new data system will be in place in 2012. The prevalence of substance abuse problems reported in the old data system will be compared to reporting in the new system. |

**Table 3h** **Plan Year: 10/01/11 through 06/30/2013**

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| Priority Area # 8 | Phased development of the Wisconsin mental health block grant plan toward improved alignment with SAMHSA's priorities under the new generation of block grant guidance and funding. |
| Goal | Develop an integrated mental health and substance abuse block grant that involves consumers and stakeholders in establishing state priorities and strategies to meet the critical needs of the state. |
| Strategy | It is widely known what some of the challenges and opportunities are for states to adjust their planning process to the new block grant. Wisconsin has added challenges as well as the state has transitioned to a new administration, the former block grant planner analyst left the position last year. The new planner analyst is new to state service and did not begin until this year. In addition Wisconsin's planning process calls for the Wisconsin Council on Mental Health (WCMH) to review the plan in mid-July, with subcommittee review in June. As such, much of the work on the Wisconsin plan was done in the short window of the latter portion of the first half of the calendar year as the federal guidance was being disseminated and shaped. Therefore, Wisconsin plans to work with SAMHSA toward a phased development a more deliberative process of planning involving consumers, families, key stakeholders and essential state staff. Wisconsin plans to build on the guidance provided at the2011 National Block Grant Conference. Specifically a planning process is being formed around gathering qualitative data on strengths, needs and critical gaps from all parts of the state. Moreover, bearing in mind principles like the 80-20 Pareto rule, it should be understood that much of the challenge to Wisconsin's systems come from a fairly narrow sector and that effort needs to be focused on the variables that produce the most human and economic cost. Similarly, with the positive outcomes from NIATx initiatives, it must be recognized that often times, small and deliberate efforts can have substantial effects. Tools and techniques to achieve this more deliberative planning process involving key stakeholders are as follows:<br><br>• Advise consumers, families, advocates, and stakeholders that the priorities of the federal mental health and substance abuse block grants are changing and expect a behavioral health integration with primary health; that current resource levels are not likely to be maintained; that performance-based initiatives around evidence-based practices are expected; that resources will need to be allocated based on valid outcome measures; and that in the planning process we will need consumers and stakeholders in helping to establish the best integrated mental health and substance abuse plan possible for the commonwealth, to monitor and regularly reevaluate the appropriateness of its priorities, methods and outcomes.<br>• Establish the vision of an *ideal* system that is culturally competent.<br>• Assign and contract for preliminary data needed to establish the field for strengths, weaknesses, and critical gaps in the context of new priorities of SAMHSA in a culturally and linguistically appropriate manner. Consider non-traditional measures and data points which may not currently exist.<br>• Develop timeframes for benchmark achievements within the planning process to keep the process moving forward and on-time.<br>• Conduct a Bureau of Prevention, Treatment and Recovery planning |

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| | meeting to identify key strengths, weaknesses, gaps, priorities and critical gaps, Pareto principle (80/20) issues, as well as foreseeable trends and horizons. Professionally facilitated strategic planning.<br>• Use WCMH and SCAODA to identify strengths, weaknesses, gaps, priorities, and critical gaps Pareto principle issues, as well as foreseeable trends and horizons, not to mention the vision of an *ideal* system. Professionally facilitated strategic planning.<br>• Collaboration with the Division Substance Abuse Section and DIG staff toward identifying key collaborative strategies to gather input and essential data elements. Include process to develop and obtain key client level data.<br>• Assignments and contracting for obtaining critical data elements to evaluate strengths, needs, and gaps.<br>• Plan and execute a Select Survey assessment of key stakeholders.<br>• In conjunction with regional administration, design an implement listening sessions key areas of the state, informed by above processes, to be inclusive of focus populations including Tribes, LGBTQ, minority populations, etc. Ensure processes to provide for equitable input regarding children, adults, seniors; urban and rural sectors, and focus populations.<br>• Communicate findings of surveys, focus groups, and professional/ family/consumer input back to all stakeholders inviting additional input toward identifying strengths, needs, and critical gaps.<br>• Collaborative design of an integrated planning process involving strengths, weaknesses, critical gaps, and by the Mental Health and Substance Abuse sections in alliance with SAMHSA's funding priorities and eight strategic priorities around a good and modern system.<br>• Review phased plan with identified and balanced representatives from both the WCMH and SCAODA, ensuring balance of youth and adult<br>• In consultation with SAMHSA, adapt key dashboard indicators for Wisconsin to draw upon key measures reflective of priorities.<br>• Establish tables for the priorities.<br>• Produce an integrated block grant plan with focused efforts to seize upon strengths toward addressing critical system gaps while gathering valid client level data performance/outcome measures that are communicated meaningfully to all stakeholders.<br>• Provide guidance on needed legislative changes to align Wisconsin's block grants with federal requirements and state priorities, focusing on flexibility toward meeting unforeseen demands or needs under the guidance and advisement of a combined contingent of the planning councils, WCMH as well as State Council on Alcohol and Other Drug Abuse (SCAODA).<br>• Identify key data needs; establish plan for creating and maintaining a data system to measure critical outcomes.<br>• Establish regular performance monitoring intervals and adjust plan based on effectiveness of efforts, new system challenges or developments, and reappraised priorities. Ensure that shifts in resources allow existing initiatives time to adjust in sustaining critical efforts. |
| Performance Indicator | Development and submission of an integrated behavioral health (mental health and substance use) plan for Wisconsin |
| Description of Collection & Measuring Changes in Performance Indicators | Completed integrated behavioral health plan inclusive of stakeholder collaboration and input. |

# *Section 5 – Mental Health Block Grant Projected Expenditures*

Mental Health Council Members:

See The MHBG Budget Plan In The Briefing Paper

# *Section 6 – Important Elements of the Modern Mental Health System*

## 1. Activities that Support Individuals in Directing Services

### Consumer Relations Coordinator

The Consumer Relations Coordinator is a key member and staff support to the Statewide Recovery Implementation Task Force, which is an advocate and consumer driven group of approximately 20 leaders from across the State. The Task Force meets every other month. Through a committee structure, the Recovery Implementation Task Force is instrumental in providing direction, feedback and guidance to the DMHSAS on issues related to both policy and program. All consumer participants are provided stipends and trainings, which offer learning opportunities to build upon their leadership skills to enhance full participation as meaningful partners in this state level task force. The committees of the Task Force include Inpatient Recovery, Evidence Based Practices, Peer Support / Peer Specialist and Transformation via CCS.

### Grassroots Empowerment Project, Inc.

Grassroots Empowerment Project, Inc. (GEP) is a consumer-run, non-profit agency that is contracted to provide *technical assistance and sustainability development for individual peer-run recovery centers.* The Department of Health Services, Division of Mental Health and Substance Abuse Services is contracting with Grassroots Empowerment Project, Inc. (GEP) for $114,000 annually from federal MHSBG funds to provide technical assistance to develop and foster independence of the consumer-run organizations that are ongoing and start-up under Part A of the Request for Proposal (currently contracted to Stable Life, Inc.). GEP is contracted to provide technical assistance to teach the Board of Directors of each consumer-run organization how to become and/or recruit community experts such as grant writer and community leaders, and provide general board technical assistance for Board members on fund raising, technical writing, and public relations to assure that local peer organizations are both accepted and supported by the individual communities. Fostering organizational independence of the consumer-run organizations through fund raising, marketing and fee setting for services at the local level is a critical component of the contract.

The future of consumer-focused recovery based mental health services rests not within a format system but with the consumers themselves. Helping consumers develop a strong local voice, with a visible peer support presence, will help consumers have an effective voice in local funding.

Grassroots Empowerment Project provided technical assistance to teach consumer-run organizations that are ongoing and start-up under Part A of the contract with Stable Life, Inc. how to become and/or recruit essential community experts such as grant writers, community leaders, fund raising, technical assistance and public relations. GEP taught consumer-run organizations how to foster long-term financial independence and viability through fund raising, marketing, fee setting for services, grant-writing and other strategies at the local, state and wider levels if necessary. GEP also provided technical assistance as determined and requested by consumer-run organizations based upon individual need and request.

The Department of Health Services is contracting with Grassroots Empowerment Project, Inc. (GEP) for $97,876 annually from the federal Community Mental Health Services Block Grant funds for the purpose of building a statewide consumer network where consumers serve as mentors, advocates, teachers, leaders

and staff who can draw on their personal experiences. The network will provide education, resources, leadership development and support for adult and older adult consumers.

The grant program seeks to develop and sustain an infrastructure of strong self-advocacy, consumer peer support, education and empowerment for adults and older adults that fosters and supports consumer involvement as the Wisconsin system transforms into a recovery-based, consumer-focused service delivery system. In that transformed and integrated system, community values are embraced, peer support and consumer involvement expected, self determination respected, and flexible support services evolve as needs change.

Grassroots Empowerment Project will:

1. Develop, sustain and grow an infrastructure and network of consumers that provide education and empowerment for adults and older adults, that promotes strong self advocacy and consumer peer support skill building
2. Foster consumer involvement with statewide activities that link with other organizations and transformation initiatives of the Department
3. Identify statewide consumer (adults and older adults) that have the skills the grantee can use in the network who may be interested in providing community involvement facilitation
4. Identify and connect with other agencies of diverse racial/ethnic, cultural and rural background that serve a similar population
5. Recommend an array of technical assistance and technical assistance needs
6. Demonstrate attainment of the above outcomes with measurable data.

## Stable Life, Inc.

Stable Life, Inc., a consumer-run non-profit agency, provides *fiscal monitoring of peer run recovery centers*, toward development and maintenance of an infrastructure of strong self advocacy, family and consumer peer support, and education and empowerment for adults and older adults. Through this infrastructure of consumer and family involvement in consumer-run organizations Wisconsin is propelled into a recovery-based, consumer-focused, and family-centered service delivery system. Stable Life, Inc. is contracted to manage the distribution of $223,000 annually of MHSBG funds for the purpose of awarding new dollars and/or renewing existing contracts for peer-run recovery centers. Additionally, $50,000 annually is allocated to cover the cost of the provision of technical assistance and oversight for proper and appropriate use of distributed funds to the peer-run recovery centers.

Strengthening the financial stability of existing consumer run recovery centers and drop-in sites as well as growing other organizations as funding permits helps ensure that consumer access to peer run services will eventually be available statewide. In 2009 there were 12 consumer-run organizations across the state receiving funding through monthly direct-deposits.

Outcomes expected through the provision of these funds are to be measured as number of focus groups held, and creation of a steering committee such that there is a change in the recidivism rate in the justice system, while decreasing the number of people on waiting lists for CSP services. Technical assistance to these organizations includes: assisting organizations to assess, strengthen and standardize existing bookkeeping systems to pay the bills incurred in running peer drop-in centers and recovery centers. While improvements in bookkeeping are necessary in differing degrees among the 12 organizations, all of the organizations, except one relatively new organization, have received IRS 501 (c) (3) non-profit status and are submitting the required annual 990 reports. By establishing simple financial and data collection systems additional funding from a number of sources is able to be integrated into a financially sound and accountable system. Similarly, basic commercial money management techniques are being taught to each organization to ensure sites have the capacity and skill sets for accountability in financial growth.

## Clubhouse Programs

Clubhouse programs are an important part of Wisconsin's consumer-driven services. Clubhouse programs provide peer support, social interaction, vocational, recreational, and re-integration services. The Grand Avenue Club in Milwaukee, the Yahara House in Madison, the Harbor House in Racine, Spring City Corner Clubhouse in Waukesha, and the Community Corner House in Wausau are five clubhouses modeled after the Fountain House. Clubhouse programs are organized into units, in which members maintain the clubhouse by producing newsletters, maintenance and meal preparation, record keeping, and running retail stores.

## National Alliance on Mental Illness

The National Alliance on Mental Illness (NAMI) Wisconsin, Inc. has offered support, education and advocacy to Wisconsin consumers and families for over thirty years. NAMI Wisconsin is a grassroots organization with 34 affiliates serving an estimated 40 counties statewide and has membership of about 2,700. The organization represents mental health consumers, family members, mental health, and other professionals. NAMI Wisconsin maintains a database with over 6,000 contacts statewide. Individuals who self-identify as mental health consumers represent nearly 40 percent of the total NAMI Wisconsin membership. NAMI Wisconsin promotes recovery principles and incorporates recovery principles into all of their trainings and programs. The NAMI Wisconsin mission is to improve the quality of life of people affected by serious and persistent mental illnesses and to promote recovery.

Through NAMI Wisconsin and the network of local NAMI affiliates, over 15,000 contacts are made throughout the state annually providing support and education. NAMI Wisconsin has focused on meeting the needs of veterans affected by mental illnesses and their families. Veteran support groups and a Family-to-Family training specific to veteran families have reached over 120 individuals.

NAMI Wisconsin maintains a toll-free information line for family members and consumers, provides individual advocacy services and hosts a NAMI Wisconsin website that includes education, advocacy, and service information. NAMI Wisconsin has also had several initiatives to conduct outreach to underserved populations. NAMI Wisconsin is currently revising and updating its resource, "The Family and Consumer Resource Guide."

NAMI Wisconsin provides NAMI national training programs, including In Our Own Voice, Family-to-Family, Peer-to-Peer, Support Group Facilitator training, Parents and Teachers as Allies, NAMI Basics and NAMI Connection. The Family-to-Family training Program, taught for years in WI and nationally, has recently received national recognition as an evidence-based practice. NAMI Basics is a family education program based on Family-to-Family that is designed for families with young children with serious emotional disturbances. In 2010 additional NAMI Basics teachers were added. NAMI Connection is a new consumer support group model that is active and growing. In Our Own Voice continues to be a positive education and anti stigma program reaching health care providers as well as community members in 2010.

NAMI Wisconsin added two new local affiliates now covering 46 counties in 2011. Meeting the needs of veterans and their families is a continuing process with plans to expand veteran support groups and Family-to-Family classes for veteran families. Outreach to under-served population groups has been spearheaded by a workgroup of diverse family members, consumers and community leaders. In 2011, outreach efforts to the African American, Latino and LGBT communities are being piloted in three large affiliates around the state.

## NAMI Wisconsin Consumer Council (NWCC)

The NAMI Wisconsin Consumer Council (NWCC) was formed in 2005. The NWCC is a committee of the NAMI Wisconsin Board of Directors and is exclusively comprised of consumers. The NWCC derives its organizational structure from the NAMI National Consumer Council. The NWCC Council hosted two leadership initiatives in 2010. These included a summit on living well and finding success when living with mental illness and featured Austin Mardon. The other initiative allowed the state Consumer Council to reach out to three new communities to help them develop local Consumer Councils. The NWCC is also responsible for planning numerous workshops for the annual NAMI Wisconsin conference. The NAMI Wisconsin Recovery Project writes a recovery-based section in four issues of the "Iris" annually, which is the bi-monthly NAMI Wisconsin newsletter. The Recovery Project operates a recovery-oriented lending library, speaker's directory, and brings in national advocates for presentations in Wisconsin.

## Mental Health America of Wisconsin

Mental Health America of Wisconsin is the lead contracted agency for MHBG-funded prevention and early intervention activities. MHA is one of 320 local affiliates of National Mental Health America. The MHA of Wisconsin has 16 employees, three offices statewide with their primary office in Milwaukee, and a budget of more than $1.4 million. The nonprofit organization is dedicated to helping all people live mentally healthier lives. Their mission is to promote mental health, prevent mental disorders, and achieve victory over serious and persistent mental illness through advocacy, education, information, and support.

In 2010-2011 statewide coordination for suicide prevention has been a major focus of the MHA. Under their leadership Prevent Suicide Wisconsin was launched following collaboration with a number of partners including various state agencies such as DHS partners of DMHSAS and Division of Public Health, but including DPI, DCF, and others. Community partners such as Helping Others Prevent and Educate about Suicide (HOPES) as well as the Medical College of Wisconsin and others have been involved in the initiatives. Working with a statewide Steering Committee created during 2010, the suicide initiative was branded, materials developed, and a website, *Prevent Suicide Wisconsin* (PSW)[19], was established. The initiative has created materials to promote suicide awareness and recognition that Wisconsin has a newly created resource for suicide prevention. Another successful suicide summit was held in May of 2011 with attendance over 100+ comprised of partners and community teams from across the state.

MHA continues to work with local school districts on suicide prevention projects. MHA submitted a proposal on behalf of the State of Wisconsin for federal funding under the Garrett Lee Smith Memorial Youth Suicide Prevention grant for June 1, 2006 through May 31, 2009 of $1.3M. MHA has reapplied in 2011 for another federally funded grant application for youth suicide prevention for WI with the DHS again designating MHA as the lead agency to apply. The MHA continues to work with local communities, the Wisconsin School for the Deaf and other school districts, and a tribe on suicide prevention projects. Technical assistance and gatekeeper training is provided to the school districts and communities through direct guidance, resources, and educational opportunities to school districts, mental health providers, child welfare staff, parents and others about youth suicide and school mental health through conference presentations, publications and a best practices CD which includes a start-up toolkit and protocols to deal with issues surrounding suicide for schools and communities. Technical assistance includes direct guidance and resources from experts in the area of child suicide prevention such as the Suicide Prevention Resource Center. MHA offers educational opportunities to school districts, mental health and AODA providers, and parents about youth suicide and school mental health through conference and community presentations and publications.

[19] Prevent Suicide Wisconsin website: www.preventsuicidewi.org.

Another priority area for the MHA has been working for the passage of mental health and substance abuse insurance parity. These efforts in partnership with the New Day Coalition and the support of Lt. Governor Lawton led to successful passage of WI legislation in 2010 signed by Governor Doyle.

MHA has another primary focus to address mental health in the workplace in partnership with Wisconsin United for Mental Health, which has been addressing the promotion of mentally healthy workplaces in a variety of ways: symposia to address mental health in the workplace, training presentations for mental health professionals and health plan administrators, and employers on the importance of sustaining mental health insurance benefits, promotion of the integration of mental and physical health; information pertaining to mental health in the workplace for employers and consultation. Additionally MHA and Wisconsin United for Mental Health received a 2010 WI Partnership Program (WPP) development grant award to identify best practices and policies that support mentally healthy workplaces and environments. Goals include continuing to promote mental health and employee engagement in health and lifestyle education, information, and implementation screening, and early identification of employees who may be struggling with mental health disorders within the workplace and/or returning to the workplace. Another goal is to bring employers, administrators, health plan providers, consumers and healthcare providers together from across the state in creating buy-in and rationale for best practices to create mentally healthy workplaces. Goals continue to identify resources, research and information along with identifying potential strategies and barriers for implementation of mentally healthy workplaces. An Advisory Board and the principal investigator are working to identify key businesses and community partners in planning future steps on how to implement best practices and strategies.

## Wisconsin Family Ties

Wisconsin Family Ties, Inc. (WFT) is a statewide, not-for-profit organization run by families for families that include children and adolescents who have emotional, behavioral, and/or mental disorders. Their mission is to provide greater understanding, acceptance, and support in the community for these families. WFT is supported by the Division of Mental Health and Substance Abuse Services and is affiliated with the National Federation of Families.

WFT has family advocates who team with families and the professionals working with them. They work with schools, social services, mental health services, or the juvenile justice system, and help families locate resources clarify options and understand their rights. WFT has parent representatives involved on the local, state, and national level to build awareness.

WFT helps families find support groups in their area or helps parents start one. Families can share challenges and possible solutions with other families. This enables families with children who have SED in both urban and rural areas of the state to better access resources, services and find emotional support. WFT also aids families and professionals to find important and up-to-date information on laws, school issues, behavioral and emotional disorders, and other resources. WFT provides:

- A toll-free help line for families
- A quarterly newsletter
- A resource Library with books, articles, videos, audio tapes and magazines.
- An up-to-date web site

Often, WFT advocates are involved with families being served through collaborative systems of care which utilize the "wraparound" approach. In rural areas, WFT facilitates networking between families through family fun events, provides scholarships for families to attend conferences, and produces newsletters with information on resources and events for families with children who have SED.

## Independent Living Centers

Eight Independent Living Centers (ILCs) serve mental health consumers and people with other disabilities throughout the State, see http://www.ilcw.org/partners.html. Wisconsin ILCs are community-based, consumer-directed, not-for-profit organizations. Independent Living Centers are nonresidential organizations serving persons of all ages. Each of these centers provides:

- Information, assistance and referrals;
- Independent Living Skills Training;
- Cross-disability Peer Support;
- Individual and systems advocacy;
- Assistive Technology device loans; and
- Other services to promote independent living of people with disabilities.

## Disability Rights Wisconsin

Wisconsin's protection and advocacy agency is Disability Rights Wisconsin (DRW), formerly the Wisconsin Coalition for Advocacy (WCA).DRW is the designated state agency, which receives funding directly from the federal Center for Mental Health Services as a part of the Protection and Advocacy for Individuals with Mental Illness (PAIMI) program. The Protection and Advocacy for Individuals with Mental Illness (PAIMI) Program was established in 1986. Each state has a PAIMI program, which receives funding from the national Center for Mental Health Services. Agencies are mandated to (1) protect and advocate for the rights of people with mental illness and their families, and (2) investigate reports of abuse and neglect in facilities that care for or treat individuals with mental illness. These facilities and programs, which may be public or private, include hospitals, nursing homes, community-based programs, educational settings, homeless shelters, jails, and prisons. Agencies provide advocacy services or conduct investigations to address issues, which arise during transportation or admission to, the time of residency in, or 90 days after discharge from such facilities. DRW also receives funding from the DMHSAS allocation from the MHBG. The DRW provides individual advocacy services and conducts investigations throughout the state. DRW provides systems advocacy on a wide range of rights and services issues and conducts training when requested for consumers, family members, mental health providers, attorneys, and the general public on issues relating to the rights of persons with serious and persistent mental illness, stigma, recovery, recovery-oriented services, trauma-informed services, and access to appropriate services. In 2010-2011, DRW received $75,000 in MHBG funds annually to implement its protection and advocacy activities.

# 2. Data and Information and Technology

Wisconsin has a variety of data systems through different divisions, departments, and areas that usually operate independently; however, although many of these data systems obviously capture information about adults with SMI or youth with SED but are not interactive with the mental health data systems. For example, all HUD funded homeless programs participate in the Homeless Management Information System known in Wisconsin as Wisconsin Service Point (WISP). The PATH programs began using WISP to record the services provided, and the data for the PATH Annual Report is embedded in the system. WISP will be able to provide data on individuals who are homeless and referred to county mental health services. HUD also requires the local continua of care to do a "point in time survey" during the last week in January and in July to determine the number of people without housing on a given night. This year, PATH grantees will be required to participate in the "point in time surveys" Though some county mental health departments participate in this survey, if more counties volunteered to participate, there would be a more accurate understanding of the number of individuals who are homeless in the state. Although PATH data are available to DMHSAS, these data are not interoperable with the main behavioral

health data-system (HSRS).

Wisconsin has several client-level data reporting systems for mental health consumers. Most importantly, the Human Services Reporting System (HSRS) mental health data used for URS/NOMS reporting is primarily client-level data. All demographic, service, and mental health functional status data is collected on a client-level basis in HSRS. The service data is collected on a summary basis as opposed to a detailed encounter basis. Instead of reporting the hours for every service encounter, the HSRS only accommodates monthly summaries of hours of service. Thus, identifying exact dates of service on a daily basis is not always possible.

However, pilot testing of a new information technology system that accommodates service encounter-level mental health data is currently underway. The new data system encourages county providers to record state and federal mental health data in their own local information systems as opposed to recording data in State data entry screens only. The data can then be transferred from the provider's local information system to the State, but the provider will still have access to the data in their local information system for data analysis and quality improvement. Encounter-level service data includes a service record for every service encounter (i.e., outpatient session, inpatient stay) a client receives. Data recorded for every service encounter includes unique individual identifier, date of service, type of service, units of service, and provider. The new data system will simplify provider's direct transfer of data to the State, increase data quality feedback reports for counties, and create more flexibility in adapting State data systems to changing requirements.

For counties and contracted providers who do not initially have the capability to record MH/SA data in their local information system, the Wisconsin DHS is developing a web-based direct data entry system administered by the State for counties who do not have local information systems. Permanent new dual options for data entry and submission will be available for counties to choose from depending on their local information technology capacity.

# 3. Quality Improvement Reporting

Wisconsin currently collects, monitors and measures NOMS indicators as well as a variety of other indictors. Efforts are being made to update the data systems to client level data. Collaborative development of performance-based quality improvement strategies are being developed.

# 4. Consultation with Tribes

Wisconsin is home to six Native American nations through 11 federally recognized tribes[20]. These Tribes, along with upper Michigan in 1965 formed the Great Lakes Inter-Tribal Council (GLITC), a non-profit corporation of 12 tribes, whose mission has evolved to support member tribes in expanding sovereignty and self-determination[21]. In February 2004, the Governor signed Executive Order[22] number 39 acknowledging the unique relationship Wisconsin has with the Native American tribes and directing departments to collaborate and develop consultation plans. Prior to this, in 1972, the Department recognized the unique status of American Indians with the creation of a Tribal liaison position, which later evolved into a Tribal Affairs office with responsibilities that included government-to-government relations. On June 28, 2005, the Department ratified its *Policy Regarding Consultation with Wisconsin's*

[20] Wisconsin's Native American Tribes:
http://www.wisconsin.gov/state/core/wisconsin_native_american_tribes.html
[21] Great Lakes Inter-Tribal Council: http://www.glitc.org
[22] Wisconsin State Tribal Relations Initiative: http://witribes.wi.gov

*Indian Tribes*[23], being signed by both the Department Secretary and the Governor. In the policy, each tribe is recognized by the State for its unique status and its right to existence, self-government, and self-determination. Specific objectives are identified in the policy:

1) To create a collaborative effort (relationship) to improve health and well being of Tribal community members through the provision of efficient and effective health and human services.
2) To formalize the process and expectations for the [Department] to implement a government-to-government relationship and to seek consultation with and participation of representatives of Tribal governments in policy development and program activities.
3) To promote and develop methods of obtaining consultation on issues from Tribal governments and to involve their representatives in the DHFS decision making process.

Moreover, guiding principles are identified as well as the purpose and methods for meeting the objectives. Among the methods are annual meetings with tribal leaders and the Department Secretary and other Departmental administrators and staff as the Secretary so designates. Other meetings are to be scheduled as deemed necessary by a majority of the Tribal Chairpersons or Presidents or by the Secretary. The department in conjunction with appropriate Tribal program staff must establish an annual implementation plan by which the government-to-government consultation policy will be implemented including: a) Programs, b) policy and program development, c) priorities, d) consultation process, and e) evaluation process. Training sessions are also required for Department employees and others at least every six months. The policy also contains specific processes for the resolution of issues, language for determining representation of Tribal governments on committees and workgroups for long-term issues as well as short-term and *ad hoc* bodies, as well as a glossary of terms and definitions.

Currently, DHS has an active partnership with the eleven federally recognized Wisconsin tribes through the Tribal State Collaborative for Positive Change (TSCPC), which was established in 2007. TSCPC is an active and consistent forum for Native American Indian tribal mental health and AODA directors, program managers, and lead staff to learn of specific tribal initiatives in the mental health and AODA fields and to gain insights and access to local expertise in integrating mental health and AODA services. Each of the tribes conducted a COMPASS survey (focused needs assessment) with the goal of creating a strategic plan. Each of the eleven tribes established a strategic plan for co-occurring mental health and AODA. Needs identified included re-writing behavioral health policies; developing procedures to be more inclusive of co-occurring disorders; developing a template for more integrated charting between mental health and AODA; educational/training sessions on trauma; utilizing a trauma informed care framework; and expanding the trauma information into a mini-Gathering of Native Americans (GONA) event to more specifically look at historical trauma issues and help define the strengths from within the tribe for solutions based programming. A subsequent discussion of the merits of telehealth resulted in one tribe submitting a successful grant for telehealth equipment and working on establishing telehealth sessions for mental health clients.

The TSCPC also serves as a support and exchange of information forum for this group and is proving most helpful in the exchange of specific tribal initiatives, conference and other training information. The TSCPC submitted anecdotal data/input to help the Oneida Tribal Behavioral Health representative determine the level of staffing for their respective behavioral health patients beyond a strictly medical model of care. The Red Cliff Band of Lake Superior Chippewa representative requested "wages" data from the TSCPC to better establish competitive rates and sustain the staff hired to fulfill substance abuse counselor positions in the agency. Tribes are kept informed about other state Medicaid programs like the Coordinated Services Team (CST) model, discuss options in contracting with county agencies for crisis

[23] Policy Regarding Consultation With Wisconsin's Indian Tribes: http://www.dhs.wisconsin.gov/tribalaffairs/TribalConsultationPolicy.pdf

services to help decrease costs for emergency medical admissions, and learn of State Council on Alcohol and Other Drug Abuse (SCAODA) issues through one subcommittee representative. In 2009 the TSCPC successfully applied for an AmeriCorps Planning Grant, and in 2010 submitted an Implementation AmeriCorps Grant proposal. Eight Wisconsin tribes have signed resolutions to utilize 13 AmeriCorps Volunteers, focusing on prevention efforts to help decrease the effects of substance abuse issues within tribal communities. This is the first Wisconsin Inter-Tribal AmeriCorps Grant project.

# 5. Service Management Strategies

# 6. State Dashboard

Table 9 Plan Year: 10/01/11 through 06/30/2013

| Priority Area | Performance Indicator |
|---|---|
| 1) Promote evidence-based services and treatment to increase employment and to more effectively use scarce taxpayer resources in all systems that fund mental health services, including county and tribal service systems, Medicaid, and the criminal justice system. | - Total number of clients receiving supported employment from programs trained by the Dartmouth SE Initiative.<br>- The percentage of adults with SMI in the labor force who are employed in FFY 2012. (National Outcome Measure) |
| 2) Promote community-based services for adults with serious mental illnesses and children with severe emotional disturbance through the reduction in use of inpatient services. | The percentage of consumers discharged from all state and county psychiatric hospitals in FFY 2012 who are readmitted within 30 days. (National Outcome Measure) |
| 3) Increase the capacity of consumers and families to self-direct care and treatment with a focus on recovery and support from peers. | Number of certified peer specialists |
| 4) Promote the identification and appropriate treatment for children's mental health needs in the child welfare system. | The percentage of children in the State child welfare out-of-home care system with identified mental health needs as measured by a rating of 1-3 on the CANS tool. |

# 7. Suicide Prevention

Suicide is a complex and multi-factorial phenomenon with many interacting factors. Yet strategies exist to reduce suicide risk both from a community and a clinical standpoint. Means restriction and access to services are examples of the former; whereas assertive assessment and treatment of mood disorders are examples of the latter. Working in conjunction with state partners, Wisconsin will establish a process and committee to review, update, and re-write the now dated state suicide prevention plan. The *Wisconsin Suicide Prevention Strategy* last updated on May 14, 2002.[24] The updated plan will take into account the latest information about specialty populations, developing recommendations based on evidence-based and best practices for monitoring the suicide rate in those populations, exploring strategies for means restrictions (e.g., gun locks, prescription drug collection programs, etc.), rendering interventions, etc. Consideration will be given to prevention strategies in the context of social networking media.

[24] Wisconsin Suicide Prevention Strategy on Internet (May 14, 2002): http://www.dhs.wisconsin.gov/health/injuryprevention/pdffiles/WISuicidePrevStrategy.pdf

**Wisconsin Annual Suicide Rate (per 100,000) 2005-2009**

| | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|
| Wisconsin | 11.45 | 11.91 | 12.83 | 12.99 | 12.75 |
| Actual | 639 | 668 | 724 | 737 | 724 |

**Suicides and Suicide Rate (per 100,000 population) for 10-19 year olds, Wisconsin, 2005-2009**

| | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|
| 10-19 | 54 | 40 | 35 | 29 | 47 |
| Population | 787,386 | 781,664 | 773,940 | 766,446 | 765,608 |
| Rate | 6.9 | 5.1 | 4.5 | 3.8 | 6.1 |

**Suicides and Suicide Rate (per 100,000 population) for 70-79 year olds, Wisconsin, 2005-2009**

| | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|
| 70-79 | 35 | 28 | 41 | 42 | 38 |
| Population | 310,852 | 309,377 | 308,535 | 309,666 | 313,961 |
| Rate | 11.3 | 9.1 | 13.3 | 13.6 | 12.1 |

**Suicides and Suicide Rate (per 100,000 population) for 80+ year olds, Wisconsin, 2005-2009**

| | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|
| 80+ | 30 | 22 | 22 | 25 | 33 |
| Population | 225,805 | 224,764 | 229,723 | 232,305 | 230,823 |
| Rate | 13.3 | 9.8 | 9.6 | 10.8 | 14.3 |

**Suicide Rates by Sex, Wisconsin 2005-2009**

| | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|
| Male | 18.77 | 18.84 | 20.54 | 20.58 | 19.82 |
| Female | 4.26 | 5.07 | 5.22 | 5.5 | 5.77 |

**Suicide Deaths by Sex, Wisconsin 2005-2009**

| | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|
| Male | 519 | 525 | 576 | 580 | 559 |
| Female | 120 | 143 | 148 | 157 | 165 |
| **TOTAL** | **639** | **668** | **724** | **737** | **724** |

**Suicide Rates by Race/Ethnicity, Wisconsin 2005-2009**

| | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|
| Non-Hispanic White | 12.01 | 12.57 | 13.81 | 14.08 | 13.71 |
| Black | 5.39 | 8.29 | 6.67 | 5.77 | 9.71 |
| Hispanic | 6.06 | 4.54 | 5.51 | 6.45 | 5.86 |
| American Indian | 34.75 | 15.19 | 14.95 | 18.42 | 9.14 |
| Asian | 7.83 | 10.96 | 8.19 | 4.79 | 3.13 |

**Suicides by Race/Ethnicity, Wisconsin 2005-2009**

| | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|
| Non-Hispanic White | 580 | 608 | 669 | 684 | 665 |
| Black | 18 | 28 | 23 | 20 | 34 |
| Hispanic | 14 | 11 | 14 | 17 | 16 |
| American Indian | 18 | 8 | 8 | 10 | 5 |
| Asian | 9 | 13 | 10 | 6 | 4 |
| **TOTAL** | **639** | **668** | **724** | **737** | **724** |

**Suicide Rates by DHS Region, Wisconsin 2005-2009**

| | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|
| Southern | 11.32 | 11.78 | 13 | 11.87 | 13.97 |
| Southeastern | 10.69 | 11.06 | 10.83 | 12.02 | 10.65 |
| Northeastern | 12.3 | 12.73 | 15.81 | 13.35 | 14.07 |
| Western | 10.97 | 13.23 | 13.29 | 14.45 | 13.8 |
| Northern | 13.53 | 11.46 | 12.86 | 16.32 | 13.95 |

**Suicides by DHS Region, Wisconsin 2005-2009**

| | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|
| Southern | 120 | 126 | 140 | 129 | 152 |
| Southeastern | 220 | 228 | 225 | 250 | 222 |
| Northeastern | 149 | 155 | 193 | 164 | 173 |
| Western | 83 | 101 | 102 | 112 | 107 |
| Northern | 67 | 57 | 64 | 82 | 70 |
| **TOTAL** | **639** | **667** | **724** | **737** | **724** |

**Suicide Deaths by Underlying Cause of Injury, Wisconsin, 2005-2009**

| | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|
| Firearms | 301 | 299 | 335 | 343 | 344 |
| Poisoning | 152 | 146 | 151 | 157 | 155 |
| Suffocation | 139 | 155 | 187 | 173 | 176 |
| Other | 47 | 68 | 51 | 64 | 49 |
| **Total** | **639** | **668** | **724** | **737** | **724** |

**Proportion of Suicide Deaths by Underlying Cause of injury, Wisconsin, 2005-2009**

| | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|
| Firearms | 47.1% | 44.8% | 46.3% | 46.5% | 47.5% |
| Poisoning | 23.8% | 21.9% | 20.9% | 21.3% | 21.4% |
| Suffocation | 21.8% | 23.2% | 25.8% | 23.5% | 24.3% |
| Other | 7.4% | 10.2% | 7.0% | 8.7% | 6.8% |
| **Total** | **639** | **668** | **724** | **737** | **724** |

# 8. Technical Assistance Needs

# 9. Involvement of Individuals and Families

In addition to NAMI, WFT, MHA, GEP, WUMH, etc., Wisconsin plans are informed by the Wisconsin Council on Mental Health (WCMH) and its various subcommittees.

## Peer Specialist Development

With funding from the Medicaid Infrastructure Grant (MIG) awarded to the Department by CMS, the Division has partnered with a local Independent Living Center, Access to Independence, Inc (ATI) to hire a Peer Specialist Coordinator. This position has assisted the Department in creating a Certification structure in Wisconsin to ensure that Peer Specialists meet CMS standards for Medicaid billing in the major community programs in Wisconsin. Capacity and authority to hire for Peer Specialist roles already exists for the Crisis Programs, CCS and CSP although not always identified that way within billing structures (i.e., Mental Health Technicians in 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 Recovery Implementation Task Force was created to be the guiding force in the development of the Peer Specialist program. A general Wisconsin job description and competencies were developed and approved in 2008. In 2009, this committee partnered with ATI, UW Madison and UW Milwaukee in the development and validation of a competency based exam as well as the certification structure. Efforts are continued under this current plan to expand the number and dissemination of Certified Peer Specialists.

# 10. Use of Technology

## Wisconsin's eHealth Initiative Action Plan

Wisconsin is developing an eHealth system through collaboration between the state's public and private health care purchasers. The Wisconsin Collaborative for Healthcare Quality, the Wisconsin Health Information Organization, the Wisconsin Medical Society and the Wisconsin Hospital Association, major insurers and provider organizations are collaborating on the measurement and reporting of health care quality and costs. Wisconsin's work on eHealth is aligned with federal goals and activities in other states.

Wisconsin has a five-year plan which contains recommendations, plans, and a timetable to achieve the goals set out in the Governor's Executive Order for statewide health data exchange between payers, health care providers, consumers of health care, researchers and government agencies. It also recognizes the essential role of consumers and patients and seeks to empower and support individuals to take responsibility for their own health. It balances privacy rights with providers' needs to share information for safe, effective treatment.

The plan weaves together three strategies to take a coherent, whole-systems approach to transformation of the health care sector:

- Improve quality, safety and value by establishing the eHealth technology platform to provide needed information at the point of patient care.
- Encourage the development, alignment and implementation of value-based purchasing policies and actions across the public and private sectors.

- Link health information technology (HIT) and health information exchange (HIE) plans to prevention and disease management activities.

These strategies have guided the activities of the initiative since 2006. They rely on joint public-private ownership with active collaboration and coordination of related system improvement efforts. The eHealth action plan components include:

1. Establish the eHealth technology platform.
    a. HIT adoption.
    b. Regional health information exchange (HIE).
    c. Statewide HIE services.
2. Value-based purchasing policies and actions.
3. Link HIT and HIE plans to prevention and disease management activities.
4. Take an incremental approach-growing thoughtfully over time with frequent evaluation of progress.

### Technological Innovations Being Initiated Through Community Recovery Services (CRS)

CRS is developing technological innovations speed consumer service plan processing time, disseminate new and useful information to stakeholders to. CRS is using Web-based posting and a list-serve to keep steady communications with CRS sites. In addition, Adobe Connect is used to bring CRS teams together via meetings directly to their computer desktop. Most recently, the latest initiative involves the creation of an electronic case file (ECF) for all CRS consumer records. Integral to this initiative is a procedure by which counties and tribes are encouraged to submit the entire consumer service plan packet electronically via the state's newly implemented encrypted email system. The ECF exists on the secure internal computer system of the Department. The CRS Team is creating both policy and procedure to address issues such as record retention, HIPAA/HITECH compliance, cataloging, and work-in-process. ECF will be accessible by all CRS Team members simultaneously, and will also be accessible from remote locations via the Department's secure virtual private network (VPN). Adobe Acrobat technology allows physical files to be scanned into an electronic format. Submission of consumer service plans via the state's encrypted email system is expected to be a very popular procedure with Wisconsin's counties and tribes. Encrypted email is deemed to be both HIPAA and HITECH compliant, and the labor/cost savings related to the management and retention of physical records is expected to be significant over the lifetime of the benefit.

## 11. Support of State Partners

As in the case of most states, Wisconsin has experienced fiscal and budgetary challenges. Strained resources and the loss of a number of veteran state staff through accelerated retirement and downsizing has increased the workload on existing staff. Moreover with changes in administration have come changes in leadership in most departments of state government. As such, although DMHSAS has good working relationships with partners, framing those relationships in a deliberate and collaborative fashion toward meeting the expectations of SAMHSA and aligning various departmental priorities with those objectives remain challenging at this time. Through a phased submission process, Wisconsin will work toward developing those alliances and securing the necessary MOUs and letters of support over the upcoming FFY.

The State Mental Health Authority is in the Division of Mental Health and Substance Abuse Services (DMHSAS) in the Department of Health Services (DHS). DHS is one of the many cabinet level agencies that are a part of the Executive Branch of state government. Secretaries of each cabinet level

agency or department are appointed by and report to the Governor in Wisconsin.

DHS administers a wide range of services to clients in the community and at state institutions; regulates care and treatment providers; and supervises and consults with local, county and tribal public and non-profit agencies. The Department's responsibilities span a large number of program areas in six divisions, including the DMHSAS. The other divisions with their responsibilities are listed below:

- Division of Public Health (DPH) promotes the health and well being of Wisconsin citizens and visitors through programs which encourage positive and healthful lifestyles and identify preventive and remedial actions to eliminate, correct, and/or alleviate diseases and health hazards. DPH is responsible for providing public health services and environmental and public health regulation.
- Division of Quality Assurance (DQA) certifies, licenses, and surveys approximately 46 types of health care and residential programs throughout the state. Examples the health care providers certified through DQA are hospitals, nursing facilities, intermediate care facilities for persons with mental retardation, end-stage renal dialysis centers, hospice agencies, home health agencies, and mental health and substance abuse service agencies.
- Division of Enterprise Services (DES) provides management support for the department related to fiscal services, information technology and personnel issues.
- Division of Health Care Access and Accountability (DHCAA) is responsible for administering programs such as Medicaid, BadgerCare, FoodShare, SeniorCare and disability determination.
- Division of Long Term Care (DLTC) oversees the provision of long-term support options for the elderly and people with disabilities. DLTC also operates the Department's institutions for persons with developmental disabilities.
- Other state departments work closely with the State Mental Health Authority on a regular basis including the following:
    - Department of Children and Families (DCF) responsibilities include public child welfare, regulation and licensing of child caring facilities, youth development and a broad range of community programs. It oversees the Wisconsin Temporary Assistance for Needy Families (TANF) programs, called Wisconsin Works (W2), which is designed to move welfare recipients into the labor force. It also provides the direct administration and operation of Milwaukee County's Child Welfare System.
    - Department of Commerce is being phased out in favor of a quasi-governmental entity, known as the Wisconsin Economic Development Corporation (WEDC); however, the Division of Housing will transition to the State Department of Administration later in 2011.
    - Department of Corrections (DOC) administers the state adult prison, probation and parole systems, and oversees the local juvenile justice system. The DOC partners with the DMHSAS to staff the state inpatient treatment facility for MI inmates..
    - Department of Military Affairs, Division of Emergency Management, has responsibility for developing and implementing the state emergency operations plan; provides assistance to local jurisdictions in the event of a disaster; and administers private and federal disaster and emergency relief funds.
    - Department of Regulation and Licensing (DRL) is responsible for credentialing and regulating various professions and occupations in the state, including mental health and substance use disorder professionals. DRL also investigates and prosecutes complaints against credential holders.
    - Department of Veterans Affairs provides educational and economic assistance to eligible veterans. It also operates a variety of facilities, services and supports that provide support for Wisconsin's veterans who are incapacitated due to age or disability.

- Department of Workforce Development (DWD) is responsible for a variety of work-related programs designed to connect people with employment opportunities in Wisconsin. It also is responsible for job centers, job training, placement services as well as employment related services for people with disabilities through their Division of Vocational Rehabilitation.
- The Department of Public Instruction (DPI) is independent of the Governor, with an elected constitutional officer, the State Superintendent of Public Instruction. DPI provides direction and technical assistance for public elementary and secondary education in Wisconsin. They offer a broad range of programs and professional services to local school administrators and staff; distribute state and federal school aids; work to improve curriculum and school operations; and ensure education for children with disabilities.
- Department of Administration (DOA) offers direct services to Wisconsin residents and communities, including assistance with housing and energy efficiency improvements, but its primary function is to deliver a wide range of support services to other state agencies, such as maintaining the State Capitol and other state facilities. With the Department of Commerce being dismantled, DOA will assume administrative oversight of the Projects for Assistance in Transition from Homelessness (PATH) program under a Memorandum of Understanding (MOU) with DMHSAS. PATH serves individuals who are both mentally ill and homeless.

## Institutional and Inpatient Services

The Wisconsin public mental health system recognizes the importance of treatment services being available at the community level in the least restrictive environment. The community mental health system strives to provide an array of services to the consumer to reduce the need for inpatient treatment and reduce the disruption caused to the consumer and family by hospitalization. Discharge planning and a strong aftercare community mental health system are required to be initiated on the day of the consumer's admission. Such planning is key to keeping the length of the hospital stay to a minimum, assuring minimal re-admissions, and promoting recovery.

When required, psychiatric hospitalization in Wisconsin occurs in one of the following five settings: state mental health institutions, county mental health hospitals, two veteran's administration hospitals, private psychiatric hospitals, and general medical/surgical hospitals. DMHSAS has administrative management of the two state mental health institutes: Mendota Mental Health Institute in Madison and the Winnebago Mental Health Institute in Winnebago. These facilities provide specialized, acute treatment to children/ adolescents, adults, older adults and forensic mental health consumers with the long-term goal of reintegration into the community. The institutions provide training and consultation as requested to community-based programs.

In addition to the two state mental health institutes, DMHSAS also operates three additional facilities; data from these facilities is not included in the information in this plan, unless otherwise specified:

- The Wisconsin Resource Center (WRC) is administered by the Wisconsin Department of Health Services in partnership with the Wisconsin Department of Corrections. WRC is a specialized mental health facility established as a prison under s. 46.056, Wisconsin Statutes. WRC is also identified as a treatment facility for the placement of Sexually Violent Persons (SVPs) detained or admitted pursuant to Chapter 980, Wisconsin Statutes.
- The Mendota Juvenile Treatment Center (MJTC) is a secure correctional facility located on the grounds of the Mendota Mental Health Institute in Madison, Wisconsin. MJTC staff serve the mental health needs of male adolescents transferred from Division of Juvenile Corrections

institutions. Youth move to and from MJTC based on assessment of their mental health and security needs.

- Sand Ridge is a secure treatment facility in Mauston, WI, providing specialized treatment services for persons committed under Wisconsin's sexually violent persons law, Chapter 980, Wisconsin Statutes.

Counties have a general statutory responsibility and a fiscal incentive to provide comprehensive community programs. If a client between the ages of 22 and 65 is admitted to a private or state psychiatric hospital, then MA reimbursement is not available, therefore the county is responsible for paying for an indigent patient's care in that facility. If a county uses inpatient facilities extensively, it will be expensive. In contrast, if a county chooses to develop community services for its adult residents with severe and persistent serious and persistent mental illness, then it may use saved inpatient dollars for community services.

Table 2 below outlines the trends in the average length of stay of patients who have a mental disease or disorder of all ages by funding source for all Wisconsin hospitals (general and psychiatric). It should be noted that the data for the categories of self-pay and other/unknown are based on small numbers of persons compared to the other payer categories. Therefore, outliers in the data tend to skew the average length of stay. The overall data trend for all Wisconsin hospitals generally portrays a sustained drop in the average length of stay throughout the ten-year period.

Several factors that likely will result in a decreased utilization of inpatient hospitalization by counties:

1. Prior to June 29, 2009, law enforcement officers could independently determine that a person should be taken into custody under an emergency detention. 2009 Wisconsin Act 28 added a requirement that the county human services department must approve each emergency detention. County human services department are taking this opportunity to determine if the person's needs could be met in a community setting rather than through emergency detention.
2. 2009 Wisconsin Act 28 makes counties responsible for the matching funds portion of Medicaid reimbursement for admissions of children (under age 22) and elders (age 65+) to either of the two state mental health institutions. This statutory change provides an additional incentive to counties to use the least restrictive placement consistent with the child's or elder's needs.
3. BPTR started a Mental Health Collaborative Project to reduce readmission rates to psychiatric hospital units within nine counties. The Network for Improvement of Addiction Treatment (NIATx) at the University of Wisconsin is consulting with the counties on quality improvement techniques to help reduce readmissions. NIATx is a pioneering improvement collaborative that works with substance abuse and behavioral health organizations. Many of the counties are working on improvements in the discharge planning process and the transfer to community providers (e.g., outpatient mental health clinic), such as making a follow-up call two days after the hospital discharge to ensure that the person has an appointment with the community provider, has filled the prescription given to the person by the discharging hospital, etc.

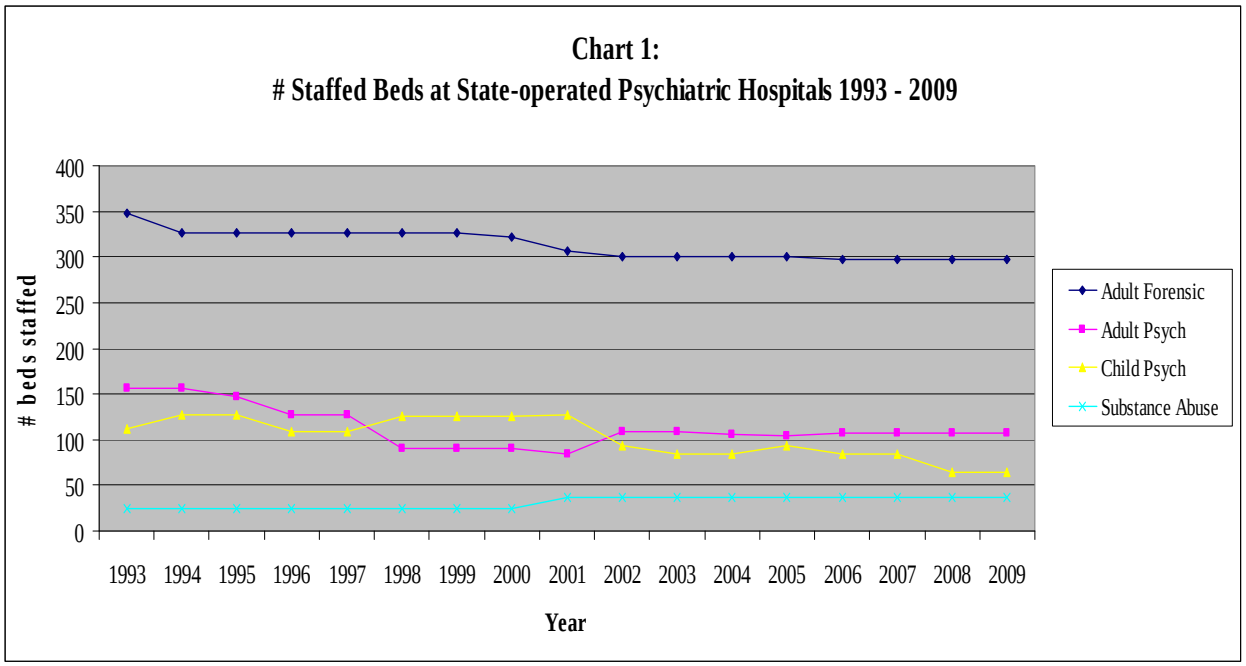
**Table 2**
**Wisconsin Hospitals - Average* Length of Stay (LOS)**

| Payer | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|---|---|---|---|---|
| Medicare | 12.55 | 12.49 | 11.87 | 9.62 | 9.37 | 8.11 | 11.2 | 10.85 | 11.59 | 11.33 |
| Medicaid | 12.18 | 11.25 | 9.94 | 12.29 | 12.41 | 11.22 | 7.73 | 7.46 | 7.17 | 6.83 |
| Other Govt. | 6.97 | 5.73 | 5.91 | 26.49 | 30.17 | 6.60 | 5.27 | 5.17 | 5.23 | 5.15 |
| Private Ins. | 8.22 | 8.81 | 10.04 | 5.85 | 5.97 | 5.51 | 6.15 | 6.21 | 6.03 | 5.94 |
| Self Pay | 24.17 | 16.2 | 16.94 | 7.97 | 6.15 | 6.66 | 20.29 | 18.37 | 20.36 | 20.21 |
| Other/Unknown | 5.86 | 42.75 | 8.02 | 19.81 | 33.89 | 21.15 | 6.8 | 6.30 | 6.52 | 6.56 |
| **TOTAL LOS** | 11.24 | 10.70 | 10.75 | 10.39 | 11.25 | 9.47 | 9.15 | 8.90 | 9.11 | 8.78 |

Source: July 2010 - Bureau of Health Information, Division of Health Care Access and Accountability
*The total average LOS cannot be computed by averaging each column of figures due to variance in the number of people in each category. The variation in average length of stay within payer group over the years is in part accounted for "outliers" and by difference in the population size by payer group (e.g., the number of persons with "Other Government" funding in CY 2004 was 3,272 and in CY 2009 was 1,625; the number of persons with "Other/Unknown" funding in CY 2004 was 757 and in CY 2009 was 1,698).

## State Mental Health Hospitals' Bed Capacity and Use

Chart 1 shows the number of "staffed" beds for the state's two mental health hospitals and Chart 2 shows the average daily census at the two state hospitals. Table 3 shows the data for these two charts. As the average number of "staffed" inpatient beds has decreased in the last 10 years (Chart 1), the average daily census has remained stable (Table 3) indicating a more efficient use of the inpatient beds in the state. The state plans to work towards further reduction in the use of these hospitals particularly for children through the hospital diversion program. Both children's staffed state psychiatric inpatient beds and inpatient utilization have steadily decreased since 1995.



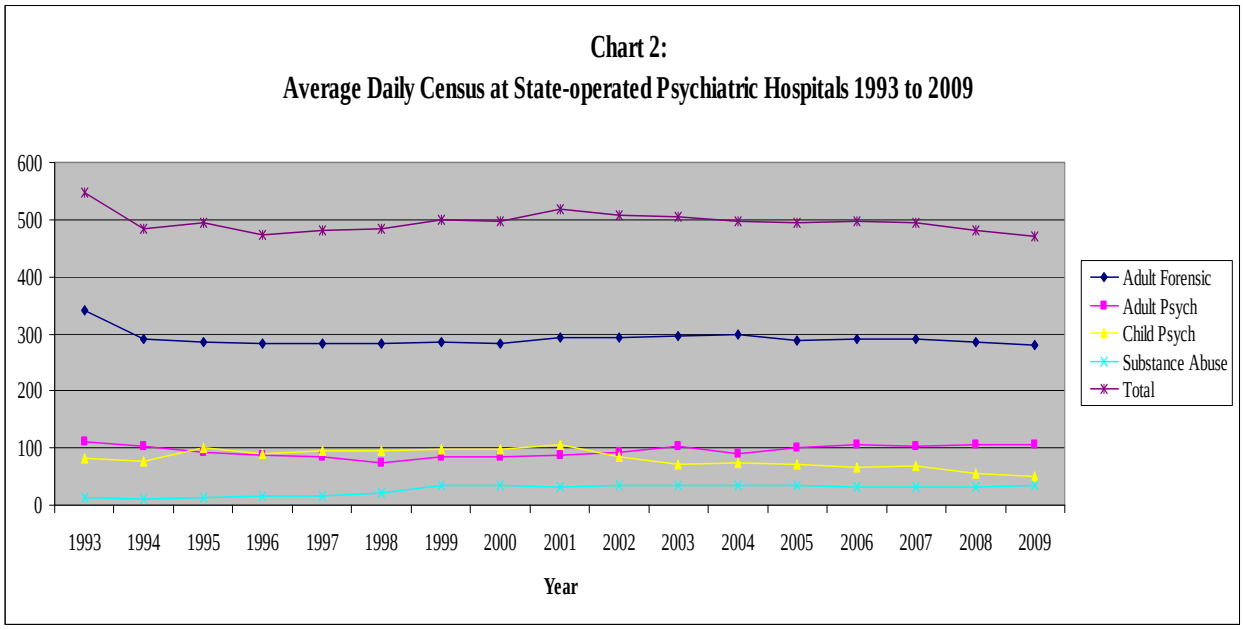



Table 3 does not indicate a significant reduction in the use of state-owned hospital beds for adults, but it does indicate that children's beds were reduced by 20 in 2008. The utilization rate is low for a state population of over 5.5 million persons. This is because there has been a decrease in private general psychiatric beds throughout Wisconsin causing inpatient bed shortages due to current economic short falls, staff reallocations, and shortages in the workforce. Other challenges center around the point at which the reduction of inpatient psychiatric beds becomes a negative factor on the ability of a comprehensive community-based system to provide timely and age appropriate access to consumers across the life span. A delay in access to inpatient services can mean that the severity and duration of the illness may be increased, a longer hospital stay is required, and there is greater demand for specialized mental health services, medications and other health care treatment.

Chart 3 shows that the average length of stay has decreased over the past ten years when looking at all payer groups for all inpatient mental health hospitalizations. A similar trend is generally evident when looking at the average length of stay for the payer groups of Medicaid, Medicare and Other Government. The average LOS tended to be higher for the State Mental Health Institutes than in all Wisconsin hospitals (see Chart 4). The general trend of a decrease in the average length of stay for each of the payer groups and overall is evident in the data for the Mental Health Institutes.

## Table 3:
## State-operated Psychiatric Inpatient Hospital Utilization (Average Daily Census)
(State Fiscal Years 2000-2009)

| State Psychiatric Inpatient Hospital Beds (staffed) – State Fiscal Years 2000-2009 | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 |
| Adult Forensic | 322 | 306 | 301 | 301 | 301 | 301 | 298 | 298 | 298 | 298 |
| Adult Psych | 91 | 85 | 109 | 109 | 105 | 104 | 107 | 107 | 107 | 107 |
| Child Psych | 125 | 127 | 94 | 84 | 84 | 94 | 84 | 84 | 64 | 64 |
| Substance Abuse | 25 | 37 | 37 | 37 | 37 | 37 | 37 | 37 | 37 | 37 |
| Total | 563 | 555 | 541 | 531 | 527 | 536 | 526 | 526 | 506 | 506 |

DMHSAS information (2010)

| State Psychiatric Inpatient Hospital Utilization (Average Daily Census) – State Fiscal Years 2000-2009 | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 |
| Adult Forensic | 283.1 | 293.1 | 294.6 | 296 | 298.3 | 288 | 290.8 | 290.6 | 285.8 | 280.3 |
| Adult Psych | 84.3 | 86.4 | 93.4 | 103 | 89.9 | 99.7 | 106.6 | 102.4 | 106.6 | 106.6 |
| Child Psych | 97.1 | 104.7 | 85.5 | 70.6 | 75.2 | 71.9 | 67.1 | 68.3 | 55.6 | 49.4 |
| Substance Abuse | 33.7 | 32.6 | 33.4 | 35.0 | 34.5 | 34.9 | 32.8 | 32.3 | 32.2 | 35.1 |
| Total | 498.2 | 516.8 | 506.9 | 504.6 | 497.9 | 494.5 | 497.3 | 493.6 | 480.2 | 471.6 |

DMHSAS information (2010)

## Chart 3

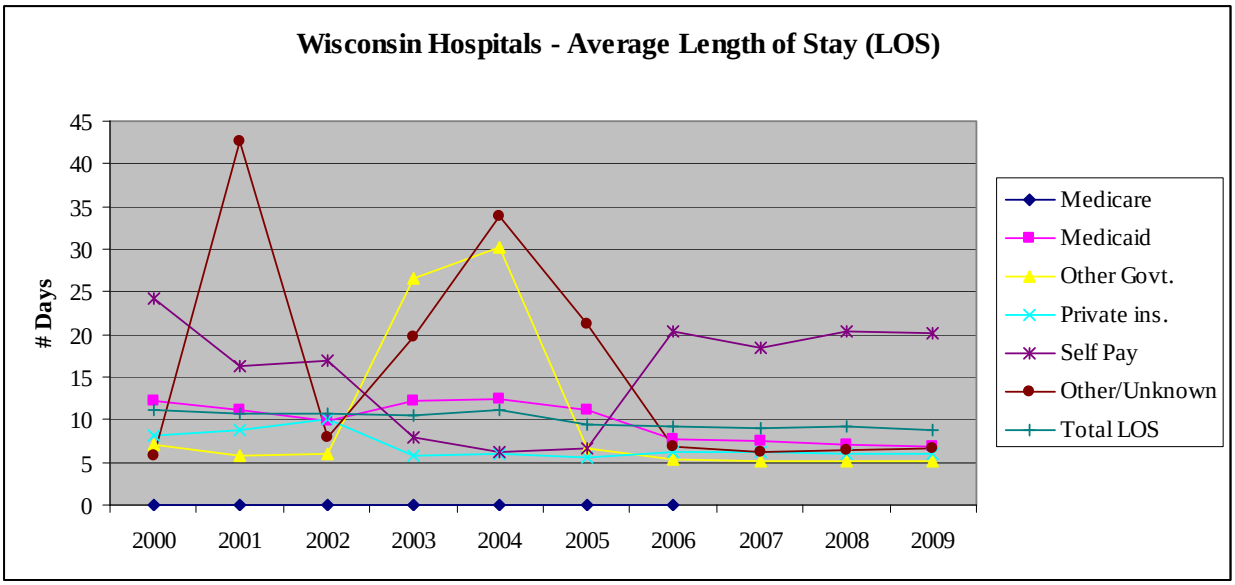



Chart 5 provides the number of psychiatric beds in Wisconsin hospitals in 2009. In 2009, the number of psychiatric beds available is 1,781, the number staffed is 1,603, and the average daily census for psychiatric beds in Wisconsin hospitals is 1,134. As of July 2010, there are 4,685 beds in 411 community-based residential facilities, and 2,281 beds in 591 state licensed adult family homes that potentially could serve persons who have a mental illness.

**Chart 4**

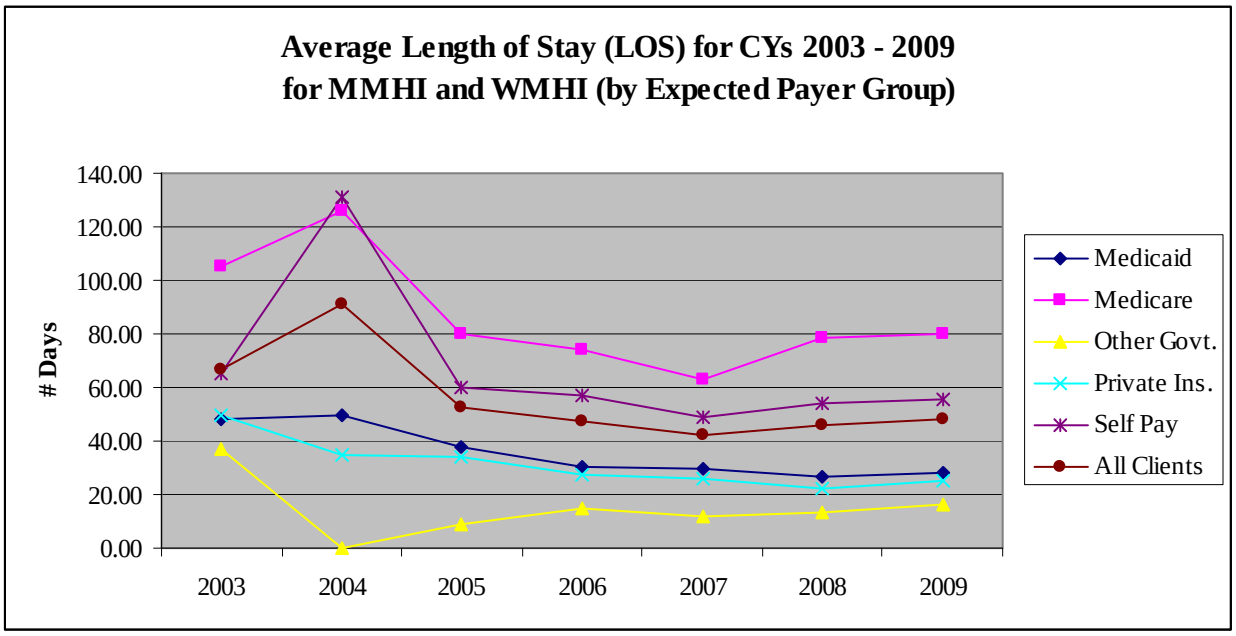
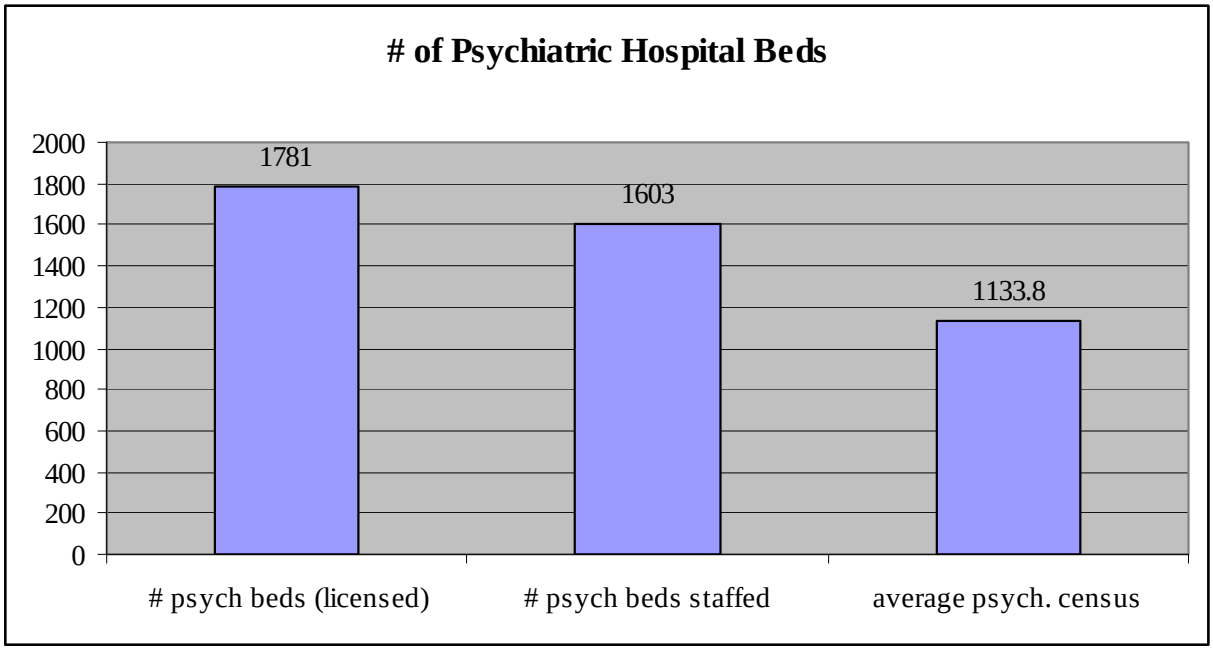



**Chart 5**




The information of # psych beds staffed and average psych. census is drawn from responses to the 2008 Annual Survey of Hospitals and the Fiscal Year 2008 Hospital Fiscal Survey, and represents each hospital's pages from the Guide to Wisconsin Hospitals, Fiscal Year 2008, Wisconsin Hospital Association Information Center. The number of psych beds (licensed) is from the 2010 data from the Division of Quality Assurance. These two data sources represent information for all hospitals in Wisconsin with the exception of the two Veterans Administration hospitals.

## Services for Persons Residing in Nursing Homes

In 2010, the contracted Preadmission Screening and Resident Review (PASRR) agency completed 8,783 Level II screens for persons who have a mental illness. Two (< 0.1 percent) of the persons screened were determined not to need nursing facility placement and 235 (2.7 percent) of the persons screened were found to need specialized psychiatric rehabilitation services, which are services necessary to prevent avoidable physical and mental deterioration, while maximizing the consumer's functional abilities. 81.9 percent of the screens were for persons ages 65 and older and 77.2 percent of all the screens found that the person has a severe medical condition or severe cognitive losses.

As of January 1, 1997, Wisconsin's PASRR policies changed to require a "change of status" resident review, where previously an annual resident review was required. The result of this policy change is that the PASRR data alone does not indicate how many persons who received a Level II Screen currently reside in a nursing facility and where these persons currently are located. To address this limitation, a process to match the PASRR data from January 1, 1996 to date with the most current Minimum Data Set (MDS) information was initiated. Based on the matched data through May 2, 2011, there are:

- 10,204 persons currently residing in a nursing facility who have received a PASRR Level II Screen.
- 1,184 of the 10,204 persons were found to not have a serious mental illness as defined by the federal PASRR regulations.
- 8,174 of the 10,204 persons were found to have such significant medical issues or cognitive losses that these persons were determined to be appropriate for nursing facility placement and to not require specialized services or specialized psychiatric rehabilitative services (i.e., qualified for a categorical determination under Wisconsin's PASRR policies).
- 846 of the 10,204 persons were found to have a serious mental illness and received a Full Level II Screen. All individuals who were determined to not be appropriate for a nursing facility placement have been discharged or barred from admission. There are no individuals in nursing facilities who were determined to need specialized services. Only 362 persons were identified via the PASRR Level II Screen to need specialized psychiatric rehabilitative services.

The number of nursing facility/IMD beds continues to decline. As of September 1, 2004, Milwaukee County Behavioral Health Complex (MCBHC) no longer was identified as a nursing facility/IMD. With the change in licensure of MCBHC there now are only 110 nursing facility/IMD beds in the state.

The number of licensed hospital/IMD beds also continues to decline, as does the number of psychiatric beds in general hospitals. The following table represents the number of psychiatric beds in all Wisconsin hospitals as of specific dates:

| 10/28/1999 | 03/07/2000 | 06/01/2001 | 06/07/2004 | 04/21/2005 | 09/18/2006 | 02/19/2009 | 07/19/2010 |
|---|---|---|---|---|---|---|---|
| **2,467** | **2,395** | **2,270** | **2,196** | **2,189** | **2,124** | **2,045** | **1,781** |

The following table identifies the number of psychiatric beds in hospitals that are designated as an IMD by ownership status:

| Hospital | County | # beds | # beds staffed | Avg. census |
|---|---|---|---|---|
| COUNTY-OWNED HOSPITALS: | | | | |
| Fond du Lac Cty Acute Psych Unit | Fond du Lac | 25 | 25 | 15.2 |
| Brown Cty Community Treatment Ctr | Brown | 68 | 25 | 24.5 |
| Milwaukee Cty Behavioral Hlth Div | Milwaukee | 144 | 144 | 108.7 |

| Hospital | County | # beds | # beds staffed | Avg. census |
|---|---|---|---|---|
| Waukesha Cty Mental Hlth Ctr | Waukesha | 28 | 28 | 17.0 |
| **TOTAL OF COUNTY OWNED BEDS** | | **265** | **222** | **165.4** |
| PRIVATELY OWNED HOSPITALS: | | | | |
| Aurora Psychiatric Hsptl | Milwaukee | 85 | 47 | 32.6 |
| Bellin Psychiatric Ctr | Brown | 71 | 47 | 21.7 |
| St Joseph  Hospital Dba Libertas | Brown | 0 | 0 | 0.0 |
| Rogers Mem Hospital Milwaukee | Milwaukee | 0 | 78 | 46.2 |
| Rogers Mem Hsptl | Waukesha | 90 | 90 | 30.0 |
| **TOTAL OF PRIVATE HOSPITAL BEDS** | | **246** | **262** | **130.5** |
| STATE-OWNED HOSPITALS | | | | |
| Mendota Mental Hlth Institute | Dane | 394 | 264 | 255.9 |
| Winnebago Mental Hlth Institute | Winnebago | 295 | 205 | 192.0 |
| **TOTAL OF STATE OWNED BEDS** | | **689** | **469** | **447.9** |
| | | | | |
| **STATEWIDE TOTAL** | | **1200** | **953** | **743.8** |

Note: In the above table, the number of beds (licensed) is based on data from the Division of Quality Assurance - 06/17/2010.  The number of beds staffed and average census is drawn from responses to the 2008 Annual Survey of Hospitals and the Fiscal Year 2008 Hospital Fiscal Survey, and represents each hospital's pages from the Guide to Wisconsin Hospitals, Fiscal Year 2008, Wisconsin Hospital Association Information Center

Note: Some of the hospitals that report beds staffed and avg. census do not have a separate, distinct AODA or psych unit.

# 12. Mental Health Planning and Advisory Councils/Behavioral Health Councils

**Table 10: LIST OF ADVISORY COUNCIL MEMBERS—WISCONSIN COUNCIL ON MENTAL HEALTH (WCMH)**

**Plan Year: 10/01/11 through 06/30/2013**

| Name | Type of Membership | Agency or Organization Represented* | Address Phone & Fax | Email Address (If Available) |
|---|---|---|---|---|
| Jackie Baldwin | Parent | | PO Box 268, 170 Highway 70, St. Germain, WI 54558 (715)605-2097 | mailto:jackiebaldwin@frontier.com |
| Corrie Briggs | Parent | | 91 Amherst Circle, Hudson WI 54016 (715)386-6007 | mailto:corentb@sbcglobal.net |
| Nic Dibble | State Education Representative | Department of Public Instruction | DPI PO Box 7841, Madison WI 53707-7841 (608)266-0963 | mailto:nic.Dibble@dpi.wi.gov |
| Sheryl Gora-Bollum | Provider | | Mail Stop H04-004, 1900 South Ave, La Crosse WI 54601 (608)775-3627 | mailto: slgorabo@gundlath.org |
| Shel Gross | Advocate | | Mental Health America, 133 S. Butler St., Room 330, Madison WI 53703 (608)250-4368 | mailto:shelgross@tds.net |
| Kim Eithun Harshner | State Social Services Agency | Department of Children and Families | Department of Children and Families Child Protective Services, 201 E. Washington Ave, 2nd Floor, PA Box 8916, Madison WI 53708-8916 | mailto:KimEithun@wisconsin.gov |
| Dr. Jerry Halverson | Provider | | 34700 Valley Rd, Oconomowoc, WI 53066 (608)469-8610 | mailto:jlhalverson@rogershospital.org |
| Gary Hamblin | State Department of Corrections | Department of Corrections | Department of Corrections, 3099 E. Washington Ave PO Box 7925 Madison WI 53707-7925 | mailto:garyhamblin@wisconsin.gov |
| Lorinda Krinke | Parent | | 2017 Sherman Ave | mailto:krinkelori@yahoo.com |

**Plan Year: 10/01/11 through 06/30/2013**

| Name | Type of Membership | Agency or Organization Represented* | Address Phone & Fax | Email Address (If Available) |
|---|---|---|---|---|
| | | | #3,<br>Madison WI 53704<br>(608)219-0142 (c)<br>(608)261-0532 | |
| Les Mirkin | State Vocational Rehabilitation Agency | State Vocational Rehabilitation Agency | 4913 Fond Du Lac Trail, Madison WI 53705<br>(608)242-4865 | mailto:Leslie.Mirkin@wisconsin.gov |
| Marlia Moore | State Medicaid Agency | State Medicaid Agency | 3009 Artisan Lane, Madison WI 53713<br>(608)266-9749 | mailto:marli.moore@wisconsin.gov |
| Mary Neubauer | Consumer | | 4570 S. Nicholson Ave #16 Cudahy WI 53110<br>(414)807-6505 | mailto:maryneubauer@aol.com |
| Jo Pelishek | Parent | | 217 W. Knapp Street,<br>Rice Lake WI 54868<br>(715)736-1232 Ext 2 | mailto:JoPelishek@drwi.og |
| Don Pirozolli | Advocate | | 136 Albert Circle Belleville WI 53508<br>(608)515-6907 | mailto:donpirozzoli@aol.com |
| Kathy Roetter | Provider | | 2611 12th Street S Wisconsin Rapids WI 54494<br>(608)715-421-8821 | mailto:kroetter@co.wood.wi.us |
| Joann Stephens | Consumer | | W7897 Eagle Ave Westfield WI 54806<br>(phone NA) | mailto:joann@stablelifeinc.org |
| Sister AnnCatherine Veierstahler | Consumer | | 3601 South 41st Street, Milwaukee WI 53221<br>(414)581-3274 (c) | srann@hopetohealing.com |
| Benita Walker | Consumer | | 1325 E. Johnson St.,<br>Madison WI 53703<br>(608)251-2905 | bswalker@execpcp.com |
| Judy Wilcox | Advocate | | 202 N. Blount St #22<br>Madison WI 53703<br>(608)255-8913 | mailto:judywilcox@charter.net |
| Dona Wrenn | State Housing Agency | Wisconsin Department of Commerce | 201 W. Washington Ave Madison WI 53703<br>(608)264-7625 | mailto:donna.wrenn@wisconsin.gov |
| | | | | |

**Plan Year: 10/01/11 through 06/30/2013**

| Name | Type of Membership | Agency or Organization Represented* | Address Phone & Fax | Email Address (If Available) |
|---|---|---|---|---|
| APPOINTMENT IN PROCESS | | | | |
| Linda Harris | State Mental Health Agency | Division of Mental Health and Substance Abuse Services Department of Health Services | DHS-DMHSAS<br>1 West Wilson Street, Room 850,<br>PO Box 7850<br>Madison WI 53707-7850<br>(608)266-2717 | mailto:Linda.Harris@wisconsin.gov |

*Council members should be listed *only once* by type of membership and agency/organization represented.

# 13. Comment on the State Plan